9.0 RECOMMENDATIONS AND ACTION PLANNING		
Extension of training of the multi-disciplinary team in Knowledge and Understanding Framework (KUF, relates to patients with Personality Disorder) and Skills Training on Risk Management (STORM, re self-harm mitigation and suicide), to include hospital and community based teams. The Review Team recommends that the Heads of Service assess availability of this training and decide a reasonable timeframe for delivery and updates to their teams.	Head of Service Adrian Corrigan & Stephaine Wethers, William Delaney	April 2022

10.0 DISTRIBUTION LIST

In addition to the review team, those who contributed to the review and those allocated recommendations, the following;

Heather Trouton, Interim Director of Mental Health and Disability Services
Jan McGall, Assistant Director of Mental Health Services
Dr Pat McMahon, Associate Medical Director
Aaron Coulter, Community Mental Health Pharmacist
Corporate Governance Department
RQIA
HSCB
NI Coroner

The patient's family

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:	Personal information redacted by HSI	**HSCB Ref Number:**	Personal Information

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**	✓	**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**	✓	**NO**		
	If **YES**, insert **date informed**: 03/02/2021				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	✓	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**)					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	✓	
	If **YES**, insert date informed:				
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:				
	a) Draft review report has been shared and further engagement planned to share final report	✓ **Draft Report Offered**			
	b) Plan to share final review report at a later date and further engagement planned				
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***				

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'I' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2 **INFORMING THE CORONERS OFFICE** **(under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*				
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**	✓	**NO**	
	If **YES**, insert **date informed**: As a SAI 16/11/2020			
	If **NO**, please provide details:			
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	✓
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES** ✓	**NO**	**N/A**	**Not Known**
	If **YES**, insert **date informed**: 03/02/2021			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	**14th March 2022**

[1] *Service User or their nominated representative*

8.0 LESSONS LEARNED

During the SAI review the Review Team identified the below learning:

1) During assessments/appointments there should be clear documentation to state if the patient consented to collateral information being sought. There should be consideration of whether collateral is needed at each assessment.

2) The SAI review team recommends that the following issue is considered in the context of the MHBC review of Waiting List Breach Letters. The patient should be informed on the Breach Letters that if they attend their GP due to a deterioration in their mental health a re-referral can be forwarded to the Trust.

3) Improved communication during joint working. The review team feel it would be beneficial if a patient is involved in multiple services that an update is provided on any urgent missed appointments/assessments. The review team recommend the practitioner due to carry out the appointment/assessment should provide an update to the practitioner/keyworker/RMO from the other Mental Health service involved in the patient's care.

9.0 RECOMMENDATIONS AND ACTION PLANNING

Recommendations	Person(s) Responsible	Timescale/Progress
During assessments / appointments there should be clear documentation to state if the patient consented to collateral information being sought. There should be consideration of whether a collateral is needed at each assessment.	Head of Service Primary Mental Health Stephanie Wethers	Immediate Effect

9.0 RECOMMENDATIONS AND ACTION PLANNING		
The Waiting List Breach Letters should be reviewed and updated to inform the patient of the process if they attend their GP due to a deterioration in their mental health.	Head of Service Primary Mental Health Stephanie Wethers	Within 3 Months
Improved communication during joint working. The review team feel it would be beneficial if a patient is involved in multiple services that an update is provided on any urgent missed appointments/assessments. The review team recommend the practitioner due to carry out the appointment/assessment should provide an update to the practitioner/keyworker/RMO from the other Mental Health service involved in the patient's care.	Head of Service Primary Mental Health Stephanie Wethers	Immediate Effect

PHA/HSCB SAFETY AND QUALITY ALERT (SQA)
3rd LINE OF ASSURANCE TEMPLATE
FOR COMPLETION BY HSC TRUSTS AND OTHER ARMS LENGTH BODIES

The attached Safety and Quality Alert (SQA) is classified as a 3rd Line SQA and requires completion of sections 2 and 3 below by the date specified and forwarded to HSCB at Alerts.HSCB@hscni.net for consideration.

SECTION 1

SQA Title:	**The Safe Use of Ultrasound Gel**	**SQA Ref:**	**HSC SQSD 33/21**
Datix Unique ID:	**Not denoted on the DoH correspondence**	**For Implementation by:**	**14/03/2022**

SECTION 2

Actions required as per SQA	HSC Trust / other ALB Assessment of Compliance - SHSCT			
	If implemented in full by the due date detail the action/s taken	If action only partially implemented by the due date, detail:		
		Reason	Work that is ongoing	Planned completion date
Recommendation 1 Appoint an executive member of staff, supported by clinical leaders, heads of departments (using ultrasound gel) and heads of procurement to oversee the implementation of the actions outlined below	Following receipt of this nPSA the Senior Manager for Standards, Risk and Learning (Medical Directorate) has been working with Trust operational an purchasing colleagues as well as with regional PaLS colleagues to identify all ultrasound products that are being used within the SHSCT and ensure that the alert has been appropriately shared and the appropriate risk control measures are in place to ensure the recommendations outlined in this alert are being adhered to			
Recommendation 2a Review and amend policies, protocols, training and awareness-raising materials to ensure they are aligned to UKHSA guidance for safe use of ultrasound gel, including that: a. **Sterile** ultrasound gel in single use containers is always used: • for invasive procedures if an invasive procedure is likely to be undertaken in the following 24 hours		A review of ordering information (stock, catalogue stock / non stock, Pharmacy) has been reviewed / quality assured to ensure all areas that use sterile ultrasound gel are fully informed of this nPSA and the safety guidance outlined within it. It has taken time to collate all this information with PaLS	The Trust has developed Standard Operating Procedures for implementation within those areas identified as being a user of either sterile or non-sterile ultrasound gel. These documents stipulate the guidance requirements of both the nPSA and the referenced national guidance below:	**30/04/2022**

• in labour where there is high likelihood of C-section or use of invasive instrumentation during delivery • where there is contact with or near to non-intact skin • where the ultrasound examination is near to an indwelling invasive device where there is contact with mucous membranes (sterile gel to be used inside and outside of probe covers), • for severely immunocompromised patients • for all procedures in high-dependency/intensive-care settings including neonatal intensive care units			Good infection prevention practice: using ultrasound gel - GOV.UK (www.gov.uk) Good infection prevention practice using ultrasound gel (khub.net) These documents are currently being approved by the Trust's Infection Prevention and Control team. Once approved these will be shared with the relevant service managers for review / tailoring to their specific clinical requirements. A staff awareness raising programme will be undertaken once these procedures are implemented within the relevant services.	
Recommendation 2b For **non-sterile** ultrasound gel used outside of the indications above, ensure only pre-filled disposable (i.e. non-refillable) bottles or single-use sachets are used		A review of ordering information (stock, catalogue stock / non stock, Pharmacy) has been reviewed / quality assured to ensure all areas that use sterile ultrasound gel are fully informed of this nPSA and	The Trust has developed Standard Operating Procedures for implementation within those areas identified as being a user of either sterile or non-sterile ultrasound gel.	**30/04/2022**

		the safety guidance outlined within it. It has taken time to collate all this information with PaLS	These documents stipulate the guidance requirements of both the nPSA and the referenced national guidance below: Good infection prevention practice: using ultrasound gel - GOV.UK (www.gov.uk) Good infection prevention practice using ultrasound gel (khub.net) These are currently being approved by the Trust's Infection Prevention and Control team for onward sharing the relevant service managers for review / tailoring to their specific clinical requirements. A staff awareness raising programme will be undertaken once these procedures are implemented within the relevant services.	

Recommendation 3 Cease using large containers of ultrasound gel intended for decanting: a. dispose of any containers in use, as well as the bottles decanted into b. remove any such bottles or containers from storage and clinical areas c. amend purchasing systems so that these products cannot be purchased		A review of ordering information (stock, catalogue stock / non stock, Pharmacy) has been completed and all areas using 5L canisters of non sterile gel have been identified – this has taken time to complete. Alternative Ultrasound gel products have been identified and Suppliers / Dispensing areas have confirmed supply and demand can be met.	Work is ongoing to ensure a transition programme is in place to ensure the practice of decanting non sterile gel into bottles is ceased. Supporting SOPs clearly stipulate that this practice must not be undertaken Liaison with Purchasing (SHSCT) and PaLS has been undertaken so that when the transition away from the 5L canisters (T014) is complete, a block on future SHSCT orders by e-procurement will be requested	30/04/2022

SECTION 3

To: Health and Social Care Board (HSCB) Mailbox at Alerts.HSCB@hscni.net

I confirm that the designated senior manager/s have been advised of this response and are content that it should be submitted to the HSC Board.

Signed:	Personal Information redacted by the USI
Name and Designation of person submitting response:	Caroline Beattie Senior Manager – Standards, Risk and Learning
Name of HSC Trust or other ALB:	SHSCT
Date:	14/03/2022

Southern Health and Social Care Trust

Medical Directorate

Memorandum

To:	Operational Directors, Divisional Medical Directors, Governance Co-Ordinators
c.c.	Stephen Wallace, AD Systems Assurance; Dr D Gormley, DMD; Fiona Davidson, Head of Clinical Audit
From:	Dr Maria O'Kane , Medical Director
Date:	7th March 2022
Subject:	**Participation in National Audits Programme 2022-2023**

Dear Colleagues,

Please see below, the embedded list of 2022-2023 National Clinical Audit and Clinical Outcome Review Programmes, produced by the Healthcare Quality Improvement Partnership UK (HQIP) and NHS England. This excel template details a suite of **71** National Audits for consideration by the Trust to participate over the next year. (NSHSE-QA-List-2022-23-FinalDecember2021.pdf (hqip.org.uk).

The list has already been pre-circulated as part of the weekly governance de-brief paper and shared via Divisional Medical Director monthly meetings.

I now ask that you complete an excel template identifying:

1. The relevant HQIP National Audits that your directorate / divisions intend to participate in during 2022-23. Some of these are continuous audit programmes that we submit to, year on year.
2. The name(s) of the locally identified SHSCT clinical audit lead.

HQIP audit programme 2022-20

Please return completed spreadsheet to [redacted] by **Monday 28th March 2022**.

Regards,

Dr Maria O'Kane
Medical Director

National Audit Programme 2022-23

This Programme is defined by the Healthcare Quality Improvement Partnership UK (HQIP) and NHS England.

No.	National Clinical Audit and Clinical Outcome Review Programme	Host Organisation	Trust Participation? Y / N / N/A	Reason If No / NA	Clinical Audit Lead (if identified)	ACUTE	CYP	MHD	OPPC
1	Breast and Cosmetic Implant Registry	NHS Digital							
2	Case Mix Programme (CMP)	Intensive Care National Audit & Research Centre (ICNARC)							
3	Child Health Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)							
4	Cleft Registry and Audit NEtwork (CRANE)	Clinical Effectiveness Unit of The Royal College of Surgeons of England							
5	Elective Surgery (National PROMs Programme)	NHS Digital							
6	Emergency Medicine QIP - **Pain in Children**	Royal College of Emergency Medicine							
7	Emergency Medicine QIP - **Assessing for Cognitive Impairment in Older People**	Royal College of Emergency Medicine							
8	Emergency Medicine QIP - **Mental Health (self-harm)**	Royal College of Emergency Medicine							
9	Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People	Royal College of Paediatrics and Child Health (RCPCH)							
10	Falls and Fragility Fracture Audit Programme (FFFAP) - **Fracture Liaison Service Database**	Royal College of Physicians (RCP)							
11	Falls and Fragility Fracture Audit Programme (FFFAP) - **National Audit of Inpatient Falls**	Royal College of Physicians (RCP)							
12	Falls and Fragility Fracture Audit Programme (FFFAP) - **National Hip Fracture Database**	Royal College of Physicians (RCP)							
13	Gastro-intestinal Cancer Audit Programme (GICAP) **National Bowel Cancer Audit**	Royal College of Surgeons (with project management subcontracted to NHS Digital)							
14	Gastro-intestinal Cancer Audit Programme (GICAP) **National Oesophago-gastric Cancer Audit**	Royal College of Surgeons (with project management subcontracted to NHS Digital)							
15	Inflammatory Bowel Disease Audit	IBD Registry							
16	LeDeR - learning from lives and deaths of people with a learning disability and autistic people *(Previously known as Learning Disabilities Mortality Review Programme)*	NHS England							

No.	National Clinical Audit and Clinical Outcome Review Programme	Host Organisation	Trust Participation? Y / N / N/A	Reason If No / NA	Clinical Audit Lead (if identified)	ACUTE	CYP	MHD	OPPC
17	Maternal, Newborn and Infant Clinical Outcome Review Programme	MBRRACE-UK led from the University of Oxford							
18	Medical and Surgical Clinical Outcome Review Programme	National Confidential Enquiry into Patient Outcome and Death (NCEPOD)							
19	Mental Health Clinical Outcome Review Programme	National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), University of Manchester							
20	Muscle Invasive Bladder Cancer at Transurethral REsection of Bladder Audit (MITRE) *Work streams previously listed under Urology Audits. Listed A-Z here to correlate with NHSE OA List 22/23*	British Association of Urological Surgeons							
21	National Adult Diabetes Audit (NDA) - **National Diabetes Core Audit**	NHS Digital							
22	National Adult Diabetes Audit (NDA) - **National Diabetes Foot care Audit**	NHS Digital							
23	National Adult Diabetes Audit (NDA) - **National Diabetes Inpatient Safety Audit**	NHS Digital							
24	National Adult Diabetes Audit (NDA) - **National Pregnancy in Diabetes Audit**	NHS Digital							
25	National Asthma and COPD Audit Programme (NACAP) - **Adult Asthma Secondary Care**	Royal College of Physicians (RCP)							
26	National Asthma and COPD Audit Programme (NACAP) - **Chronic Obstructive Pulmonary Disease Secondary Care**	Royal College of Physicians (RCP)							
27	National Asthma and COPD Audit Programme (NACAP) - **Paediatric Asthma Secondary Care**	Royal College of Physicians (RCP)							
28	National Asthma and COPD Audit Programme (NACAP) - **Pulmonary Rehabilitation Organisational and Clinical Audit**	Royal College of Physicians (RCP)							
29	National Audit of Breast Cancer in Older Patients (NABCOP)	Clinical Effectiveness Unit of the Royal College of Surgeons of England							
30	National Audit of Cardiac Rehabilitation	University of York							
31	National Audit of Cardiovascular Disease Prevention *Primary care*	NHS Benchmarking Network	Not Applicable to SHSCT						
32	National Audit of Care at the End of Life (NACEL)	NHS Benchmarking Network							

No.	National Clinical Audit and Clinical Outcome Review Programme	Host Organisation	Trust Participation? Y / N / N/A	Reason If No / NA	Clinical Audit Lead (if identified)	ACUTE	CYP	MHD	OPPC
33	National Audit of Dementia	Royal College of Psychiatrists							
34	National Audit of Pulmonary Hypertension	NHS Digital							
35	National Bariatric Surgery Register	British Obesity and Metabolic Surgery Society							
36	National Cardiac Arrest Audit (NCAA)	Intensive Care National Audit and Research Centre (ICNARC) / Resuscitation Council UK (RCUK)							
37	National Cardiac Audit Programme (NCAP) - **National Congenital Heart Disease**	Barts Health NHS Trust							
38	National Cardiac Audit Programme (NCAP) - **Myocardial Ischaemia National Audit Project**	Barts Health NHS Trust							
39	National Cardiac Audit Programme (NCAP) - **National Adult Cardiac Surgery Audit**	Barts Health NHS Trust							
40	National Cardiac Audit Programme (NCAP) - **National Audit of Cardiac Rhythm Management**	Barts Health NHS Trust							
41	National Cardiac Audit Programme (NCAP) - **National Audit of Percutaneous Coronary Interventions**	Barts Health NHS Trust							
42	National Cardiac Audit Programme (NCAP) - **National Heart Failure Audit**	Barts Health NHS Trust							
43	National Child Mortality Database (NCMD)	University of Bristol							
44	National Clinical Audit of Psychosis (NCAP)	Royal College of Psychiatrists							
45	National Early Inflammatory Arthritis Audit	British Society for Rheumatology							
46	National Emergency Laparotomy Audit (NELA)	Royal College of Anaesthetists							
47	National Joint Registry	Healthcare Quality Improvement Partnership (HQIP)							
48	National Lung Cancer Audit	Royal College of Surgeons of England (since 1 February 2022 and previously Royal College of Physicians)							
49	National Maternity and Perinatal Audit (NMPA)	Royal College of Obstetricians and Gynaecologists (RCOG)							
50	National Neonatal Audit Programme (NNAP)	Royal College of Paediatrics and Child Health (RCPCH)							

No.	National Clinical Audit and Clinical Outcome Review Programme	Host Organisation	Trust Participation? Y / N / N/A	Reason If No / NA	Clinical Audit Lead (if identified)	ACUTE	CYP	MHD	OPPC
51	National Ophthalmology Database Audit (NOD)	Royal College of Opthamologists							
52	National Paediatric Diabetes Audit	Royal College of Paediatrics and Child Health (RCPCH)							
53	National Perinatal Mortality Review Tool	MBRRACE-UK led from the University of Oxford							
54	National Prostate Cancer Audit (NPCA)	Royal College of Surgeons of England							
55	National Vascular Registry	Royal College of Surgeons of England							
56	Neurosurgical National Audit Programme	Society of British Neurological Surgeons							
57	Out of hospital cardiac outcomes (OHCAO)	University of Warwick							
58	Paediatric Intensive Care Audit Network (PICANet)	Universities of Leeds and Leicester							
59	Perioperative Quality Improvement Programme (PQIP)	Royal College of Anaesthetists							
60	Prescribing Observatory for Mental Health - **Improving the quality of valproate prescribing in adult mental health services**	Royal College of Psychiatrists							
61	Prescribing Observatory for Mental Health - **The use of melatonin**	Royal College of Psychiatrists							
62	Renal Audits - **National Acute Kidney Injury Audit** *Previously listed under Chronic Kidney Disease Registry and/or UK Renal Registry*	UK Kidney Association							
63	Renal Audits - **UK Renal Registry Chronic Kidney Disease Audit** *Previously listed under Chronic Kidney Disease Registry and/or UK Renal Registry*	UK Kidney Association							
64	Respiratory Audits - **Adult Respiratory Support Audit**	British Thoracic Society							
65	Respiratory Audits - **Smoking Cessation Audit- Maternity and Mental Health Services**	British Thoracic Society							
66	Sentinel Stroke National Audit Programme (SSNAP)	King's College London							
67	Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Serious Hazards of Transfusion (SHOT)							
68	Society for Acute Medicine Benchmarking Audit (SAMBA)	Society for Acute Medicine							

No.	National Clinical Audit and Clinical Outcome Review Programme	Host Organisation	Trust Participation? Y / N / N/A	Reason If No / NA	Clinical Audit Lead (if identified)	ACUTE	CYP	MHD	OPPC
69	Trauma Audit & Research Network (TARN)	The Trauma Audit & Research Network (TARN)/University of Manchester							
70	UK Cystic Fibrosis Registry	Cystic Fibrosis Trust							
71	UK Parkinson's Audit	Parkinson's UK							

Southern Health and Social Care Trust

Quality Care - for you, with you

Safety, Quality & Experience South

WORKING TOGETHER

A strategy to ensure the best possible patient experience through involvement and improvement





Southern Health and Social Care Trust **2022-25**

Working together | Excellence | Openness & Honesty | Compassion

Contents

Foreword

As a wellbeing organisation, the Trust embraces the need for strategy and actions to increase emphasis on improving the **safety, quality and experience** of our services for our service users. (SU)

We are delighted to share with you the Patient Experience Strategy of the Southern Health and Social Care Trust.

This strategy has been co-produced with a wide range of stakeholders including patients, carers and staff over a period of time. We are very grateful to all for their enthusiastic participation in its creation.

The Trust has a recognised history of working closely with our public to improve both public and patient involvement in service design and in seeking new ways of hearing our patients' voice and improving services in response. However we have more to do and this strategy sets our vision, aims, objectives, values, and plans to continue improving experience across a wide range of services.

The strategy sets out how we can further integrate the work of our Patient Experience team, our Patient Public Involvement team, our Quality improvement team and our feedback through complaints and compliments to really focus on strengthening and widening how we actively hear and respond to our service users to really improve services.

As a Trust we are fully committed to supporting our excellent staff to deliver this vitally important strategy. We will work in partnership with all who deliver and use our services to listen and improve at all interfaces across Acute, Children's and Young Peoples services, Mental Health and Learning Disability services and Older People and Community services and across all staff groups.

We look forward to achieving the objectives we have set and meeting the needs of those who use our services.

Personal Information redacted by the USI

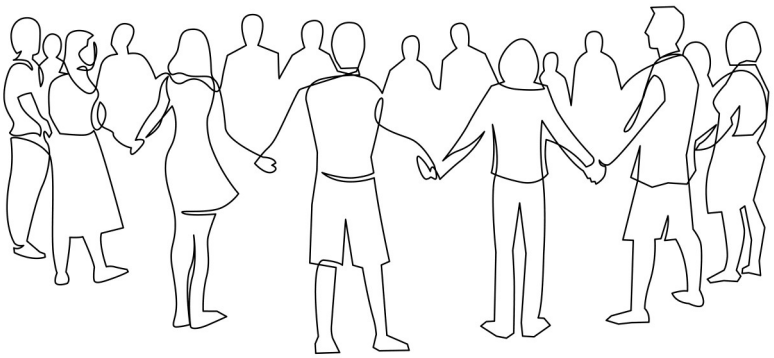
Heather Trouton, Executive Director of Nursing, Midwifery and AHP's

John Wilkinson, Non Executive Director

Introduction

The Southern Health and Social Care Trust (Southern Trust) in Northern Ireland provides acute and community health and social care services to a population of some 373,000 adults and children living in the council areas of Armagh City, Banbridge and Craigavon, Mid Ulster (Dungannon and South Tyrone localities) and Newry, Mourne and Down (Newry and Mourne localities).

The Trust recognises that the future success of health and social care is dependent on effective partnerships and our ability to work together providing system leadership and collective ownership of the outcomes we achieve.



Our Vision and Values

The Strategy is underpinned by the Trust's strategic vision, values and objectives

Our **VISION** is simply articulated in our existing 'strapline':

'Quality Care - for you, with you'

Our vision encompasses our core commitment to deliver safe, high quality care that is co-produced and co-designed in partnership with service users and staff

Our **VALUES** can shape everything we do, every single day. They are visible in every interaction we have each with other, our patients, their families and our partners. The behaviours associated with our values define 'how' we are expected to approach our work and sit alongside 'what' we do and the attitudes and approaches we take to work.

Working together - We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all

Excellence - We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high quality, compassionate care and support.

Compassion - We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.

Openness and Honesty - We are open and honest with each other and act with integrity and candour.

These values will enable us to make it easy for our patients and service users to be real partners, allowing us to work together, valuing and maximising their lived experience. They will help us ensure that we are compassionate, open and honest and listen to understand, taking action to make things even better in response to what we have heard. We want this approach to become second nature to us in everything we do.

There are a range of other values and approaches key to the success of this strategy some of which are displayed below

Our OBJECTIVES are:

- Being a great place to work - supporting, developing and valuing our staff
- Making the best use of our resources
- Improving our services
- Supporting people to live long, healthy and active lives
- Promoting safe, high quality care
- Working in Partnership

We have a strong history of delivering effective community development approaches and of engaging and involving patients, clients and carers. This has been recognised both locally and across the region as being exemplary and influential in the development of systems, processes, resources and learning to support the strategic positioning and practical implementation of service user involvement and co-production methods across the health and social care system.

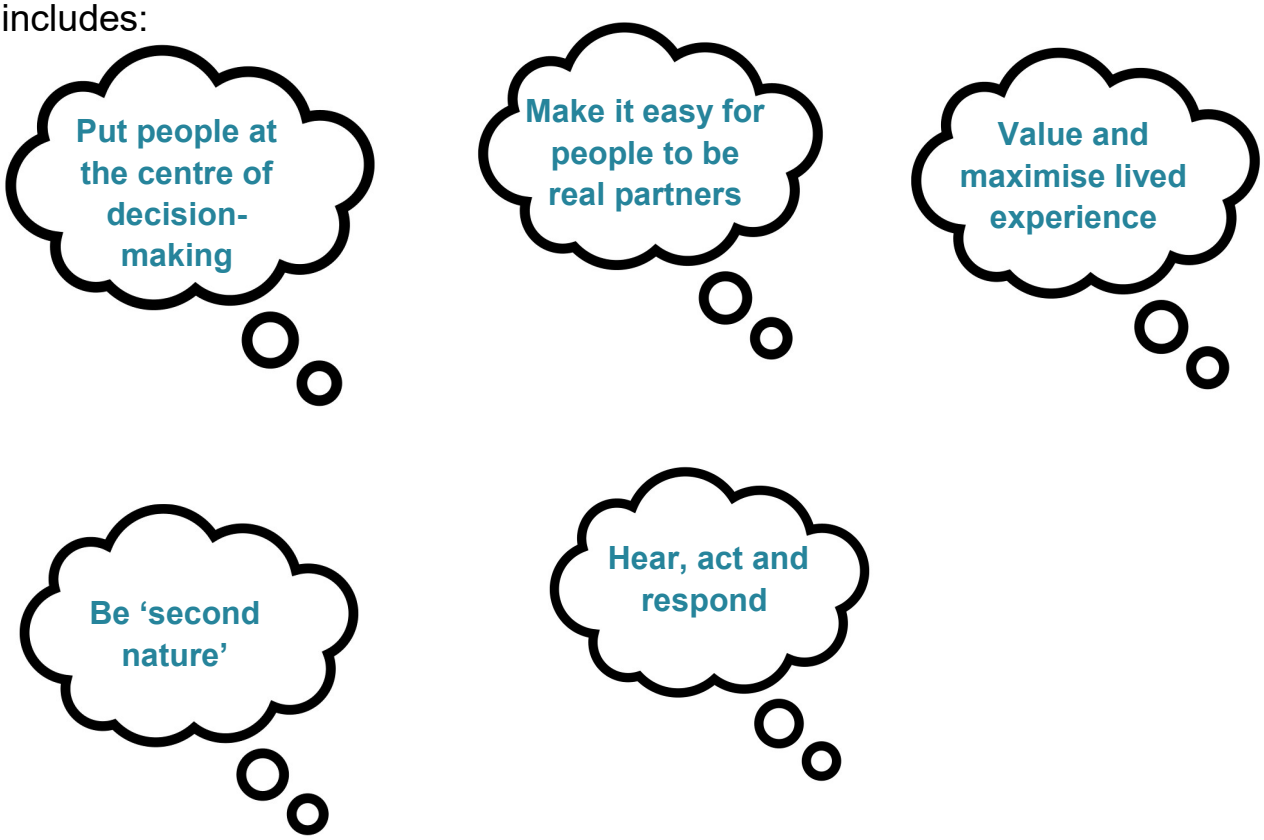
We are proud of the approaches that we have embedded across our organisation to ensure that engagement, involvement and co-production are part of the working practice of our staff and that service users, carers and other stakeholders are involved in the development of the mechanisms, processes, training and resources to embed this.

Building on these successes, and recognising the need to continually challenge our effectiveness, the Trust has produced this strategy to ensure that we are achieving greater integration in our vision for and approach to Patient and Client Experience (PCE), Personal and Public Involvement (PPI), Quality Improvement (QI) and Clinical and Social Care Governance.

Why involvement and collaboration matters

Involvement enables people to voice their views, needs and wishes and to contribute to plans, proposals and decisions about services.

This includes:

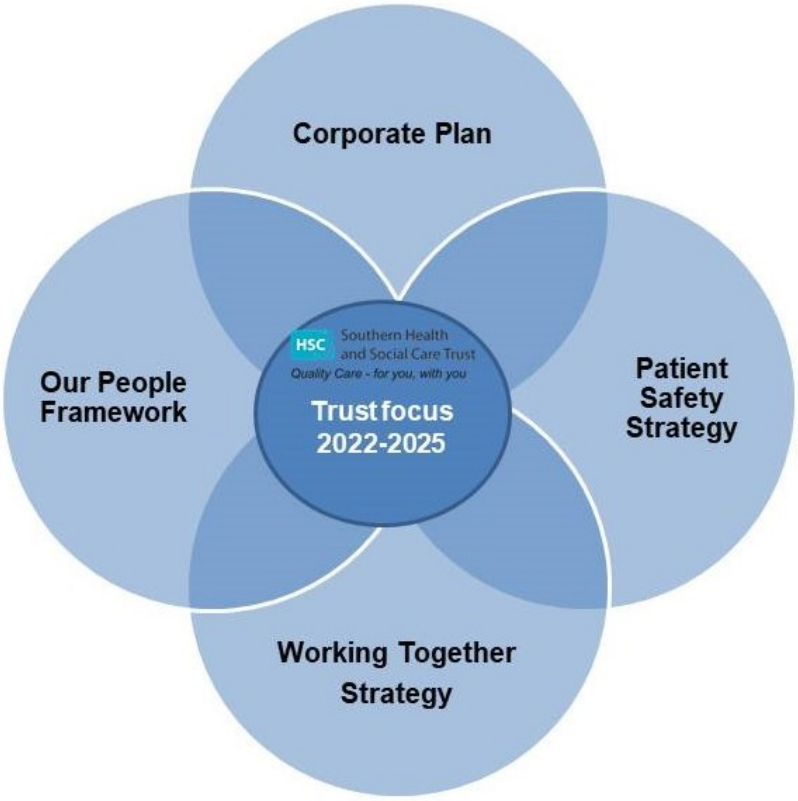


Collaboration in the health and social care system is about working together to improve services, experiences and outcomes.

We want to continuously involve and collaborate with our patients and service users, not just because there is a legal requirement to do so (Appendix 1), but even more importantly because it is the right thing to do.

Involvement and collaboration will enhance the quality and safety of our services and care, improve outcomes and support the Trusts reputation. It will also deliver on the key objectives of the Health and Wellbeing 2026 – Delivering Together Strategy. Evidence shows that improving patient experience can reduce the cost of care which provides better value for money.

It is anticipated that this strategy will be implemented in conjunction with our Patient Safety and Corporate Strategies. A key enabler to these strategies is 'Our People' Framework which focuses on transforming our culture in order to transform our care. The implementation of these strategies will be supported through the application of a quality improvement approach.



Stakeholders

This strategy is applicable to:

Our involvement journey

The Trust commenced the process of developing an integrated organisational strategy to incorporate Personal and Public Involvement and Co-production, Patient and Client Experience, Quality Improvement and Clinical and Social Care Governance in 2019/2020.

A desktop review of Patient Experience strategies and action plans was undertaken.

An engagement workshop was held with key stakeholders including service leads, patients and service user representatives in January 2020.

In November 2020, a series of 3 engagement work shops were hosted by the Trust.

Participants included, service users and carers, service leads, front line staff and support staff, patients, Patient Client Council, Community and Voluntary Sector Organisations, the Chief Executive and Directors and Non Executive Directors.

A further three co production workshops took place between February and April 2021 to write the strategy document.

These were independently facilitated by the HSC Leadership Centre and involved a smaller group of service user representatives and staff.

The Trust consulted on the draft strategy. It was shared with all who participated in the workshops, community and voluntary groups and all staff through both operational and professional lines.

How will we hear?

Care Opinion
What's your story?

Patient and Client Council

TEN THOUSAND VOICES

Our Strategic Objectives

To successfully embed service user and carer involvement and feedback at all levels of the organisation, to improve services for our users, this strategy sets out a range of objectives and commitments. An Action Plan for Year 1 will be progressed to deliver on these (Appendix 2). The action plan will be reviewed and updated on an annual basis.

1. Work together to listen and improve

To achieve this we will:

Establish a Care Experience Hub (forum)

Develop an annual plan of service improvement based on patient feedback

Proactively increase and support service user involvement at all levels, including specialist interest groups

Promote inclusivity equality and diversity and increase the involvement of underrepresented groups

Undertake an annual PCE review

2. Train and learn for improvement

To achieve this we will:

Engage service users and staff to find out what skills and knowledge they need to improve Service User involvement and response to feedback

Implement a training plan to meet needs for both staff and service users

Share learning from innovation and best practice to drive improvements across services

3. Keep everyone informed

Use a range of media and other approaches to ensure that we are communicating in an open and timely way, the developments that support the achievement of our objectives.

To achieve this we will:

Use a range of media and other approaches to communicate developments and learning e.g. Face book , twitter , local newspapers, User Involvement Panel, Community and Voluntary sector and partner organisations

Southern I and Intranet for internal communication

Care Opinion as direct patient feedback

Annual PCE Improvement report

How will we know we have succeeded?

Measuring Outcomes

- We will provide evidence of improvement in response to service user and carer involvement and feedback through integrated reporting.
- Our annual improvement report will evidence change.
- Care Opinion will be used extensively in all services with changes made in response to feedback.
- We will see an improvement in our annual PCE surveys.
- Our service users will be a natural and core part of Care Experience hubs.

A range of performance indicators will be used to populate a dashboard to evidence progress against this strategy, refer to Appendix 3.

References

Donaldson, L. (2014) The Right Time, The Right Place, Department of Health: Belfast.

Department of Health (2011) Quality 2020 - a ten year strategy to protect and improve quality in health and social care in Northern Ireland, Department of Health: Belfast.

Department of Health (2017) Health and Wellbeing 2026 - Delivering Together, Department of Health: Belfast.

Department of Health (2018) Co-Production Guide for Northern Ireland - Connecting and Realising Value Through People, Department of Health: Belfast.

Department of Health Social Services and Public Safety (2009) Improving the Patient & Client Experience, Department of Health Social Services and Public Safety: Belfast.

Health & Social Care Board and Department of Health (2017) Attributes Competency Assessment Tool, Department of Health: Belfast.

Appendix 1

Effective involvement is a priority outlined in the Department of Health's (DOH) Health and Wellbeing 2026 – Delivering Together Strategy. Personal and Public Involvement has been a statutory requirement since 2009 and has been further enhanced by the DOH Co-production Guidelines which were published in 2018.

Patient and Client Experience standards have been in place since 2009. During 2011, the Department for Health published 'Quality 2020' - a ten year strategy designed to protect and improve quality in health & social care services across Northern Ireland. This Strategy saw the introduction of the Attributes Framework, which was introduced to assist individuals to assess their attributes for leadership of quality & safety and to support organisations to build capability and capacity of the workforce to lead initiatives which would enhance the provision of safe, high quality services.

Until 1998, there had never been a framework to progress quality and patient safety in the NHS. From that time, a comprehensive approach was introduced with standards set by the National Institute for Clinical Excellence and in National Service Frameworks, a programme of clinical governance to deliver assurance and improvements at local level backed up by a statutory duty of quality, and inspection of standards and clinical governance arrangements. In 2014 the Donaldson Report made a series of recommendations in respect of governance including the need to have systems and processes in place to review and act on system wide data and the need to strengthen the patient's voice.

In August 2018, the Chief Nursing Officer for Northern Ireland asked Trusts to create an integrated partnership plan which builds on and harmonises existing Personal and Public Involvement, Co-production and patient experience work. Within the Southern Trust, this has been extended to include Patient & Client Experience, Personal and Public Involvement and Co-production, Quality Improvement and Clinical and Social Care Governance.

Appendix 2: Year 1 (2022-2023) Action plan

Year 1 (2022-2023) Action plan			
Work together to listen and improve			
Objective and commitments	**Actions**	**Lead**	**Timeframe**
Establish a Care Experience Hub	Identify directorate leads Identify Service User representatives Identify representatives from PPI, QI, CSCG and PCE Set terms of reference and frequency of meetings	Head of Service for PCE and N&M QI and Head of Community Development and User Involvement	End of Q 1
Develop an annual plan of service improvement based on patient feedback	Develop a Directorate Quality, Involvement & Experience Plan template Directorates to identify	Care Experience Hub Directorates leads/SMTs	Template developed by end of Q 1, for reporting 6 monthly thereafter

	priorities and include in directorate plan Monitor progress against plan		
Proactively increase and support service user involvement at all levels, including specialist interest groups	Establish baseline of numbers of service users involved and the number of opportunities for involvement across the Trust	Head of Community Development and User Involvement	Baseline by end Q 1
	Develop and implement a registration process for new service users		Registration process in action end Q 1
	Develop a database of opportunities for involvement in line with Directorate action plans		Database developed by end of Q 1
	Develop and implement a recruitment plan to include a social media campaign		Recruitment plan completed and implementation commenced in Q 1
	Develop and implement a training schedule for newly registered service users		Training schedule completed and implementation commenced in Q 1
	Develop and implement a support structure and process for service users		Support structure developed and implementation commenced in Q 1

	Facilitate the alignment of Service Users to Directorate Working Groups		Baseline by end Q 1
Promote inclusivity equality and diversity and increase the involvement of underrepresented groups	Develop and implement a recruitment, training and support plan to include a targeted approach towards underrepresented groups	Head of Community Development and User Involvement Head of Equality	Recruitment, training and support plan completed and implementation commenced in Q 1
Undertake an annual PCE survey	Consider content and scope of survey Agree format with PCE Steering Group/Committee	Head of Service for PCE and N&M QI in conjunction with Care Experience Hub	Report on progress end Q 2 Full report in Q 4

Train and learn for improvement			
Objective and commitments	**Actions**	**Lead**	**Timeframe**
Engage service users and staff to find out what skills and knowledge they need to improve SU involvement and response to SU feedback	Undertake a Training Needs Analysis	Care Experience Hub	End Q 2
Implement a training plan to meet needs both for staff and service users	Directorates to prioritise training needs Establish links with training providers Monitor uptake of training	Care Experience Hub	Report on progress end Q 3
Share learning from innovation and best practice to drive improvements across services	Hub will identify learning and best practice for sharing Establish links with Learning From Experience Forum Input learning into central learning repository	Care Experience Hub	End Q 3

Keep everyone informed			
Objective and commitments	**Actions**	**Lead**	**Timeframe**
Use a range of media and other approaches to communicate developments and learning	Hub will identify learning and best practice for sharing Engage with communications to agree approach and communication plan	Care Experience Hub and Communications Team	Q 1
Southern I and Intranet for internal communication	Hub will identify learning and best practice for sharing Engage with communications to agree approach and communication plan	Care Experience Hub and Communications Team	Q 1
Care Opinion as direct patient feedback	Care Opinion will continue to be promoted with patients and staff	Care Experience Hub and Head of Service for PCE and N&M QI	Q 1
Annual PCE Improvement report	Identify and collate themes and improvements for inclusion in the annual report	Care Experience Hub	Q 4

Monitoring and reporting			
Objective and commitments	**Actions**	**Lead**	**Timeframe**
A baseline Patient Experience and Involvement Survey will be undertaken	Develop survey content and online delivery method Survey 'go live' for 4 weeks, accompanied by social media campaign Collate results and compile report	Care Experience Hub	Q 2
Integrated reports will be produced for PCE Steering Group and Committee	Draft template for review by relevant directors and director responsible for PCE Complete report in conjunction with Care Experience Hub	ADs (PPI, QI, CSCG and PCE)	Q 1

Appendix 3 – Performance Indicators

Performance Indicators	Reporting Method
1. An annual Patient Experience and Involvement Survey will be undertaken	PCE Steering Group/Committee
2. The number of stories received through Care Opinion will be monitored on a monthly/quarterly basis.	Quarterly report to PCE Steering Group/Committee
3. The % of patients satisfied with their recent experience will be monitored by analysis of the criticality scores	Quarterly report to PCE Steering Group/Committee
4. Response rates to stories will be measured in line with regional direction (response within 7 working days) Target is 90%	Quarterly report to PCE Steering Group/Committee
5. A minimum of 5 changes per directorate per annum will be made in response to feedback which highlights areas for learning and improvement	Quarterly report to PCE Steering Group/Committee
6. Positive themes in Care Opinion stories will be aligned with regional reporting on compliments	Quarterly return of all positive compliments within Care Opinion stories submitted to Corporate Complaints
7. Analysis of themes and areas for learning and improvement will be undertaken in collaboration with corporate governance/QI/PPI/PCE so that themes and trends can be identified on a quarterly basis.	Quarterly report to PCE Steering Group/Committee
8. A minimum of 12 sessions of Care Opinion Responder training will be delivered yearly	Quarterly report to PCE Steering Group/Committee
9. Changes and improvements will be communicated to patients/staff/service users	Quarterly report to PCE Steering Group/Committee
10. 10,000 More Voices action plans will be progressed	Quarterly report to PCE Steering Group/Committee

11. Estates will undertake a minimum of 5 initiatives per year in response to user feedback	Quarterly report to PCE Steering Group/Committee
12. The number of complaints received within the top 3 most frequent subject areas will reduce	Quarterly report to PCE Steering Group/Committee
13. Where learning and / or service improvements have been identified as necessary through the investigation of a complaint, changes will be implemented.	Quarterly report to PCE Steering Group/Committee
14. The Service User Quality Improvement Award Programme will run twice yearly to build quality improvement capacity and capability among our service users	Quarterly report to PCE Steering Group/Committee
15. The Quality Improvement Team will support directorate leads to undertake improvements based on service user feedback within their areas.	Quarterly report to PCE Steering Group/Committee
16. A baseline of the numbers of service users involved and opportunities for involvement across the Trust will be produced in quarter 1, Year 1	Report at PCE Steering group and committee
17. Increase by 20% per year the number of service users registered as being involved in service planning/developments	Report at PCE Steering group and committee
18. Increase by 20% per year the number of opportunities for service user involvement across the Trust	Report at PCE Steering group and committee
19. Increase by 20% the number of staff and service users to have completed PPI training at each of the 3 levels	Report at PCE Steering group and committee

Willis, Lisa

From: Trouton, Heather
Sent: 06 June 2012 15:21
To: Brown, Robin
Cc: Mackle, Eamon; Reid, Trudy; Corrigan, Martina
Subject: Urology Job plans

5 Plans

Follow Up Flag: Follow up
Flag Status: Flagged

Robin

Following our discussion this am, I have asked Martina to send you a copy of all 5 job plans in the team job plan for Urology Team South.

I have spoken to Eamon this afternoon re the issues that Aidan and Michael have raised re changing their minds about evening theatre sessions.

Would it be possible for you to review the job plans as is and see if you think they are reasonable, And secondly see if there is any way that Aidan and Michael could be facilitated with 9-5pm sessions so that they would not have to do evening sessions. None of us have any wish to impose something that they would not be comfortable with, albeit that when first raised they were very happy with the evening sessions and it was only Mehmood that did not want to move to evening theatre work.

I am conscious that we are interviewing next week based on the job plans advertised but would be really grateful if you could have a look.

Thanks
Heather

Willis, Lisa

From: Trouton, Heather
Sent: 20 February 2013 17:44
To: Rankin, Gillian
Subject: RE: Urology job plans

Follow Up Flag: Follow up
Flag Status: Flagged

Gillian

Martina has gone through these. She is happy with the capacity of outpatients and theatre to meet the SBA agreed. However there are other aspects which need further clarification , eg one consultant being given every Monday morning to Triage and 5 consultants attending a grand ward round on Thursday am and 5 consultants going to the MDT Thursday pm.

At this point in time Robin is also going through with the other consultants as he advises they were not signed up to same.

We are not currently keeping process back but will keep on top of same.

Heather

From: Rankin, Gillian
Sent: 18 February 2013 17:22
To: Trouton, Heather
Subject: Urology job plans

Heather,

Would you update me on progress in assessing activity to be delivered in urology job plans before we go to advert? Conscious we said we would do inside 2 weeks Thanks, Gillian

Willis, Lisa

From: Mackle, Eamon
Sent: 27 February 2013 17:30
To: Corrigan, Martina; Brown, Robin
Cc: Trouton, Heather
Subject: RE: Urology job plans

Follow Up Flag: Follow up
Flag Status: Flagged

Hi Robin

Thanks for all the work you have done in respect of the Urology Job plans. I know Michael is very keen to advertise the post but until the job plans are agreed it will not be possible to do so. I am conscious therefore that the steps as laid out in your summary could introduce a further delay if the principles discussed and agreed with the Urologists, over almost 2 years of Monday evening meetings, have not been followed in the proposed job plans. Therefore, to avoid any unnecessary delays, could you forward them to me to check before they go to the urologists for signing.

Many thanks

Eamon

From: Corrigan, Martina
Sent: 27 February 2013 11:08
To: Brown, Robin
Cc: Trouton, Heather; Mackle, Eamon
Subject: RE: Urology job plans

Dear Robin,

As you will be aware Michael and I have been working through the figures in respect to the activity required to be delivered by the Urology Team through their job plans. There has been a few tweaks and these have now been made with Zoe and Malcolm. I know from Michael that there has been some verbal discussions with the other urologists about the job plans but I was wondering if there is full sign off from them on what is now the nearly completed version. Heather has advised that you were going to speak with the rest of the team in respect to this and I was wondering if you have had the opportunity to do this as I will need to send out the assumptions of what the clinics etc. will look like once these have been signed off as I think this is important that the urologists know what they are signing up to in terms of volumes expected from them in their clinics. I don't want to send these assumptions to the rest of the team until I know that you have talked to them. (I have included these assumptions below).

I also know that Michael is anxious to get the 5th post to the specialty advisor over the next day or so as Patrick Keane is going on 2 weeks annual leave. I also know that Michael has spoken to him and that he has said that he will not pass the job if it is over 10 PA's and that it has 2 SPA's included in it, so Michael has asked Zoe/Malcolm to take out a few clinics to show this, whilst Michael has said that it is only temporary and once we would appoint we could negotiate to have this added back in I am not happy about this in case whoever we appoint won't agree to the clinics being added back in and this will mean we will definitely not meet the required activity agreed with the Board, to me it may make more sense to take out e.g. grand ward round or MDT which would be easier to put back in.?

ASSUMPTIONS ON WHAT NEEDS TO BE INCLUDED IN CLINICS IN ORDER TO DELIVER THE AGREED ACTIVITY

Willis, Lisa

From: Young, Michael
Sent: 04 March 2013 12:31
To: Mackle, Eamon
Cc: Corrigan, Martina; Trouton, Heather; Brown, Robin
Subject: urology

Follow Up Flag: Follow up
Flag Status: Flagged

Eamon

Thank you for your remarks. Although not actually stated, I would assume that most might interpret, from the length and content, that you neither support the new post nor the whole urology team plan. This is disappointing as considerable in-depth thought has been put into the whole process.

The Trust, several years ago, defined activity levels with the DoH. This indeed relates to the monday evening meetings held by the Trust, to which you refer. The outcome was clearly acknowledged in terms of outpatient clinics required to meet DoH requests as well as theatre and day surgery sessions. In summary, this was 11 clinics and 9 theatre sessions per week with each consultant doing 0.5 dsu per week.

The job plans recently presented for the team delivers on average 2.5 clinics per week per consultant, as near as the Trust can provide 2 theatre sessions and alternate week dsu. In addition to this, the necessary speciality sessions, which were not addressed adequately in the previous proposed plans, are now introduced. Our thoughts on the shortfall in oncology and stone specific clinics are now included to a certain degree as well. The dsu, theatre and clinics per week comply in full with the DoH agreement. I have discussed with Martina the exact clinics, in terms of type and number per week/month, to be performed (as certain clinics have different templates). The mathematics for the new system has been calculated and this indeed complies with the agreements as calculated by the Trust's administrative team. Our current clinic setup now have defined templates set by the Trust which comply in terms of template design (but may in some circumstances need extended in duration ie 3 to 4 hours to help with capacity).

The design in the individual job plans has in fact been so finely tuned that amalgamating them has created a team program, which allows for a team approach to look after the departments needs when for instance someone is on leave.

It should also be noted it has been clearly defined in meetings with DoH that demand beyond contract is not the Trust's responsibility .ie excessive referrals. I agree that we need to ensure and focus on the clinic slots being correctly and fully filled. If this is achieved then any excess is outside of contract yet with full slot allocation we meet our objective. All this is not helped by changes imposed by DoH targets since the original agreement. It should be noted that current job plans are different to the proposed ones. It should also be noted that there will be other possibilities to enhance the outpatient numbers during the emergency week's clinical duties.

The whole urology team plan is presented to the Trust. It provides the complete requirements the DoH has asked for in terms of what the Trust has signed up to do on a sessional basis. Further to the anticipated plans and the aspirations for urology in the Southern Trust, in good faith, the team members have already started the extra services in the Western Board and the evening theatre lists which is outside of existing job plans (again may I note this has been done in good faith).

May I note that there were no similar demands for the same team plan when advertising last year and my offer to apply the same job plan to the post in question being re advertised was rejected. This, I must say, does raise certain doubts about the process and line taken currently.

I would like to point out that the whole urology team, having been fully involved in the process, are in agreement and committed to the plans currently provided. It would be a shame for the Trust to reject such an approach of a department.

Further points are raised in your email in reference to urodynamics, ward round and mdt. There still is a misunderstanding about what is involved in urodynamics and what we do in that specific clinical session. Further information on this should be discussed. The agreement with regards to the ward round was in fact that the time allocated would be split 50/50 DCC/SPA. With hand over of clinical care for on-call, makes such a round necessary. Core MDT membership is different to attending mdt. There will be cases and circumstances when the urologists providing the bulk of the stone surgery will want to discuss their oncology work

Willis, Lisa Staffing.

From: Trouton, Heather
Sent: 29 October 2013 09:01
To: Clegg, Malcolm; Mackle, Eamon
Cc: Corrigan, Martina
Subject: RE: Urology rota - outcome of monitoring

Follow Up Flag: Follow up
Flag Status: Flagged

Malcolm

Yes we do need to meet. We would need my Young there as he manages the rota.

As there are so many gaps at urology middle grade, 3 vacancies , this is a problem, 2 regs to assist in theatre, attend clinics, do flexible cystoscopy lists, support nurses in Thorndale and do all the ward work. However I think we could get this down possibly.

I will see when Eamon and Michael could be free.

Heather

From: Clegg, Malcolm
Sent: 28 October 2013 17:40
To: Mackle, Eamon; Trouton, Heather
Subject: Urology rota - outcome of monitoring

Mr Mackle/ Heather,

Would it be possible to have a quick meeting to discuss the Urology monitoring and how we take this forward. Monitoring has ended up as band 3 and average weekly hours are still very high (59.13 per week) even though we had expected these to reduce when the urologists came off on-call from August.

Can you let me know when you would be available and I will come to you. I appreciate Martina may have wanted to attend, but I think she is still on leave.

Thanks

Malcolm

Malcolm Clegg
Medical Staffing Department
Ground Floor Trust HQ
Southern Health and Social Care Trust
Craigavon Area Hospital
BT63 5QQ

Tel: Personal Information redacted by USI

Willis, Lisa

From: Corrigan, Martina
Sent: 16 May 2014 18:05
To: Parks, Zoe; Mackle, Eamon
Cc: Trouton, Heather; Clegg, Malcolm
Subject: RE: Urology Job Planning

Follow Up Flag: Follow up
Flag Status: Flagged

Zoe

We have been waiting for the fifth consultant to commence before moving to the Team Jobplan and Mark Haynes started on Monday past (12th) and the plan was to move them all onto this jobplan, however because we have the approval for the 6th post and John O'Donaghue is starting in August we will not be able to move to the 5-person Job plan and Michael and I are planning to sit down in June to try and see what this is going to look like. The issue here is that we will then need to present and get approval from the rest of the consultants so it may be a while before we get agreement and get them all on the right PA's .

I will keep everyone informed when we have this exercise completed.

Thanks

Martina

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

Telepho Personal Information redacted by USI
Mobile:
Email: n

From: Parks, Zoe
Sent: 15 May 2014 11:16
To: Mackle, Eamon
Cc: Corrigan, Martina; Trouton, Heather; Clegg, Malcolm
Subject: Urology Job Planning

Mr Mackle,

I was wondering if you could advise me on the update for Urology Job Planning. I have noticed that the PA's currently paid to the Urologists does not match what is held on the electronic job planning system. The Directors want us to ensure we have an electronic job plans which reflects how all consultants are paid, particularly where we are paying over and above 10PA's.

The following disparities exist in Urology:

	Paid	Job Plan on Zircadian
Dr Glackin	10.5PA's	11.5 PA's
Dr A OBrien	12 PA's	11.25 PA's

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
1916	ACUTE	13/01/2009	Safe, High Quality and Effective Care	Laboratory failing Accrediation due to External Clinical Waste Bins being kept in a unsecure location	External Clinical Waste bins are kept in an insecure location. This has been highlighted as a critical non compliance during recent Clinical Pathology Accreditation Inspections and could lead to the laboratory failing Accreditation.	Where possible bins are locked using a key but often locks are faulty.	11.05.10 - risk reviewed by R Carroll and B Magee -- risk mitigated and closed. Letter sent to Mr A Metcalfe requesting that the waste bins be secured. Referred to Directorate Risk Register 11.05.10 - risk reviewed by R Carroll and B Magee -- risk mitigated and closed.	VLOW
1922	ACUTE	19/01/2009	Safe, High Quality and Effective CareEffective organisational governanceBest use of resourcesFinancial viability, reform, and control of costs	Oral surgery instrumentation used in CAH OPD is not currently decontaminated in line with DHSSPS March 2008 recommendations	Risk of cross contamination to patients due to ineffective decontamination of dental instrumentation. Risk of non compliance with Regional Decontamination strategy.	Currently using 'Little sister' bench top sterilizers to decontaminate instrumentation. Bench top sterilises are tested daily by the users and quarterly by Estates in house staff and external contractors.	Update 27.5.11 - Significant instruments have been purchased. However the full order has not been received. Further orders have been processed but there is still a delay in supply. continue to check delivery 25.3.11 - Waiting delivery of new instruments which will improve access to decontamination. Will review any residual gap after delivery. 05.05.10 - Business case to be with SMT by 26.05,10 Business case to be submitted by 31.03.09 for transfer of local decontamination to a centralised facility.	HIGH
1931	ACUTE	23/01/2009	Safe, High Quality and Effective Care	Risk to health & safety of patients in ENT, OPD with ongoing extra clinics	Cross infection risk as ENT sinuscopes are not decontaminated in line with DHSSPS recommendations due to lack of sufficient scopes to meet demands. 10 scopes available for clinic with potential to need to access 40 decontaminated scopes as all are new patients. Risk to organisation through litigation; adverse publicity/ complaints; loss of reputation; breach of Hine Review Recommendations. Inequality of care for patients - Friday (clean scopes), Saturday (wiped and sheathed scopes).	10 scopes available for potential need to access 40 scopes therefore decontamination between patients is not possible - scopes will be wiped using alcohol wipes and single use sheath applied (in breach of Decontamination Regulations)	"Reviewed 6/12/10- Still awaiting the fitting of cabinet scope. 1.0 Wte Band 2 to be appointed and funded by all users of decontamination to support the integration of the Naso Pharyngeal Scopes awaiting circulation. R Carroll reminded of issue 2/12/10. Meeting re funding now January 2011. Large ENT OPD clinics still operating on selected Weekends, and this risk assessment is relevant to all. 21 July 2010 - currently awaiting the fitting of specialist plug for scope cabinets. Awaiting the sourcing of stainless steel cabinets to facilitate transport of scopes to sites and departments. Paper being prepared for SMT regarding the permanent appointment of CSSD staff that will provide enhanced access to scope cleaning (to be complete by 31 July 2010). Aiming to have new scopes in circulation by 31 August 2010. The risks highlighted in this assessment are applicable to clinics which will be held on 24 July 2010 and 31 July 2010." Reviewed 19/5/11- Decontamination cabinet installed in DHH. DHH theatre staff awaiting validated decontamination specification from CAH OPD. Decontamination meetings ongoing with ATICS, SEC and S McLaughlin. CC 310W will fund cleaning in theatres on the CAH site for scopes in CAH until dedicated staff appointed. Pamela Mulholland to confirm access to AER and C Moorcroft to confirm support for additional time for cleaning. Theatre staff in DHH will clean during night shift. R Carroll to ensure Nursing support is released to allow for decontamination. 4 Scopes to be released to ACH/ 12 Scopes to DHH/4 BBPC and 10 Scopes CAH. Transport arrangements need to be secured for cross-site delivery Target date for Resolution: 3 June 2011 Reviewed 6/12/10- Still awaiting the fitting of cabinet scope. 1.0 Wte Band 2 to be appointed and funded by all users of decontamination to support the integration of the Naso Pharyngeal Scopes awaiting circulation. R Carroll reminded of issue 2/12/10. Meeting re funding now January 2011. Large ENT OPD clinics still operating on selected Weekends, and this risk assessment is relevant to all. 21 July 2010 - currently awaiting the fitting of specialist plug for scope cabinets. Awaiting the sourcing of	MOD
2150	ACUTE	13/08/2009	Safe, High Quality and Effective Care	Inadequate immuno cyto chemistry staining facilities	Inadequate immuno cyto chemistry staining facilities to ensure the rapid turnaround of urgent histological samples, including red flagged samples.	No control measures. System is operated to full capacity, delays are frequent.	New system of work implemented which has led to a marked reduction in the throughput of immuno slides. The benchmark is no longer a limiting factor with regard to the turnaround time of immuno cytochemistry	MOD

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
2421	ACUTE	13/10/2009	Provide safe, high quality careBe a great place to workMake the best use of resources	Lack of manual handling training for staff	Staff unable to attend MH Training due to limited places being available to cover the whole Trust. Mandatory requirement not met. Injury to staff/patients. Potential litigation for Trust. Potential damage to Trust reputation.	Use of Hoist/slide sheets/repositioning charts/training for Avant Guard beds. Past MH Training. Raised at Nursing governance meetings on an ongoing basis.	25.09.13 ongoing issue which is on Governance agenda lead nurses to scope how many staff trained and how many outstanding and forward to ELD for for action. 29.11.12 - Reviewed by AD. Ongoing issues which are being kept on the agenda. 19.10.12 - Training now organised weekly at ward level in medical wards. 25.09.12 - Ward Sisters still experiencing difficulty in securing places for ward based staff. Mrs Carroll liaising with ELD re provision of locally based training. 28.02.12 - Heads of service to scope how many staff have been trained, how many need trained and consider how this could take place. 23.01.12 - position remains unchanged. 01.10.11 Reviewed 27.09.11 by MB, EM, PS, KC, & SB - minimal backfill available but same not sufficient to allow staff out for any form of training. Escalated to Michael McConville and Anne Ross on 20.09.11. 17.05.10 - Risk reviewed by E O'R, LA and BM.	MOD
2422	ACUTE	13/10/2009	Provide safe, high quality care	Multiple training schedules for staff at Trust Level. Lack of resources to facilitate staff to go to training.	Staff unable to attend training due to multiple training schedules, therefore leaving ward short staff or staff not being updated. Mandatory requirements unable to be facilitated. With staff at training there is a potential risk of not providing safe high quality care to patients. It will deplete staff numbers at ward level therefore failure to meet the expected standards of care. This will apply pressure on colleagues who remain on the ward.	Ward Sister to manage off duty rotas and prioritise training needs/where there are high dependency levels responsibility of nurse in charge to assess situation and take decision on releasing staff for training/more flexible approaches to training eg delivered at ward level,e-learning etc.	18/08/2021- no change core mandatory training monitoring monthly but Face to Face training still an issue due to social distancing and reduced staff numbers per session. 01/06/2021- provisions have been made to allow staff to do training in their own time and to receive overtime payment to do so. 24.06.19 No change, Monitor compliance monthly. Training now available on-line. Review frequency of training. 23.9.17 - CMT remains challenging to achieve over 80% mainly due to 1- staffing challenges and 2 availability of training which is not 'online'. 1.12.16 No further update. 13.9.16 Awaiting update 27/5/16 - No change.	MOD
2394	ACUTE	02/12/2009	Provide safe, high quality careMake the best use of resources	The Orthopaedic ICATs are still being sent to Independent sector for MRI scan due to demand outstripping capacity in SHSCT.	Financial risk for the Trust.	None	Write business case for additional MRI scanner and all associated costs 11.05.10 - risk reviewed by R Carroll and B Magee -- risk mitigated and closed.	VLOW
2396	ACUTE	02/12/2009	Provide safe, high quality care	Plain film x-ray reporting by Radiologists	"Plain film x-ray reporting by Radiologists is currently 60% resulting the general wards CAH and A+E CAH not being reported by a radiologist. Potential for mis-diagnosis leading to non-treatment of life threatening conditions. Potential litigation and loss of reputation for the Trust"	Referring consultant looks at the x-ray and writes report in patients notes. The introduction of PACS will increase to throughput of the plain film reporting but will not completely remove the risk.	6.5.11 - The contract has been awarded and the directorate is working with the IS company to get the IT connected. We plan to have the pilot testing complete by next week (fri 3th June). It is expected to scan between 500-1000 per month.There is a daily 19 day escalation plan, which is working well. The tender should be up and running by end of June 2011. 09.06.10 - Plain film reporting backlog in CAH was complete 31.03.10 - 3000 plain films in total. New backlog still exists. Briefing/options papers submitted to Director for discussion at SMT 09.06.10. (RC)	HIGH
2893	ACUTE	04/12/2009	Provide safe, high quality careBe a great place to workMake the best use of resources	RQIA review maternity services - In DHH four out of seven nights there is no middle grade (Registrar) Obstetric cover	Four out of seven nights in DHH only has SHO cover on site Safe care to mothers and babies may be compromised on these four nights	Consultant on call id contactable by telephone and will respond by attending/giving advice as required. Middle grade locums are used.	10 June 2013 Changes again to the middle grade rota is incomplete and weekends are being covered by internal locums. 14-01-13 despite recruitment to all of these posts, there is still a vacant post from April 2013 caused by a resignation. 28.05.12 There is only 1 mid grade vacancy in DHH. All shifts covered by locums known to the service. Efforts to recruit staff continue. 31.8.11- 1 specialty doctor has been appointed	MOD

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2514	ACUTE	09/03/2010	Provide safe, high quality careMake the best use of resources	Vacant admin post in the Social Work department DHH as of April 2010	No admin worker for the Social Work department DHH resulting in 1. Band 6 Social Workers completing admin tasks competing with their social work role and responsibilities 2. Issue with the completion of delegated statutory functions eg child care and vulnerablae adults on to SOSCARE and COMCARE 3. No admin worker to populate COMCARE 4. No admin worker to type RIT supervision records 5. No admin worker to provide a reception service to the department. 6 Backlog of filing and processing of record Potential for harm: 1. SOSCARE not populated resulting in incomplete computerised records and failure to comply with Regional Child Protection Policy and procedures. 2. Community and hospital professionals have an incomplete case history resulting in communication failures. 3. Delayed discharges 4. Potential for complaint against the Trust 5. Potential for Litigation against the Trust 6. Professional standards not met.	1. e requisition completed for maternity cover 25.09.009 2. Admin post discussed at Corporate scrutiny 3. Staff advised of the need to separate recording for child care and vulnerable adults admin currently prioritising this work	09.03.10 - no progress to date 18.08.10 - A temp admin worker commenced in DHH, at the end of July 2010, so the stated risk is no longer valid.	VLOW
2589	ACUTE	14/04/2010	Provide safe, high quality careMake the best use of resources	From August 2010 the number of junior doctors (F2) in cardiology will be reduced by 50%	From August 2010 the number of junior doctors (F2) in cardiology will be reduced by 50% resulting in 1. A significant impact on the delivery pf patient care 2.Reduced cover across all shifts of duty 3.Increased workload for all other medical and nursing staff 4. Increased need for locum cover - expensive and potentially higher risk to patients 5.Loss of reputation for the Trust 6. Potential risk of litigation.	None at present		HIGH
2598	ACUTE	15/04/2010	Provide safe, high quality careMake the best use of resources	Failure to identify cardiac structures and abnormalities due to sub-optimal echo images	Due to mis-diagnosis, patient could die; incorrect medication given;reputation of Trust; litigation. Potential to breach waiting times for the Trust.	At present, 33% of echoes are being repeated. Clinical physiologist/ Consultant Cardiologist identifies obvious malfunction scans. Potential for 2 month delay for patients to have repeat scan performed. Audit	12.5.11 - E-mail from B Conway: Yes, this is all sorted and can be removed. 28.3.11 - Due to received the replacement Echo machine in CAH on Tuesday 29th March 2011. 03.02.10 - risk reviewed - Echo machine ordered.	HIGH
2620	ACUTE	17/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsMake the best use of resources	Insufficient capacity and resources to manage patients waiting for a review appointment in MUSC	Potential of harm to the patient secondary to not having timely management of condition and/or disease-possible progression of disease/worsening status of condition. Risk of harm to patient by unmanaged progression or monitoring of condition in a timely manner secondary to SHSCT not having sustained capacity to provide review appointments, within the appointed time. Risk of harm to Medical and Nursing staff as addressing the patients needing review are all done as 'extra sessions'. Potential for exhaustion and escalation of sick leave. There has been inadequate Nursing resources recruited to support the increase work load. Risk of escalation of clinical risks as the Trust is under strict financial constraints, and does not have an obvious form of funding for this risk. Potential harm to patient family secondary to anxiety of not having a timely review Potential of litigation against staff and Trust due to not providing treatment in a timely manner Potential of harm to reputation of Trust due to potential lack of adequate patient management	E O'R and LA are tasked to 'cleanse' the lists of patients waiting, ensuring no duplication or incorrect recording of activity. Monthly update on review backlog to give current position Specialist Nurses working in Consultation with relevant Consultants to screen urgent, and patients waiting the longest length of time. All core clinic template capacity utilised as far as practical. Heads of Service are meeting with Relevant Consultants and conveying current position on a monthly basis Control measures considered but discounted and why (where appropriate): Arranging additional clinics to target primarily Review Backlog patients- not feasible in current financial situation Reduce the current number of new patients within Outpatient template, to increase the capacity of review patients- not feasible, as performance targets will then be breached. Recruit additional Medical staff to address shortfall in capacity- not feasible in current financial situation. . : .		HIGH
2629	ACUTE	24/05/2010	Provide safe, high quality careMaximise independence and choice for patients and clientsSupport people and communities to live healthy lives and improve their health and wellbeingMake the best use of	Delays in treatments, discharges and transfers due to inadequate ambulance service DHH, MSW, FSW, HDU, Gynae	Poor outcome for patient if ambulance not available for patient to be transferred. Delays in discharges leading to poor bed flow and elective lists to be cancelled. Patients from A +E admitted to ward due to no ambulance cannot be discharged. Patients missing appointments due to lack of ambulance service. Patient may develop surgical complication due to delay in treatment. Risk of litigation to trust. Increase of complaints and loss of confidence in organisation. Death of a patient. Delay in patient flow resulting in theatre cancellation	Early booking of ambulance as patients needs. Infection risk MRSA. Assess patient re chair, stretcher. Family involvement if safe for patient. Use of voluntary drivers. Use of blue light - not appropriate use of service.		HIGH
2730	ACUTE	30/06/2010	Make the best use of resourcesBe a good social partner within our local communitiesProvide safe, high quality care	The Body Fridge in DHH Mortuary unavailable for use from the 26/5/10.	Bodies may be released to undertakers which have not been stored in optimal conditions and therefore the process of decomposition may be accelerated. James Details	Bodies to be stored in the Chapel of Rest as this room is slightly cooler than other rooms in the mortuary. This is a temporary arrangement while work on the body fridges continues. The Chapel of Rest does not provide the optimal temperature required to stabilize or slow deterioration of the body. Bodies are to be released to the undertaker as quickly as possible. On Friday 25th June arrangement put in place to transfer bodies to CAH, if the undertaker cannot be contacted to organise a quick release the bodies are transferred to CAH Mortuary.	Authorisation from Ronan Carroll (Assistant Director of Acute Services) for Brian to arrange with Cecil Renshaw (Estate Services DHH) to install a portable air conditioning unit in the Chapel of Rest Dr G Rankin (Director of Acute Services) has identified funding (23/6/10). Brian Magee awaiting confirmation that he can proceed with the procurement and installation of body fridges.	HIGH

2818	ACUTE	25/11/2010	Provide safe, high quality careBe a great place to workMake the best use of resources	Unable to provide maximum Outpatient capacity safely due to level of sick leave & lack of availability of staff in Outpatients	Unsatisfactory level of staff with appropriate training. There are staff who have been redeployed, or working via Nurse Bank that do not have access to appropriate supervision secondary to staffing levels. Staff are unable to attend mandatory training due to staff shortages. Risk of staff sickness and absence continuing to escalate due to the level of stress of working in current conditions, further decreasing Outpatient capacity. Increased risk of staff to omit detail or not have sufficient time to complete task in a measured and timely manner cause patient harm and expose Trust to negative publicity and litigation. Contributing factor is the replacement staff have limited or no Outpatient experience. Potential to directly impact staff attending mandatory training updates. This places the public, staff and the Trust to increase risk of not having access to up to date training/information and validation which may result in harm to patients and staff. Increased risk to staff and patient safety secondary to not being able to provide adequate supervision to redeployed staff, and non registered staff due to low staffing allocation. Potential of reduction in Outpatient capacity resulting in extension of waiting times for patient. Increased waiting time has potential to harm and contribute to advancing of clinical disease and/or condition. Potential to further extend waiting time for patients on the Review Backlog waiting list. Increased waiting time has potential to a harm and contribute to advancing of clinical disease and/or condition. Potential for staff to omit detail or not have sufficient time to complete task in a measured and timely manner cause patient harm and expose Trust to negative publicity and litigation. This also has an impact on the level of appropriate supervision is dictated and expected for staff who have been redeployed to Outpatients or who are allocated through Nurse Bank. Potential for staff sickness and absence to escalate secondary to working with limited nursing support. This can have significant financial harm to the Trust as well as on skill level. Contributing factor is Nurse Bank is not able to fill entire requests and Manager may have hours of notice that a shift cannot be filled. Absence of validated update training risks patient and staff safety and increase risk of harm to the patient, staff, negative publicity and litigation to the Trust. Potential harm to Trust's reputation in relation to the breaching of Outpatient waiting time targets.	Band 7 and Band 6 Managers are providing direct patient care. Band 6 staff have been taken out of the POA results room to provide patient care in Outpatients. Band 5 and Band 2 staff requested to backfill shifts. Bank staff have provided 3 block bookings (2x B5 1x B2). Staff have 'doubled up' on clinics where possible (one staff to work between 2 clinics). Pre Op questionnaires have been given to patients to release Band 5 staff to work in clinics. Specialties have been approached to relocate to alternative accommodation due to lack of staff. Near patient testing devices to be purchased to decrease the demand for staff. All staff on sick leave are being actively managed and have been referred to OHD and HR.		MOD

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2916	ACUTE	10/01/2011	Provide safe, high quality careMake the best use of resources	ASR Monohip ; hip implant Recall	Patient that have received this hip implant are at risk of ; Pain, Immobility, Surrounding tissue breakdown. Higher incidence of Revision surgery within 5 years. Litigation against Trust Patients at risk that have received The Monohip, 208 patients in SHSCT.	Being addressed regionally, patients in SHSCT and Belfast Trust. Implant recall by manufactures " DePuy ", Patients reviewed yearly by a revision orthopaedic surgeon and treatment determined as necessary. Cobalt and Chromium blood ion tests. MRI scan. Plain X Rays.	23.01.12 - All patients have been recalled and reviewed with appropriate interventions carried out if required. Patients are now in the yearly review cycle and will remain there up until 5 years as recommended per medical alert. 10.11.11 There are 148 patients in total on the SHSCT ASR database. These patients have all been assessed, had a plain x-ray, MRI and cobalt and chromium ion levels tested and all have had a first consultation with a SHSCT Orthopaedic Consultant. To date 28 patients have undergone revision surgery. It was considered that all patients should have an annual review after their first consultation however a number of patients are being closely monitored eg a follow up review in 3 months as their ion levels were borderline. Review clinics are being organised on an ongoing basis to see patients who require close monitoring within their clinically required timescales. SHSCT is continuing to liaise with BHSCT with respect to 13 BHSCT patients who had their ASR implant done by the SHSCT surgeon but who are BHSCT patients. These patients have had their tests done and checked by the BHSCT practitioner to ensure they are not high risk patients however they have not had a consultation with an Orthopaedic Surgeon. It is planned that BHSCT surgeons will see these patients. 01.10.11 All patients have had a first apt with the Consultant and are being reviewed at the required intervals. Any patients being listed for revision of surgery are being completed timely. Meetings continue fortnightly. Update 27.5.11; 181 patients allocated to SHSCT to see and treat. To date 21 pts have had revision surgery. 5 pts are listed for revision surgery; 1 pt RIP; 113 pts have been reviewed; 5pts have refused a review. This leaves 36 pts still for review. Clinics are arranged for these 36 pts. A review process will require to be put in place for these patients. Admin Support will be required. HSC Management of ASR Recall Regional Meetings continue to be held weekly.	MOD
2915	ACUTE	07/03/2011	Be a great place to work	Staff member suffering from Chiari Malformation requires a saddle chair to prevent the axacerbation of symptoms	A member of staff suffering from the condition Chiari Malformation requires a saddle chair to prevent the exacerbation of symptoms whilst working in the various sections in the Cellular Pathology Laboratory.	Restricted range of duties - The member of staff does not cut routine tissue sections using a microtome as intense prolonged use of a microtome causes fatigue, discomfort and eventually pain. Frequent change of task with micro/mini breaks to prevent fatigue.	21.6.11 - Saddle chair provided. Saddle chair supplier sourced Personal Information [redacted] and a 4 week trial of a saddle chair organised and trial commenced on the 14/10/10. Risk assessment placed on the laboratory's Q-pulse document control system on the 2/12/10 with a review date on the 1/2/11. Received and signed by the Assistant Director of Acute Services on the 3/12/10. CPL awaiting a copy of the risk assessment.	MOD
2979	ACUTE	13/05/2011	Provide safe, high quality care	Multiple records/charts per patient e.g. a patient may have STH, CAH, BPC & DHH medical notes	Patient is at risk due to information in multiple charts (no one chart may contain a full record of patient history and investigations). Trust from risk of litigation. Risk to patient of incomplete information being available at time of consultation, incorrect diagnosis due to incomplete information, delay in diagnosis, risk of injury and/or death. Reputation of Trust at risk.	Patient information is available electronically in Patient Centre, NIPACS, Labs, TOMCAT. Charts for CAH and DHH only now registered. All charts are made available if requested.	19.08.2020 Most charts have now been replaced. 24.06.19 New system - one patient one chart for all new and recent patients. Ongoing update for older files for existing patients. 7.3.18 Risk remains unchanged 28.09.17 Further work is to take place with regard to registration of CAH and DHH charts and a move to 1 patient 1 chart. Initial discussions will take place in October with Health Records managers and the Booking Centre to identify issues relating to registration, and following this a proposal will be taken to Acute SMT for discussion and agreement. 28.12.16 - work ongoing with continuing to reduce number of charts per patient in circulation - robust weed and destruction of charts takes place every year and registration reduced. Risk reducing each year. 12.9.16 work still continuing on reducing the number of charts per patient - this is an ongoing exercise. A trial of going "paperlight" was conducted in June - Aug 16 which would reduce the amount of paperwork generated per patient however, until such time as a "write on" information system is available we cannot progress with paperlight / paperless clinics as information still needs to be recorded on the patient visit.	LOW
2991	ACUTE	26/05/2011	Provide safe, high quality care	Cancer performance risk	Decrease in cancer performance from previous years. 10/11 = 85% for 62 day pathway. Highest risk is urology cancer pathways.	Escalation policy and action plans drafted. Meeting with urology teams. Working towards 1-stop clinics.	See Risk 2942	MOD

2993	ACUTE	26/05/2011	Provide safe, high quality careBe a great place to work	Gaps in Medical Staffing. Daisy Hill Hospital	Gaps at junior and middle grade level in Medicine in DHH Hospital impacting on numbers of doctors on duty particularly during the out of hours period. Due to the gaps on occasions one junior doctor may be left covering medicine in Daisy Hill Hospital - increased clinical risk and potential for adverse events leading to patient harm.	A locum middle grade recruited in January 2011 to address immediate pressures. Assistance given from Renal Medical Staffing complement for two evenings per week. Ad-hoc locum shifts as and when required to address remaining gaps. However, despite these actions other gaps may remain. In the medium to longer term there is a plan for an additional junior doctor to be provided via NIMDTA however recurrent funding is required for this post.	29.09.22 - Risk Reviewed. Improved allocation of SpR from NIMDTA in August. Also stroke specialty doctor commenced Sept 2011. Risk downgraded to Moderate	LOW
3002	ACUTE	13/06/2011	Provide safe, high quality careBe a great place to work	Extremely high level of maternity leave in CAH pharmacists	Extremely high level of maternity leave in CAH pharmacists from summer 2011 (15/36). Current recruitment for maternity leave cover is 2 for 1 - 5 junior pharmacists recruited as cover but only 2 have taken up post so will be 9 pharmacists short during period June to Sep 2011 and 7 short from Sep - Dec 2011. Unable to provide clinical cover for wards and no leave cover at all for other clinical pharmacists. Risk of serious medication incidents not being detected on wards before they reach the patient. Risk will increase in August with intake of newly qualified doctors. High work load of remaining pharmacists wild put them at risk of making an error themselves when dispensing/ checking.	Initially remaining pharmacists allocated to highest risk wards and some temporary junior pharmacists recruited as cover. March 2012 three pharmacists on mat leave.	Feb 12 - Currently 6 staff off work, two to return within 4 weeks, remaining 3 by end of March 2012.	LOW
3019	ACUTE	07/07/2011	Provide safe, high quality careBe a great place to work	Fire	Risk of Fire throughout the Acute Directorate	Evacuation plan implemented for every ward and department. Embedded procedure of simulated drills twice yearly throughout all wards, once in hours and once out of hours. Acute fire committee and reps currently in place for all divisions. All wards have fire files. Checks carried out in basement areas. Estates ensure fire alarm and detection, escape lighting, first aid fire fighting equipment, suppression systems, plant, equipment and other installations are checked, tested and maintained in accordance with good maintenance practice. Regular fire safety checks are being carried out in Residential accommodation on the CAH and DHH sites and records are maintained. Nominated Officers and Deputy Nominated Officers have been identified for all wards and depts on each site. A number of fire risk assessments have been undertaken and actioned to reduce risk. Waste Management Policy and Procedures are in place and subject to monitoring. Smoke Free Policy is in place. Soft furnishings and textiles are purchased through BOS PaLS so comply to standards of fire retardancy. Fire Safety training programme is in place for all staff and fire safety training records are held centrally and reports are issued to Heads of Service. Arson Policy is in place.	18.12.13 Need to have a further desktop	LOW
3020	ACUTE	18/07/2011	Provide safe, high quality careBe a great place to work	Management of Sex Offenders when accessing hospital services	Potential for sexual, emotional and psychological abuse. Those at risk: other patients, staff and members of the general public. Issues with the management of those convicted sex offenders who are known and not known to Hospital Services. Concerns re unplanned access to Hospital Services. No formal mechanism within the Hospitals to share information gained through LAPPP. Potential for litigation and damage of Trust reputation. No Policy and Procedure in place regionally to manage the risk within the hospital setting.	Trust representative at PPANI. Convicted sex offenders referenced through the Soscare system. No formal mechanism within the Hospitals to share information gained through LAPP. No Policy and Procedure in place regionally to manage the risk within the hospital setting.	07.10.13 - Draft Protocol tabled at the Procedures Committee and document accepted - minor additions required. Document to be shared with Regional Emergency Social Work Service. Draft Protocol allows information provided at the LAPPP meetings to be shared with Acute services. The focus is on registered category 2 & 3 sex offenders. Draft protocol completed January 2013. Document equality screened.	MOD
3028	ACUTE	26/08/2011		Staff shortages are adversely impacting on the quality of the Cellular Pathology Service	By 24 august 2011 3 BMS staff were off on long term sick or maternity leave. This equates to 18% of the WTE BMS staffing in Cellular Pathology. A further member of staff whose husband took a stroke on 19 August 2011 has the potential to be off, when included with existing staff off this equates to 23% of the WTE BMS staffing in Cellular Pathology. Coupled with annual leave commitments over the remaining August into October 11 period this reflects a reduction in WTE BMS staffing of 38%. the situation should improve after mid October 2011 with the WTE BMS staffing shortage due to maternity and long term sick falling to 12%.	All part-time BMS and MLA staff were asked if they would consider increasing their hours. One MLA has increased their hours from 0.6 WTE to 0.9 WTE effective from the 24 August 2011 to 30 November 2011.	One has increased their hours from 0.6 WTE to 0.9WTE effective from 24 August 2011 to 30 November 2011. 22.11.11 Temporary arrangements are now in place in the lead up to the accreditation visit. These arrangements include:-1 An increase in part time working hours for a member of staff. 2 An increase in overtime for key staff. 3 The transfer of a maximum of 150 cervical cytology tests per week for a six week period to the Western Trust for processing and reporting. On Monday 22 August 2011 the gynae cytology backlog was 400 smears. On Friday 26 August 2011 the gynae cytology backlog was 700 smears. An increase of 40% in 4 days. The gynae screening backlog will continue to be monitored. If the backlog reaches 1000 smears arrangements may have to be made to have it sent to another laboratory for screening and reporting.	MOD
3026	ACUTE	02/09/2011	Safe, High Quality and Effective Care	Mixed Sex Accommodation	Mixed Sex accommodation can have a significant impact on maintaining privacy and dignity to patients whilst in hospital. In the following areas emergency treatment will take priority over segregation: coronary care, intensive care, A&E, theatre and recovery wards, medical assessment unit. Those at risk are patients requiring admission to CAH/DHH and patients requiring admission to specialist units.	SHSCT Policy on the admission of patients to a mixed sex ward. Acute Services Directorate Escalation Procedure. Safeguarding Vulnerable Adults Procedure. Patient Support Services. Clear signage on toilet and washing facilities.		
3057	ACUTE	28/12/2011		Arrangements for the transfer of acutely ill patients between acute sites in the SHSCT and to acute sites in other Trusts	This risk has been highlighted due to impact on medical cover when patients are transferred out of hours from Daisy Hill Hospital, however we are now also aware that we do not yet have sufficient robust information in relation to the number, nature and times of transfers in the acute system	1. A Proforma has been issued for completion when transfers arise in our system. Completed Proforma are being submitted to Amie Nelson for collation and analysis 2.On DHH site, efforts are being made to schedule a 3rd SHO to be on duty OOH in the event that one of the doctors need to transfer with a patient. Consultant on-call must be contacted about any transfers OOHs, with a decision taken on who should transfer with the patient and what support is required from the consultant during this time. Work is also underway to put a sustainable OOH rota arrangement in place in the medium term. 3.Meeting has been arranged by Director of Acute for early January 2012 to review out of hours cover in both CAH and DHH in the context of a regional review of H@N	25.09.13 lead nurses to scope number of acutely ill patients transferred between sites/other trusts within past year both in hours and OOH and highlight who accompanied these patients 29.11.12 - Arrangements in place to facilitate transfer of patients between sites.	MOD

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3064	ACUTE	09/01/2012		Faulty Lifts in DHH outside labour ward	Lifts outside Delivery Suite which service the maternity ward, frequently breaking down. Health and Safety Issue for transferring mothers in labour or in an emergency situation.	Plan in place for Estates works to commence early 2012. Currently using second lift. Exploration of possible use of Evacuation Chairs.	29-08-12 one lift replaced and one refurbished. No further issues. 28.05.12 Fire evacuation chairs now purchased. Parts for 2nd lift currently being replaced. 26.04.12 Work completed on back lift.	MOD
3165	ACUTE	22/06/2012	Provide safe, high quality care	Inadequate Speech and Language Therapist	Inadequate Speech & Language Therapist. Stroke patients waiting up to 3 days to be seen by Speech and Language Therapist. No Speech and Language Therapist allocated to MAU resulting in inappropriate management of patients care/treatment.	Staff trained in swallow assessment	25.09.13 - 80% staff in stroke ward CAH and XX% stroke ward DHH now trained in swallow awareness. Ongoing training for other ward areas.	HIGH
3166	ACUTE	25/06/2012	Provide safe, high quality care	Urology Access Waiting Times	Urology access waiting times have increased significantly from 36 weeks for inpatient and daycases. First appointment ICAT patients has increased from 17 weeks.	This is currently being addressed via approval to go to Independent Sector and the appointment of new consultants.	3/3/15 - TO BE TAKEN AS PER AD CCS/ATICS 10.12.14 - Cancer targets are being met, i.e., 31 and 62 day pathway. While red flag and urgent appointment times are being met this is utilising all outpatient capacity leaving routine patients with longer waiting times. A new service model is being trialled which may improve the totality of waiting times in the long term. Inpatient/Day Case waiting times for routine patients remain challengin with the focus on treating cancer patients within the standards. 12.5.14 - with respect to the urology performance against the 62-day cancer target, there are 21 patients over 62+days of which 11 pts waiting over 85+days. With respect to haematuria 1st appointment now sitting at D16 which is an improvement on the previous positions due to a combination of drop in demand and extra capacity on a Saturday. 12.02.14 Urology waiting times are extended throughout the Province due to demand and capacity issues. The HSCB have commissioned a further Regional review of Urology Services . The SHSCT will partake in this Regional review. In the meantime, Team South will focus its resources on meeting the cancer waiting times within this specialty	MOD
3191	ACUTE	03/09/2012	Safe, High Quality and Effective Care	62 Day Cancer Performance	Trust fails to meet performance standard due to increase in red flag, capacity issues, inability to downgrade and Regional issues.	Daily monitoring of referrals of patients on the 62 day pathway. Escalations to HoS/AD when patients do not meet milestone on pathway. Continuous communication with Regional with regard to patients who require PET and ITT patients for Thoracic Surgery, 1st oncology appointment. Monthly performance meetings with AD/HoS and escalations of all late triaging	7/10/21- All tumour site pathways continue to have capacity problems throughout due to the ongoing pandemic. Referral levels for majority of tumour sites have continued to increase and are back to pre covid levels and in some instances higher than original volumes. Most tumour sites are affected by limited access to surgery. The trust continues to engage with RPOG and participate in theatre equalisation meetings. There are internal weekly meetings to review cat 2 surgeries and decisions regarding allocation of theatre sessions are made accordingly. Fortnightly cancer check point meetings continue involving MDT leads and senior management, where clinical teams have opportunities to escalate areas of concerns and potential solutions where possible. Fortnightly cancer reset meetings with HSCB are also continued. 20/09/2021- Covid has continued to have a negative impact on the 62 day pathway due to the fact that face to face appointment slots at outpatients and procedure lists such as endoscopy have been reduced in order to comply with IPC precautions. Attempts have been made to negate some of these losses by increasing virtual activity in the form of enhanced triage and virtual clinic appointments. However, the Trusts access to theatres and endoscopy lists has been reduced due to the fact of ICU beds being increased from 8 to 16 beds. Surgical specialties continue to prioritise their cases in line with the FSSA guidance. This is collated weekly and reported monthly to HSCB. 18/08/2021- Access times monitored but high volumes of new patients waiting to be seen at our Respiratory Clinics. Continue to monitor access for bronch. 24/02/2021- cancer access times have increased throughout due to COVID . Fortnightly meetings with specialties and escalated to HSCB. June 2020 Review of risk remains high due to COVID pandemic. Reduction in services due to social distancing and risk of COVID. Clinical space, theatre capacity availability is a challenge across all services. Dec19 Review of same risk remains unchanged. 06/08/2019 - Ongoing increase in red flag referrals across multiple tumour sites continues, leading to	HIGH

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3304	ACUTE	16/01/2013	Provide safe, high quality care	Lone Workers in X-Ray after 12 midnight	Risk to the welfare of the lone Radiography staff working out of hours shifts either in CT or when performing Mobile radiography in remote areas of the hospital. On both instance the lone Radiographer is required to come into the x-ray department that is located some distance from ED and the wards. This leaves the lone Radiographer vulnerable and at risk from verbal/physical abuse/theft from visitors and patients . This potentially increases the staff's stress levels. Staff have a right to expect a safe and secure working environment.Risk of patients/visitors having free access to the x-ray department during the period from 8pm-8am as the department is not locked down securely during this period.	Staff Awareness. Restricted access in some areas. MOVA policy and procedures. Personal attack alarms issued to all staff. CCTV. Porters available to escort staff. Porters and Radiographers to lock main doors of x-ray when not in use. Radiographers required to checked that all doors into x-ray are locked before 8pm at night.Lone worker policy. IR1 Reporting.	14.11.17 Awaiting update from J Robinson 5.12.16 The lock down system is being installed W/C 12 Dec 16. 13.9.16 Situation continues to be monitored	MOD
3393	ACUTE	22/04/2013	Provide safe, high quality care	Biochemistry CPA Accreditation	Laboratory has lost its biochemistry accreditation status and is now a non-accredited laboratory	The Lab continues to perform adequately in its external quality assurance and internal quality control.	13.9.16 All findings have been cleared with inspectors. We are awaiting formal confirmation of accreditation status. this may take up to 6 months. 28/6/16 The Biochemistry inspection took place in April 2016. The inspectors recommendation is for the department to be offered full accreditation subject to satisfactory completion of findings by 7/7/2016. 28/6/16 The Biochemistry inspection took place in April 2016. The inspectors recommendation is for the department to be offered full accreditation subject to satisfactory completion of findings by 7/7/2016. 6/1/16 - Inspection to take place 1st week in April 16. 27/11/15 - Pre-inspection took place on the 8/10/15. The Inspectors advised that Biochemistry is ready for the formal inspection subject to a few minor non-conformances being addressed. Formal inspection is expected in April 2016. 8/9/15 Labs - Pre-inspection visit confirmed for 8th Oct 2015 for Biochemistry. The biochemistry team continue to progress with meeting the ISO Standards. Meetings with Dr Hall and the Senior Biochemistry team continues. 3/3/15 - Labs contacted UKAS in January 2015 to check on progress with application, and was advised it had been passed to the scheduler. Still no indication of an inspection date yet. Staffing levels - benchmarking to be undertaken. Anticipated total additionality is 11 staff, no funding identified.	LOW
3508	ACUTE	24/10/2013	Safe, High Quality and Effective Care	Overcrowding in Emergency Department CAH & DHH and the inability to off load patients from Ambulance due to overcrowding.	Delay in assessment of NIAS patients as no space to off load. Delay in ECG as no space for patient. Delay in resuscitation treatment as Resus overcrowded. Delay in treatment as Majors area overcrowded. Patient may deteriorate in waiting area as no space and delays in getting them to cubicle and doctor. Patients may deteriorate while waiting for admission bed on ward medication errors will increase as nursing staff unable to cope with delayed admissions. Patients basic nursing care may delayed as not enough nursing staff to deliver it in overcrowded ED. Patients may loose confidence in the Trust. Staff may become burnt out and stressed.	Triage (second nurse in triage in intermittent periods when staffing allows. Department escalation plan in place. See and treat pilot with band 6 and ED consultant (pilot finished). Patient flow meetings. 4pm meetings with patient flow. HALO role and ongoing monitoring	20/09/2021- ongoing, risk exacerbated by Covid- bed pressures sustained for long periods. Non commissioned beds have been opened. Surgical beds converted to medical beds. 09/03/2021- ED have completed capacity plan. All areas in acute to do the same. Escalated to Directorate. ongoing workstreams. Funding needs secured for medical gases for ambulance receiving area. Unscheduled care huddle regional actions daily. Estates ordering a modular unit for 6 cubicle receiving area. Ongoing escalation plan. 07.08.2020 - new workstreams have been setup in the Trust which may impact on overcrowding. Ongoing work to review and agree a capacity plan for both ED's. 12.08.19 MD escalation plan to be developed. Bed modelling exercise. 11.03.19- No update. 24.10.13 - There are systems in place to monitor this daily. The problem can fluctuate on certain days and become worse from November to March. Swing ward to be set up by November 2013.	HIGH
3515	ACUTE	14/11/2013	Provide safe, high quality care	Ineffective Cardiac Monitoring System in certain Wards/Departments in CAH and DHH	The current cardiac monitoring system is old and unable to monitor patients in various wards/departments in the hospital site given their physical location. Monitoring is not available for certain patients and patients then may be required to move to 1 North for monitoring unnecessarily.	Appropriate selection of patients for monitoring.	14.11.17 Waiting on decision to start work with the potential of relocating coronary care beds to the HDU in DHH. 1.12.16 No further update. 13.9.16 In relation to CAH telemetry, this has now been fully implemented in the main acute wards, cathlab, and delivery suite.DHH,is awaiting funding allocation. 27.05.16 - Work in CAH will be completed with 3 months time. Costing obtained in respect of DHH work and added to Capital Estates list for consideration. 1/3/16 Now in place residual witing being carried out. 14.07.15 - Replacement system purchased and installed. Estates undertaking wiring to ensure all acute areas are covered.	LOW

3526	ACUTE	17/12/2013	Safe, High Quality and Effective Care	Non-compliant bedpan washer disinfectors	Infection control risk to patients due to inadequate disinfection of bedpans throughout wards and departments in the Trust.	Daily testing of bedpan washer disinfectors completed by ward staff. Limited quarterly and annual testing carried out by contractor. Estates plan to provide a fully compliant quarterly and annual testing service early 2014. IPC has advised staff to carry out a visual check for cleanliness of all bedpans before use.	04/11/14 New bedpan washer disinfectors now installed. 23.4.14 Fifty new bedpan washer disinfectors received end of March 2014. Replacement programme underway according to IPC risk - to be completed by August 2014. Estates now providing a fully compliant quarterly and annual testing service. 12.02.14 Informed that order now placed 5.2.14 Contract awarded 18.12.13 Funding has been secured for the replacement of bedpan washer disinfectors. 5.11.13 pre tender meeting with Pals - tender open 8-11-13 and closes on 20-12-13 Tendering currently in progress to be finalised by end of March 2014. 28.3.14 Trust received 50 new bedpan washer disinfectors. A phased replacement programme has been agreed with IPC according to level of IPC risk and is due for completion by September 2014. October 2014 - 45 new bedpan washer disinfectors have been installed and commissioned leaving 5 spares for future new developments / replacements.	LOW

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3528	ACUTE	05/02/2014	Safe, High Quality and Effective Care	Pharmacy Aseptic Suite	The external audit of the pharmacy Aseptic Suite, which prepares all the total parenteral nutrition and the chemotherapy for oncology and haematology patients, has identified The design and fabric of the aseptic building does not meet the modern building standards for pharmacy aseptic dispensing units (critical audit finding). Application of the newly introduced capacity plan has identified the chemotherapy pharmacists' activity is exceeding 100% on a regular basis (Major audit finding) The two isolators used in the cytotoxic reconstitution section of the aseptic suite both require urgent replacement.(Major audit finding)	Increased environmental monitoring to check for failures of sterility in the unit Expiry dates of all products prepared has been reduced to a maximum of 24 hours. A daily report on the chemotherapy pharmacists activity level in relation to the capacity plan has been developed and implemented Additional activity will not be accepted by the aseptic unit until the staffing issue is resolved Additional environmental and function testing is being performed on both isolators to identify any sterility failures.	16.10.17 Unchanged 1.12.16 No further update. 13.9.16 Development Work ongoing 1/3/16 Work commenced for new suite. • Confirmation of the funding for the business case for a new build aseptic suite co-located with the Mandeville Unit was received at the end of July 2017. The design team have met throughout August with the aim of commencing the build in March/April 2017. • Recent deterioration in the fabric of the building has been addressed through an interim plan involving urgent minor works to the aseptic suite which was completed by mid-May 2016. • The external auditor revisited the suite on 26th July 2016. Their report is awaited. From discussions with the lead auditor on the day, it is expected that their report will still class the unit as high risk, but will recognise the work that has been done to manage this risk whilst the new unit is awaited. two additional pharmacist posts were funded by HSCB to address the staffing deficit that was leading to the capacity plan model showing that the pharmacists are working between 130 and 150% capacity. Both pharmacists took up post in Jan 2017 and the capacity score has been reduced to 94% Capital was identified to replace both isolators and this work was completed by January 2015.	MOD
3529	ACUTE	05/02/2014	Provide safe, high quality care	Non compliance to Standards and Guidelines issued to Southern Trust by DHSSPSNI	There is often a time lag between when the external agencies require the Trust to achieve full compliance against the recommendations outlined within standards and guidelines and when this is actually achieved. Such non-compliance poses the following risks for the patient and the organisation: Reduced ability to deliver quality patient care; Compromised patient safety and wellbeing; Poor patient outcomes - mortality/morbidity, delayed discharge, increased secondary complications; Staff members are non-compliant with evidence based working practices, lack of standardised practice, vulnerable wrt registration; Organisational risk - complaints, incidents, litigation, loss in confidence / negative publicity Service Capacity As of 30 June 2020 there are 2131 standards and guidelines identified on the Trust's S&G database. Of thes1622 were applicable to Acute Services (78%) Lack of suitable IT Recording System Due to volume and complexity of these guidelines it is a challenge for the Trust to monitor and review the compliance status of all the standards and guidelines that have been received. There is a corporate need to invest in a more fit for purpose information system . In 2017/18 BSO gave the WHSCT significant funding to support a pilot of a modified Sharepoint system that would in the first instance record and track the implementation of NICE guidelines and Technology Appraisals. The Regional NICE Managers forum acted as the project group and whilst the scope of the project was not embracive of all the types of standards and guidelines endorsed regionally it was at least a starting point. The ultimate vision was that upon completion this system would then be shared across the HSC (including the HSCB/DHSSPNIS) to provide a harmonised / standardised system that would provide effective monitoring and traceability of guidance implementation. Unfortunately this pilot has not yet yielded these desired outcomes and in the interim the SHSCT continues to use an excel spreadsheet whose functionality falls well short of service requirements. Discussions have been undertaken with Mark Toal to seek out other possbile IT solutions - these have included Qlikvue / the new Datix S&G module (which remains in prototype) / Q Pulse. This scoping work is ongoing. Given the number of standards and guidelines that are now held on this system there is risk of it collapsing and there has been a number of incidents were data saving has not occurred due to capacity issues. As a safe guard a system back up is saved on a weekly basis. There is also the added frustration that if any of the directorate governance teams are using the shared excel spreadsheet no-one else can use it. This can impact on staff not being able to carry out their administrative duties on the system at that point in time. This is inefficient and there is a risk of a lack of timely data capture. S&G Backlog S&G backlog continues since the number of newly issued S&G demands the capacity of the Acute S&G team to ensure timely implementation. Consequently there continues to be a need to review the register, identify the backlog and prioritise those standards and guidelines that need to be implemented by nominated change leads. Since 7 January 2017 the corporate S&G forum has been stood down. Whilst new processes for managing S&G have been developed, one key challenge is the timely implementation of those S&G that have a cross directorate applicability. This includes a delay in identifying the lead directorate and who will lead these pieces of work. This has resulted in some S&G circulars not meeting the required deadline to submit an assurance response to the required external agency. It also has the risk of creating 'siloed' implementation processes within each applicable directorate which in turn has the potential to produce inconsistency in any new	Provision of bi monthly assurance responses to the HSCB as part of the Trust's Positive Assurance response. Corporate governance have an Excel database in place for logging and monitoring S&G. The accountability arrangements for the management of S&G within Acute Services are well defined to ensure the risk of not complying with a guideline due to identification of an external barrier is communicated to the SMT in a timely way. There are robust processes in place to ensure timely review of E proformas to ensure any change in compliance is identified and should the compliance status be downgraded from red to green the HSCB can then be notified Within Acute Services a directorate S&G forum has been established - inaugural meeting was held 19 January 2017. Terms of reference are in place and the forum is chaired by the Director and attended by the SMT. The forum meets twice a month to review all newly issued S&G so to ensure appointment of a clinical change lead is confirmed in a timely manner, thereby ensuring implementation processes are put in place as early as possible. It also reviews and approves implementation plans requiring submission to the the relevant external agency. It approves any policy/procedures/guidance that has been developed as part of these implementation plans. Standard item for discussion at the monthly Acute Clinical Governance meetings with submission of relevant reports Patients Safety & Quality Manager (Acute Services) attends all divisional governance meetings on a monthly basis and presents tailored activity reports to determine progress at an operational level Meeting schedule is in place to ensure meetings are held with the Heads of Service to review compliance against all S&G within their areas of responsibility A new Acute Services Lead Nurse, Midwifery & Radiology S&G forum - meetings held on a monthly basis Monthly summary report is issued out to Acute SMT to communicate to all staff what new regionally endorsed S&G have been issued. A copy is also shared with the M&M chairs so that they can review and share within their committee meetings Service KPIs are in place and presented to the Acute S&G forum on a quarterly basis Acute S&G procedures manual has been developed and has been operationalised since 1/4/2017. This is subject to ongoing review and updating Acute S&G administration processes maps have been developed and are to be presented at Acute S&G forum on 01/05/2018 Standard item for discussion at SMT (monthly) and Governance Committee with submission of relevant reports / assurance	24/02/2021- being reviewed through standards and guidelines process 10/08/20 - Risk reviewed. Updated description of risk provided. March 2020 On-going monitoring and review within Acute S&G forum agenda Discussion with Trust SMT since this risk issue will be the same within the other operational directorates, albeit the number of guidelines are less 10/08/20 - Risk reviewed and description of risk updated. 02/06/2020 standards still difficult to achieve with limited funding, staffing and equipment 09.03.2020, 5.12.16 Information below remains current 19.7.16 - Decision needs to be made regarding the viability of re-appointing an AMD for Standards and Guidelines (Acute Services) - forms part of the current review of Acute Services structures. Administrative support for the Patient Safety & Quality Manager needs to be reviewed - there is currently no administrative support. Patient Safety & Quality Manager (Acute Services) has successfully achieved a one year NICE scholarship - project is to undertake a review of the directorate's process for implementing standards and guidelines - to be completed by 31/03/2017. There continues to be an urgent need to put in place a more effective information system for the logging, dissemination and monitoring of standards and guidelines. Corporate governance is currently designing an inhouse system until an appropriate regional solution is agreed. Due to ongoing work pressures Phase 1 (01/10/2015 to current date) and Phase 2 of the backlog review (all S&G issued from 01/04/2007 - 30/09/2015) will be undertaken from 01/01/2018 to 31/03/2018 has not been progressed as planned and will continue during 2019/20 workplan. Phase 1 (From 2017 to current date) has been completed. Phase 2 of the backlog (from April 2007 - Sept 2015) remains outstanding.	LOW

3619	ACUTE	11/11/2014	Safe, High Quality and Effective Care	Water Flooding and Sewage Leaks	Water and effluent leaks into any ward / department on the CAH site. Exposure / illness to raw sewage by patients, visitors or staff. - A foul smell in patient and staff areas make for difficult working conditions. - Contamination of water supply. - Increased rates of infection. - Disruption to patient care or activities in the ward / department. - Damage to equipment and the fabric of the building. - Damage to patient records and breaches under the Data Protection Act if records require to be destroyed. - Bad publicity. - No cleaning service provided in areas if Domestic Services resources require to be re-deployed to assist with clean up. - Additional pressure within Domestic Services may mean a longer response time for terminal cleaning / bed cleaning which could effect bed availability.	Bag it and Bin it posters are displayed in all toilets and have been communicated to all staff via desktop messages. On the poster there is a request for staff to report any slow flushing toilets to Nursing staff. - Posters are displayed in all sluice rooms advising staff not to flush wipes, conti wipes, J cloths and hand towels. - Leak detectors are in place in some areas. - Piping has been replaced in two Health Records libraries in the basement. - In the Health Records libraries the roof tiles have been removed to help see any leaks at an early stage and a large number of charts have been moved and sent to secondary storage in Armagh to avoid them having to be placed on top of the filing bays. - Domestic Services have a process for dealing with flood / sewage incidents. - There is weekly jetting of drains. - Heads of Services were asked to ensure all alcohol wipes were removed from all toilet and bathroom facilities (action from a meeting held 14/05/14). - The Assistant Director of Functional Support Services sent a communications to her AD colleagues in Acute and Heads of Service on 8/10/2014 appealing to all staff not to flush wipes down the toilets and requesting their support in dealing with this problem. - Maintenance staff have spoken to Ward Sisters in Maternity and staff in Maternity are advising patients and staff re the Do's and Don'ts of waste. - There is greater awareness amongst Nursing staff regarding the potential problems and consequently there is better reporting to Estates.	3/3/15 Posters are displayed and all staff communicated with. Leak detectors are in place in some areas. Piping has been replaced in two Health Records libraries in the basement and some roof tiles removed to help see any leaks at an early stage. Large number of charts have been moved and sent to secondary storage in Armagh. Process in place to deal with flood / sewage incidents. Weekly jetting of drains. Heads of Services were asked to ensure all alcohol wipes were removed from all toilet and bathroom facilities. Communication from AD FSS to ADs/HOS on 8/10/2014 remind all staff not to flush wipes down the toilets and requesting their support in dealing with this problem. Work between Maintenance & Maternity staff to advise patients & staff re the Do's and Don'ts of waste. Greater awareness amongst Nursing staff regarding the potential problems and better reporting to Estates.	MOD

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3653	ACUTE	15/04/2015	Provide safe, high quality care	Infection control due to release of sewage into clinical areas	Escape of sewage from sewerage system causing: Infection: Exposure of patients, visitors and staff to increased risk of infection, Contamination of catering/food preparation areas Contamination of drinking water Clinical services - disruption: Closure/cancellation/disruption to clinical services (including due to odour) Patient records damage: May cause damage/loss of patient records Property/infrastructure damage: May cause damage to flooring, ceilings, walls and general building infrastructure Possible damage to electrical systems Possible damage to IT systems Equipment damage: Possible damage to medical devices and equipment Public reputation: Adverse publicity Adverse political interest Legal challenge: Possible breach of Data Protection Act Breach of health and safety legislation (Health & Safety at Work Order) Possible breach of common law duty of care Possible breach of environmental legislation Increase use of resources Addition deep cleaning requiring addition staff and consumables	Information, instruction and training: Use of posters in all sluice rooms Use of splash screen information on computers for staff Senior managers informed of measures required to reduce the incidence of sewage leaks (email from Assistant Director of Clinical Support Services) All clinical staff brief on waste disposal and incident reporting Incident management: Incident reporting systems in place - DatixWeb and Estate Services Help Desk Domestic Services have a process for managing reported sewage incidents Estate Services have waste sewage disposal sub-contractor arrangements in place Proactive measures: Jetting of sewerage system in known areas of frequent blocking Ceiling tiles removed in record stores to aid detection of leaks Automatic leak detection installed in some areas Alcohol wipes removed from all toilet areas Restructuring of record stores (surplus files place in Armagh) Pipe runs replace in two record stores Replacing of old "push-fit" pipe system with welded joint system on a cost benefit basis	1.12.16 No further update. 13.09.16 The drainage issues in the main acute ward block has been mainly resolved in last year's ward works and the risks minimised due to the infrastructure issues(blockages still can occur due to inappropriate items being flushed down the sanitary points) In relation to the maternity block, £250k of funding has been allocated,awaiting business case being approved (possibly at next SMT) to commence with the procurement of the works and implementation on site by March 2017. 7/3/16 South side replaced and north side replaced on ground level. Basement works continuing. 22/7/15 This risk continues to be managed. Approval of 475k Revenue funding by SMT will enable some repairs to sewage system in CAH to be completed this year.	MOD
3660	ACUTE	20/04/2015	Provide safe, high quality careMake the best use of resources	Non compliance with testing of decontamination equipment as per DHSSPS guidance	Insufficient resources to carry out the full range of testing on decontamination equipment as per DHSSPSNI guidance.	All high risk decontamination equipment i.e. sterilisers, washer disinfectors, endoscope washer disinfectors will be tested as per DHSSPSNI guidance. Some of the lower risk contamination equipment i.e. bedpan washer disinfectors will be tested 4 monthly rather than 3 monthly as per DHSSPSNI guidance. Interim revised testing schedule approved by the IPC team and AE(D). Interim revised testing schedule will be reviewed annually. Additional revenue funding will be requested if availability of insufficient resources is on-going.	April 2015 Bedpan washer disinfectors will be tested 4 monthly rather that 3 monthly as per DHHSPSNI guidance.	VLOW
3663	ACUTE	29/04/2015	Provide safe, high quality care	Single CT Scanner available on DHH	If the CT scanner breaks down there is a potential to cause major operational difficulties in terms of assesssement and treatment of patients and delay in diagnosis.	In the event of a breakdown we have divert arrangements in place with NIAS whereby patients will not be brought to DHH but taken directly to CAH. In the short term there is a second unit on site until March 2020. An IPT business case has been written to reitain a modular CT Scanner in DHH.	Dec2021- meeting with HSCB in January 2022. 03/12/2021 - Currently awaiting feedback from DOH regarding the IPT. The provider is querying if the lease will be extended by March 2022 as they have other third parties interested in the unit. 14/09/2021- Medium term plan to build a CT suite in DHH with 2x x-ray machines and one MRI. Finance and Planning have asked the Regional Imaging Board. Clarification has been sought but not yet received. Trust running at risk even without funding March 2021 Need to secure additional funding to maintain the modular CT scanner for the next financial year March 2020 The Trust will build a new scanning suite in DHH which will provide 2 CT Scanners and an MRI scanner. There is currently no timeframe for the new suite due to the electrical infrastructure which needs to updated before the new suite is put in place 3/12/19 there are 2 CT scanners in place in CAH to cope with capacity and any downtime to the main scanner. DHH has 1 scanner which is being replaced, currently being covered with one ground level modular service in place during replacement. Risk remains as only one scanner in DHH and in case of downtime patients diverted to CAH. 7/8/19 Mobile CT Currently available on DHH site to reduce the workflow on main scanner. Work is planned for Sept/Oct to replace the existing DHH CT scanner and during the building works a mobile scanner will be available to facilitate DHH inpatients and ED patients. In the event of breakdown the transfer policy between CAH and DHH will be implemented. Nov18 Second CT Scanner is now in situ in CAH. 7.3.18 Mobile CT Scan is operational on site. 5.12.16 Mobile CT scanner now on site. Funding up until 31.3.17 to seek further funding to retain on site 17/18.	MOD

3689	ACUTE	08/06/2015	Provide safe, high quality care	Delayed reporting of Histopathology samples	Patients are at risk of a delay in the diagnosis and treatment of a variety of conditions as a result of a backlog of histopathology specimens for reporting. this backlog is caused by a reduction in the reporting histopathology capacity. Only consultant histopathologists report these samples. There is currently 1 vacancy and a capacity gap of 2 WTe Histopathologists. he delay could result in a delay in diagnosis and or treatment that would affect the efficacy of treatment and or lead to patient harm.	Some additional reporting sessions are being undertaken by pathologists. All samples are triaged in an effort to ensure that the more urgent or critical samples are processed and reported as a priority. A Locum histopathology has been source and the Trust is attempting to identify a second. The Northern Trust has indicated its willingness to report specimens. Recruitment to the vacancy is being pursued Placed on Directorate Risk register on 8/6/2015 ID: 3689. Placed on Performance risk register Oct 2015.	05/09/2017 Recruitment has been successful with outstanding vacancies being filled in September 2017- the is currently a minimal reporting backlog 1st February 2017 update - we have successfully recruited a permanent pathologist who should start 1st April 2017. we have a locum stating soon. we continue to use vacancy funsing and some elective care (endoscopy) funding to close the gap in capacity 5,.12.16 We continue to have 2 Consultant vacancies we are currently using a number of waiting list sessions from both internal staff and consultants from other Trusts for assistance in core time. Turnaround times are being actively monitored. 13.9.16 Locum Consultant pathologists have been employed since June 2016. The first of these has already left and the second is due to leave at the end of September 2016. In addition another part-time pathologist is leaving for a post in Belfast reducing the establishment by a further 6 P.A.s. There is an active recruitment process and the Trust is actively seeking replacement locum pathologists. 13.06.16 Referral to laboratories outside of Northern Ireland. This has been discounted as the histopathology information would be lost to the regional system. It may have to be considered if the risk does not reduce. Referral to Belfast and or WHSCT. Neither Trust has indicated that they have capacity to take additional samples.	LOW

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3829	ACUTE	13/09/2016	Safe, High Quality and Effective Care	Absconding patients from all Wards & Department	Patients at risk of leaving the ward or department without investigations, diagnosis and management plan in place. Patient risk - Incomplete treatment for medical or mental health issues leading to physical and/or mental health deterioration Risk of self harm / death Staff risk- unable to deliver care to patients, risk of violence and aggression when trying to persuade patients to avail of assessment, treatment and care for their illness.	Level of absconding rates identified. Absconding patient protocol in place. Staff awareness raised. Datix reporting in place. Short life working group established to review access to wards and departs promoting pts and staff safety.	19/11/21 Update from Lead Nurse SEC- A working group is currently developing a criteria method to help guide the level of supervision required in nursing observations in relation to mental health"Enhanced Care Observation (ECO)". A training component is also being developed for staff prior to the pilot of this tool. There is a corporately led MDT working group who have produced a draft SHSCT point of ligature policy which has been shared for consultation prior to final approval. 20/09/2021- Lead Nurse SEC update- absconding policy used at ward level. Patients identified at risk will be placed in a bedspace as much as possible that provides supervision/visibility. Referral to Psych liaison. Also current working group to establish a "patient at risk" assessment tool which incorporates all levels of risk and care planning. There is also work ongoing regarding access to psych services within Acute. 20/09/2021- Escalated as per trust policy in ED. 18/08/2021- Absconding policy in place and escalated to HOS if incident occurs. Reported via Datix process. 09.03.2021- within ED a risk assessment is carried out if PSNI accompany patient under article 130 a joint risk is completed with nursing team. ED AMU review absconding patients with PSNI and mental health at interface meetings 24.02.2021- still ongoing issue and the staff adhering to policy and datix submitted with review taking taking place for each case. 24.06.2019 Absconding policy available - any incidents submitted on Datix, reviewed and staff aware. 23/2/2018 - Additional measures have been introduced to access and egress from ED and AMU. Swipe card is required. Statistics need to be reviewed before consideration can be given to reducing the risk rating. Situation continually monitored.	HIGH

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

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

Issue	Action (Deadline)

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

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

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

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

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

SOUTHERN TRUST
ELECTIVE CARE DIRECTORS' MEETING

FRIDAY 26 FEBRUARY 2016
11.00am – 1.00pm
Conference Room 3, Linenhall Street

AGENDA

1. Welcome and introductions

2. Delivery of Core and Waiting Times – OP and IPDC

Summary of core attached with SHSCT internal comments (yellow boxes)
Key SBA issues related to

- G surgery – middle grade issue affecting capacity
- Urology – change in model to blue sky as per HSCB endorsed approach
- T&O – 10th consultant currently locum and working on trauma facing job place
- In-house activity undertaken at risk will inflate overperformance of SBA in some areas

3. In-house Additionality

HSCB refused Trust bid for additional but sought delivery of activity worth £800k. This is coded to core activity for Trust and will result in number of areas overperforming. We have this coded separately and will be able to separate out from core activity going forward

4. Independent Sector Update

40M monitoring round monies

- Trust submitted via finance update on slippage on spend – circa £221l
- Trust continues to monitor IS closely

Diagnostic monies

- IS not identifying any risk
- Endoscsopy – no provider in year or in 16/17
- NOUS – if required in 16/17 need to do open tender – can't secure from eligible provider list – 4 – 6 months lead in time

5. Endoscopy

- Underperformance associated with long term sickness of nurse Endoscopist
- Inability to secure top up volumes in IS (as above)
- Significant risk re planned patients (1 year now)
- Need commitment for funding for 16/17

6. Diagnostics

- On track from access perspective , except endo above
- Currently validating volumes to be undertaken and will identify any slippage early next week

7. AOB

AHP –

- Numbers agreed with Linus/Trust re-submitted formal returns
- Model accepted in principle for areas except podiatry wehre model does not appear to reflect risks around review backlogs
- Backlog clearance plan for new and review patient prepared

Breast Reconstuction

- Work with Sara for interim and longer term solution ongoing
- Need for strategic network approach to ensure stability in longer term

T&O way forward

- Meeting to be arranged with David to discuss
- Trauma risk – currently overperforming significantly on trauma IP and OP due to 10th trauma facing consultant post (via locum)
- If securing permanent post will be risks with trauma in future and potential recruitment of consultant with non commissioned sub specialist interest

Trouton, Heather

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

From: David McCormick [mailto:Personal Information redacted by 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 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

Telepho Personal Information redacted by USI
Mobile:
Email: m

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Relevant

Action List

Project Name	Urology Review Backlog Action Plan	Organisation	SHSCT		Project Owner	Martina Corrigan	Date Written:	06/05/2011
Item No.	**Action / Issue**	**Person Responsible**	**Due Date**	**Progress report so far**	**% Complete**	**Progress Tracker**		**Exception report/ Issues/ help required**
1	Update project Plan	HOS	06/05/2011	complete	100%			
2	Triage Patient Centre Letters 2008 backlog review patients will be triaged utilising administrative triage, nurse triage and consultant triage	HOS/Lead Nurse/ Specialist Nurses	31/03/2011	complete	100%			
3	Triage Patient Centre Letters 2009 backlog review patients will be triaged utilising administrative triage, nurse triage and consultant triage	HOS/Lead Nurse/ Specialist Nurses	31/03/2011	nurse triage complete- consultant triage ongoing	50%			on a weekly basis to ensure that momentum is maintained in triaging these letters. However it should be noted that through nurse/admin triage any patients that were deemed urgent have been given an urgent appointment with consultant
4	Triage Patient Centre Letters 2010 backlog review patients will be triaged utilising administrative triage, nurse triage and consultant triage	HOS/Lead Nurse/ Specialist Nurses	30/06/2011	nurse triage complete- consultant triage ongoing	50%			HOS working and meeting with consultants on a weekly basis to ensure that momentum is maintained in triaging these letters. However it should be noted that through nurse/admin triage any patients that were deemed urgent have been given an urgent appointment with consultant
5	Triage Patient Centre Letters 2011 backlog review patients will be triaged utilising administrative triage, nurse triage and consultant triage	HOS/Lead Nurse/ Specialist Nurses	ongoing from 1 July	ongoing not to commence until 1 July	0%			
6	Calculation of clinic requirements to undertake review backlog - 2008 review backlog	HOS	30/04/2011	complete	100%			18 additional clinics required to clear this backlog

7	Calculation of clinic requirements to undertake review backlog - 2009 review backlog	HOS	30/04/2011	complete	100%						67 additional clinics required to clear this back
8	Calculation of clinic requirements to undertake review backlog - 2010 review backlog	HOS	30/04/2011	complete	100%						93 additional clinics required to clear this backlog
9	Timetable of additional clinics to be undertaken	HOS	30/04/2011	complete	100%						To clear 2008 will take until October 2011 (approximately) To clear 2009 will take until November 2012 To clear 2010 will take until approximately July 2013 However HOS working with all consultants to see who has the most capacity to see if this specialty can pool in order to bring this date forward
10	Establish current capacity per site and identify any operational considerations	RBC Manager / HOS	31/03/2011	ongoing	50%						
11	Discharge Review Practices	Ward Sister overseen by Lead nurse	ongoing	ongoing	25%						This work is ongoing and it was agreed to be reviewed after one month, that is week commencing 9 May

12	Referral and booking centre interactions - development of an escalation plan which will allow the referral and booking centre to highlight capacity gaps in relation to urgent reviews	Head of Health records/ HOS	30/04/2011	ongoing	25%		
13	Referral and booking centre interactions - development of clear protocols for the referral and booking centre regarding the allocation of patients to review slots	AD/AMD	30/04/2011	ongoing	25%		
14	referral and booking centre interactions - development of clear protocols for the addition of patients to the urgent review lists	AD/AMD	30/04/2011	ongoing	25%		
15	referral and booking centre interactions - guidance to be developed and agreed with clinicians in respect of what patients are added to the urgent waiting list	HOS	30/04/2011	ongoing	25%		this is an agenda item on departmental meeting on 26 May 2011
16	referral and booking centre interactions - 'top of list' patients validated and actioned	OSL	ongoing	ongoing	25%		
17	Communication - ensure clear communication between clinical and administrative staff in respect of review requirements supported through the Ward Sister scrutiny of review appointment requests	Ward Sister overseen by Lead nurse	ongoing	ongoing	25%		this work is ongoing and it was agreed that this would be reviewed week beginning 9 May 2011
18	Administrative Processes - Undertake baseline assessment of compliance with the IEAP per consultant	OSL	30/04/2011	ongoing	75%		

19	Administrative Processes - Clinical guidelines to be agreed around application of IEAP i.e. robust criteria for re-appointments of DNAs etc	AD/AMD	31/05/2011	ongoing	25%						
20	Administrative Processes - Establish quarterly report to identify the number of patients who fall out of line with the IEAP	OSL	01/06/2011	ongoing	25%						

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Action List

Project Name	Urology Review Backlog	Organisation	SHSCT		Project Owne	Martina Corrigan	Date Written:	06/05/2011
Item	**Action / Issue**	**Person**	**Due Date**	**Progress report so**	**% Complete**	**Progress**	**Exception report/ Issues/**	
21	Administrative processes - Develop clear administrative and clerical protocols for the management of review patients ie compliance with IEAP, DARO functionality, addition of patients for review appointment at same time as listing for surgery and avoidance of duplication	OSL	30/04/2011	ongoing	50%			

Received from Mrs Heather Trouton on 15/04/22. Annotated by the Urology Services Inquiry.

DRAFT 10 – 2 January 2008

Department of Health, Social Services and Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí
www.dhsspsni.gov.uk

NORTHERN IRELAND CANCER ACCESS STANDARDS – A GUIDE

CONTENTS

Introduction

1. The NI Cancer Control Programme was published in November 2006. Within the Strategy there is a commitment to ensuring the timeliness of referral, diagnosis and treatment for suspected cancer patients. This document provides answers to some frequently asked questions about cancer access standards

- **2007/08 - '98% of patients diagnosed with cancer (decision to treat) should begin their treatment within a maximum of 31 days'**

- **2007/08 - '75% of patients urgently referred with a suspected cancer should begin their first definitive treatment within a maximum of 62 days. Where the performance of a tumour group currently exceeds this standard, performance should be sustained or improved against current levels'**

- **2008/09 - '95% of patients urgently referred as a suspected cancer should begin their first definitive treatment within a maximum of 62 days'.**

In addition there is also the existing two week waiting time standard for breast cancer patients:

- Maximum two week wait for referral for suspected breast cancer to date first seen from 1st August 2000.

This has been reinforced in Priorities for Action 2007/08.

- **"All breast referrals deemed urgent according to regionally agreed guidelines for suspected breast cancer should be seen within two weeks of the receipt of the GP referral"**

2. All these targets are being monitored through a regional cancer waiting times database tool offered to Trusts. The core data requirements will be circulated during December 2006.

Part 1- Who is responsible for meeting the targets and returning data?

1.1 Who is responsible for meeting the standards and returning data for Cancer Access Standards?

There is shared responsibility for the patients in the 62 day target between the First Seen Trust and the Treating Trust. This includes all records, i.e. the patients achieving the target and those breaching the target. The responsibility lies with the First Seen Trust to refer the patient in a timely manner allowing the Treating Trust adequate time to plan the treatment and deliver the diagnostic investigations in an appropriate timeframe to enable the target to be met.

Any breaches of the target will count half for both the Trust to which the patient was first referred and half to the Trust where the patient was treated. Accurate data needs to be communicated proactively to minimise delays in the patient pathway and ensure robust data quality.

This gives the Treating Trust enough time to properly plan the treatment within the target time and not delay the start of first definitive treatment. Any other Trust who may be involved in a patient's care (but not the treating trust or initially referred trust), must also expedite the processes through to 'first treatment'.

Where a 62 day breach occurs a discussion **must** take place between the referring and treating Trusts and agreement reached as to the reason for the breach, prior to identifying it on the database.
The trust where a patient is first seen following an urgent suspected cancer referral for returning data on these patients up to the date first seen.

1.2 Who is responsible for meeting the targets and returning data on the 31 day decision to treat to treatment target / 62 day referral for suspected cancer to first treatment target?

The trust administering the first definitive treatment is responsible for providing the information to support the targets on time to first treatment. See 1.2 regarding the shared responsibility for breaches of the target. They are also responsible for returning data on these patients to monitor the targets and for explaining breaches on existing standards (see below). The referring Trust will be responsible for ensuring the data items are transferred to the treating Trust.

Some patients on the 62 day pathway are first seen under the Cancer Access standard at one trust and are then referred on to another trust for treatment. The independent Regulation and Quality Improvement Authority (RQIA) may decide as part of its future work to assess the performance of all trusts in the care pathway in achieving the 62 day standard, from the end of 2008. So, in this case both trusts are responsible for ensuring that the 62 day waiting time target is met.

The new Health and Social Care Authority (HSCA) is responsible for commissioning services in line with the 31 and 62 day targets for their patients and should track waiting times for their managed population through the collection of cancer waiting times.

1.3 What information is required on breaches?

Detailed reports on breaches are required on all patients that wait longer than the target time and should include how long the patient waited, reason for the breach in the target and action put in place to prevent further breaches. The reasons for the breach should still be recorded for patients where there are good clinical reasons that a patient has waited longer than the target time (see para 2.6).

1.4 How does the database support the work of Service Improvement?

The collection of data has been designed to support the focus of service improvement by the Service Delivery Unit and the Northern Ireland Cancer Network. It allows the collection of a number of additional data items on cancer patients along the patient pathway, which the best evidence has shown are useful to service improvement.

1.5 Whose activity is it? Who is responsible for recording it?

Some questions have been raised about which trust code to record when a patient receives treatment. In general this is straightforward, but there are circumstances where you will need to consider the commissioning route for the care.

Some questions elsewhere in the UK have been raised about which trust code to record when a patient receives treatment. In Northern Ireland this is straightforward and there is no need to consider the commissioning route for the care.

Part 2 - Which patients do the standards apply to?

2.1 Do the targets include patients who are not referred through the Suspected Cancer Referral route?
The 31 day target applies to all new diagnoses of cancer regardless of the route of referral. For example this will include urgent GP referrals, urgent Consultant referrals, routine referrals and screening referrals.

The General Practitioner will ensure the urgent suspected cancer referral is sent within 24 hours of their consultation with the patient.

The 62 day target applies to patients who are referred through the urgent suspected cancer referral route. However, the standard applies to ALL patients referred through this route, irrespective of whether the referral was received within 24 hours.

2.2 Which patients should be included in the monitoring?
The Cancer Control Programme has set standards for all patients cared for under the HPSS in Northern Ireland and these patients should be monitored.

In the case where a patient is initially seen by the specialist privately but is then referred for first definitive treatment under the NHS, the patient should be included under the 31 day decision to treat to treatment target.

It is anticipated, the majority of definitive first treatments will be provided in secondary or tertiary care.

2.3 Do the treatment standards apply to patients receiving treatment for recurrence of cancer?

The standards only apply to patients with a newly diagnosed cancer. Some patients have metastases at presentation and so the treatment may be to the metastatic site rather than the primary site.

The standards do not apply to a patient receiving treatment for a recurrence of cancer. Clearly good clinical practice involves treating patients with recurrence as soon as possible on the basis of clinical priority.
When a patient is diagnosed with a second new cancer, which is not a recurrence, then the standards will apply to the treatment of this cancer (see part 6 for further details).

2.4 Do the treatment targets apply to patients who decline treatment?
Patients who decline any treatment should be excluded from the monitoring. However, even if there is no anti cancer treatment almost all patients will be offered a palliative intervention (e.g. stenting) or palliative care (e.g. symptom control) and these patients should be monitored.

2.5 Do the treatment targets apply to patients who die before treatment commences?
The targets concern waiting time to treatment. Hence patients who die before treatment commences should be excluded from the monitoring.

2.6 Are there any cases when the treatment time will exceed the standard time?

In a small number of cases there will be good clinical reasons for treatment time exceeding the target time. A generic example of this is where a patient is referred under the suspected cancer referral and there is diagnostic uncertainty as to whether they have cancer or not. These patients may require repeat diagnostic tests in order to reach a diagnosis.

> A patient who requires a particularly complex combination of scans and biopsies
> A patient for whom there is genuine clinical uncertainty about the diagnosis and the clinician elects to observe the patient over (say) a three-month period.

These patients will exceed the 62 day wait and this should be recorded on the cancer waits system. Detailed reasons on why these patients exceeded the target time should be recorded on the data collection process. It will not be appropriate to make adjustments in these cases.

The NI Cancer Network has endorsed the details of the thresholds allowed to take account of these clinical exceptions. These are based on the Healthcare Commission threasholds published in 2005. Examples of the suggested clinical exceptions are included in 4.23.

2.7 How do we monitor the following patient pathway? A patient is referred with a small breast lump which is fully assessed (e.g. by triple assessment, examination, imaging and needle biopsy) and is thought to be benign. The patient is reassured that the risk of this being cancer is low, but the clinician wants to check progress in 3 months. At that time it is clear that the lump is larger and a repeat biopsy shows cancer.

From the patient's perspective the interval between referral and diagnosis is clearly greater than 3 months. The waiting time reported should reflect this. We have always recognised that a small number of patients will breach for clinical reasons and this would be such a case.

2.8 At what point does a 'red flag' suspected cancer patient cease to be tracked as a potential 62 day wait patient?

A suspected cancer referral patient will cease to be tracked if a formal 'non-malignant' diagnosis is made (e.g. COPD). The patient comes off the 62 day monitoring. If the patient is subsequently diagnosed with cancer, they will enter the 31 day pathway from the date of decision to treat. This will include patients that are diagnosed with in-situ disease as these patients are not included in the cancer waits targets (except DCIS in breast care).

Where a suspected cancer referral patient is followed up due to diagnostic uncertainty (e.g. TRUS biopsy negative with a raised PSA), the patient remains on '62 day tracking', but will become a clinical exception as and when prostate cancer is diagnosed, if they are treated outside the 62 days.

It should be noted that where a GP has deemed a patient to be a 'red flag' suspected cancer they should be followed through on the cancer pathway and monitored as such. If a consultant assesses a patient to be urgent based on their triage of the referral letter or on their findings at initial hospital assessment they should be tracked in the same way.

Following this examination if the Consultant or Senior Clinical Grade Doctor considers the patient is not a suspected cancer patient, they can formally notify the GP within 24 hours of their decision and remove the patient from the 62 day pathway. The decision of the Consultant or Experienced Senior Clinical Grade Doctor must confirm in the patients notes that the "the patient has now been seen and the clinical opinion is that the patient does not have any evidence of a malignancy. In view of this, I am satisfied that this patient can be removed from the cancer 62 day tracking process". A suggested template to confirm this process is shown below. This formal recording is

necessary and will allow the decision to be audited at a later stage.

Consultants should not however ‘downgrade’ referrals deemed ‘red flag’ suspect cancers by a GP, without prior consultation with the referrer or face to face assessment with the patient by a Consultant or Experienced Senior Clinical Grade Doctor. Each Trust will need to identify the appropriate means to obtain consent for the consultation with the referrer, for each of the patient pathways.

The monitoring process allows for the separate identification of these different sources of referral and the analysis of the final outcome of the process. Suspected Breast Cancer Referrals are the exception to this guidance and where appropriate, these can be re-graded ‘downwards’ by a Consultant or Senior Clinical Grade Doctor.

DATE:

Highly Suspicious of Cancer GP Red Flag Referrals.

Patient: **Consultant:**

DOB: **Hosp No:**

This patient has undergone the investigations on the HSC suspected cancer pathway:

OPD Appt:	
Investigations:	

This patient is waiting for the following investigations outstanding:

- **..**
- **..**

This patient has an outpatient appointment with you on:

- ..
- ..

In order to update this patients suspected cancer patient pathway I would be grateful if you could confirm

• The patient has now received all **appropriate diagnostic tests** for this pathway and no malignancy has been identified. In view of this a formal non malignant diagnosis has been made and I am satisfied that this patient can be removed from the cancer 62 day PTL tracking process.	SIGN:	DATE:
• This patient has now been seen and the **clinical opinion** is that the patient does not have a malignancy. In view of this a formal non malignant diagnosis has been made and I am satisfied that this patient can be removed from the cancer 62 day PTL tracking process.	SIGN:	DATE:
• This patient is to be continued on the HSC pathway and should receive any further investigations/appointments within 1 week of request:	SIGN:	DATE:

Please fax this completed form to Cancer Services as a matter of urgency.
Thank you for your time
Fax Number: <please insert details>

2.9 Does the referral to treatment standard apply when a patient is referred on suspicion of one cancer but is diagnosed with another within the same care spell?

Yes, any patient who is referred as a suspected cancer and diagnosed with cancer within that care spell should be monitored under the 62-day target from urgent referral to treatment. To meet this target trusts will require effective handover arrangements between specialities where this situation can arise.
Examples of the tumour groups where this may occur include:
* Gynae/Colorectal (symptoms non-specific)
* Breast/Lymphoma (axillary lumps)
* Head and Neck/Lymphoma/Lung (neck lumps)
* Upper GI/Lower GI (symptoms non-specific)

Part 3 - How are the waiting times calculated in the regional database?

The table below refers to data items which will be fully explained in the core data items document. Database field names are in capitals

3.1 Reports: The regional monitoring process will provide reports for each of the waiting times standards. The table below specifies how the monitoring process will select records for a report and how the waiting time for each patient is calculated. *For the reporting period starting x and ending y*

For Target	Database will select records where	Calculation of waiting time:
Urgent referral to date first seen	DATE FIRST SEEN is between x and y **and** SOURCE OF REFERRAL FOR OUTPATIENTS = 03 or 92 **and** CANCER REFERRAL PRIORITY TYPE = 01	DATE FIRST SEEN **minus** CANCER REFERRAL RECEIVED DATE **minus** WAITING TIME ADJUSTMENT (FIRST SEEN)
Urgent referral to date of first definitive treatment	START DATE (first treatment) is between x and y **and** SOURCE OF REFERRAL FOR OUTPATIENTS = 03 or 92 **and** CANCER REFERRAL PRIORITY TYPE = 01 **and** PRIMARY DIAGNOSIS (ICD) is cancer+	START DATE (first treatment) **minus** CANCER REFERRAL RECEIVED DATE **minus** the sum of ~ WAITING TIME ADJUSTMENT (FIRST SEEN) ~ WAITING TIME ADJUSTMENT (DECISION TO TREAT) ~ WAITING TIME ADJUSTMENT (TREATMENT)
Decision to treat to first definitive treatment	START DATE (first treatment) is between x and y **and** PRIMARY DIAGNOSIS (ICD) is cancer+	START DATE (first treatment) **minus** DECISION TO TREAT DATE **minus** WAITING TIME ADJUSTMENT (TREATMENT)

See Appendix D of the Core Data definitions document

3.2 Performance Monitoring Process:

The performance monitoring process will be consistent with the other Service Delivery Unit workstream. See Section 7 which includes more information concerning the proposed process for monitoring cancer access standard.

3.3 For monitoring purposes, how many days is one month?

A month is taken to be 31 calendar days. Two months is 62 calendar days. Two weeks is 14 calendar days.

3.4 How do we count the days waited?

The date at the beginning of the waiting period is day 0. Hence is order to meet the 14 day standard if a patient is referred on 1st February the patient would need to be seen on or before 15th February.

For those patients referred as a suspected cancer patient, the first day is day 0, this would then mean that a patient referred on the 1st November the patient would need to have received their first definitive treatment on or before the 2nd January

Part 4 - FIRST DEFINITIVE TREATMENT

4.1 Several questions have been raised by Trusts regarding both the definition of "first definitive treatment" and the date which should be recorded. These issues have been considered nationally in England by the Cancer Waiting Times Implementation group and the National Cancer Director. Within Northern Ireland the guidance has been reviewed and endorsed by each of the NI Cancer Network Tumour Groups. The advice is given in the following paragraphs:

4.2 It may be useful to consider the various types of primary "treatment package" that different patients may receive:

- Many patients will receive a single treatment modality aimed at removing or eradicating the cancer completely or at reducing tumour bulk (e.g. surgery, radiotherapy or chemotherapy). In these cases the definition of "first definitive treatment" and the start date are usually straightforward.

- A second group of patients will receive a combination of treatments as their primary "treatment package" (e.g. surgery followed by radiotherapy followed by chemotherapy). In these cases the "first definitive treatment" is the first of these modalities to be delivered, and the date is the start date of this first treatment.

- A third group of patients require an intervention which does not itself affect the cancer to be undertaken prior to the delivery of the anticancer treatment(s) – to enable these treatments to be given safely. Such interventions might include formation of a colostomy for an obstructed bowel or insertion of an oesophageal stent. As these interventions form part of the planned "treatment package" for the patient it has been agreed that the start date of the enabling intervention should be taken as the date of first definitive treatment.

- A fourth group of patients undergo a clearly defined palliative intervention (e.g. a colostomy or a stent) but do not then receive any specific anticancer therapy. For these patients the start date of this intervention should be recorded as the date of first treatment.

- A fifth group of patients do not receive any anticancer treatments but are referred specifically to a specialist palliative care (SPC) team. For these patients the date of the first assessment by a member of the SPC team is to be taken as the date of the first "treatment".

- A sixth group will receive both anticancer treatment (e.g. radiotherapy) and a specialist palliative care assessment. In this instance the date of the anticancer treatment is to be taken as date of first treatment.

- Finally, some patients do not receive any specific anticancer treatment/intervention and are not referred to a SPC team. Where the patient is receiving symptomatic support and is being monitored these patients should be classified as undergoing "Active Monitoring". It is recognised that this is somewhat unsatisfactory as this group encompasses patients with early cancer (e.g. localised prostate cancer where serial monitoring of PSA is undertaken) and those with advanced cancers for which no immediate specific interventions are considered to be warranted. These patients may, of course, require general palliative care including symptom control – given under the care of GPs and/or oncologists. [NB At a later date revisions to the dataset will be considered but these cannot be made immediately]

4.3 The first definitive treatment is normally the first intervention which is intended to remove or shrink the tumour. Where there is no definitive anti cancer treatment almost all patients will be offered a palliative intervention (e.g. stenting) or palliative care (e.g. symptom control), which should be recorded for these purposes. In more detail:

First definitive treatment type	Circumstances where this applies
Surgery	♦ Complete excision of a tumour ♦ Partial excision/debulking of a tumour (but not just a biopsy for diagnostic or staging purposes) ♦ Palliative interventions (e.g. formation of a colostomy for a patient with an obstructing bowel cancer, insertion of an oesophageal stent or pleurodesis)
Drug treatment: Chemotherapy, *Biological therapy*[+] OR Hormone therapy	♦ Chemotherapy (including cases where this is being given prior to planned surgery or radiotherapy)
	♦ Biological therapy includes treatments targeted against a specific molecular abnormality in the cancer cell (e.g. rituximab, trastusumab, glivec) and treatments which target the immune system (e.g. interferon, interleukin 2, BCG).
	♦ Hormone Treatments should count as first definitive treatment in two circumstances (1) Where hormone treatment is being given as the sole treatment modal ity (2) Where the treatment plan specifies that a second treatment modality should only be given after a planned interval. This may for example be the case in patients with locally advanced breast or prostate cancer where hormone therapy is given for a planned period with the aim of shrinking the tumour before the patient receives surgery or radiotherapy.
Radiotherapy	♦ Given either to the primary site or to treat metastatic disease. This should include cases where radiotherapy is being given prior to planned surgery or chemotherapy.
Specialist Palliative Care (SPC)	♦ Given via hospital SPC teams ♦ Given via community SPC teams ♦ Given via hospices (if known by the Trust)
Active monitoring	♦ When none of the other defined treatment types apply and the patient is receiving symptomatic support and is being monitored. The date of commencement of active monitoring should be the consultation date on which this plan of care is agreed with the patient, including the intervals between assessments (e.g. serial PSA measurements for prostate patients). This treatment type may be used for any tumour site if appropriate. ♦ For the purposes of waiting times the field active monitoring should also be used to record patients with advanced cancer who require general palliative care.

[+]*Biological therapy – For the purposes of the performance monitoring Biological Therapy should be recorded as "chemotherapy" in the field PLANNED CANCER TREATMENT TYPE as defined in Core Data Definitions document.*

4.4 What is the date of treatment where treatment is self-administered?
The Start date of treatment is taken to be the date of the outpatient appointment where the patient is given the prescription.

4.5 Where should palliative procedures such as stenting be recorded?
To be consistent with the Cancer Dataset any procedure should be recorded under surgery. Section 7 of the cancer dataset is designed to collect all surgery and all other procedures and hence a palliative procedure such as stenting should be recorded under surgery. Of course the waiting dataset will not tell us whether the surgery is curative, palliative or what the intervention is. Trusts and networks may want to record the intention of the surgery or the OPCS 4 code of the procedure, but that is beyond what is required nationally to monitor waiting times.

4.6 How should we record supportive care drugs on the database?
Where a patient receives palliative care only they may of course be treated with supportive care drugs, but this is not recorded as first treatment. The first treatment should be recorded as one of the following:

i. Where the patient does not receive any anticancer treatments but is referred specifically to a specialist palliative care (SPC) team. For these patients the date of the first assessment by a member of the SPC team is to be taken as the date of the first "treatment".

ii. Where the patient is not referred to an SPC team and is receiving symptomatic support and is being monitored these patients should be classified as undergoing "Active Monitoring".

4.7 How should a patient who is diagnosed incidentally for cancer be monitored?

Some patients may be diagnosed for cancer during routine investigations or while being treated for another condition. This is why we have set targets from decision to treat to treatment, and once cancer is diagnosed the patient should be treated without delay. These patients should be monitored under the 31 day decision to treat to treatment target. Where the patient is treated immediately at point of diagnosis the decision to treat will be the same date as the date of the operation. (e.g. when a patient is unexpectedly found to have a cancer during surgery for a suspected benign condition).

4.8 Can a diagnostic procedure also be counted as treatment?
A purely diagnostic procedure (including biopsies) does not count as treatment unless the tumour is effectively removed by the procedure, examples of this would be a polypectomy during a Colonoscopy or an excision biopsy of a melanoma.
If an excision biopsy is therapeutic in intent (i.e. the intention is to remove the tumour) then clearly this will count as first treatment, irrespective of whether the margins were clear.

4.9 – How are patients who are treated for cancer under a clinical trial monitored?
The cancer waits standards apply to all patients treated under the NHS and so has to include patients treated under clinical trials. A suspension does not apply simply because a patient is participating in a clinical trial.

4.10 Are Carcinoid tumours reported for cancer waits?
Carcinoids of the appendix are coded as D37.3 and so are not reported for cancer waits, but carcinoids of any other site are coded to a C code in ICD10 and so are reported for cancer waits.

Haematology

4.11 If a patient has a blood transfusion would this count as first treatment?
If a patient is not planned to have active anticancer treatment (e.g. chemotherapy or radiotherapy) then a blood transfusion should count - as a palliative care treatment (e.g. for

chronic lymphocyte leukaemia).
In all other circumstances the blood transfusion would not count as first treatment.

4.12 Would anti-biotics be counted as first treatment for low grade gastric lymphomas?
Yes anti-biotics would count as start of treatment for low grade gastric lymphoma.

4.13 What counts as treatment for lymphoma?
The removal of a lymph node is a biopsy to establish diagnosis and would not count as start of treatment as there is disease throughout the body. Patients will be treated with chemotherapy, radiotherapy or observation depending on the biopsy diagnosis.

Breast

4.14 In the treatment of breast cancer what is the position when a patient has immediate reconstruction as part of the first definitive treatment?
When a patient has immediate reconstruction as part of the first definitive treatment this should be within a month of decision to treat where this can possibly be achieved. However if a patient is offered alternative definitive treatment within a month, i.e. Mastectomy without immediate reconstruction, but instead chooses to have the immediate reconstruction at a somewhat later date, the provider should not be penalised for this. Full details on these patients should be provided by the trust in the exception report.

4.15 Does Sentinel Node Biopsy count as start of treatment in breast cancer?
This does not count as start of treatment as this is a diagnostic procedure to determine whether cancer has spread to the lymph nodes.

Lung

4.16 Would "open and close" lung surgery count?
A small number of patients will undergo open and close surgery on the lung, which does not resect the lung. Although this does not remove the tumour this should still be counted as it is a treatment procedure, although the outcome is unsuccessful.

4.17 In lung cancer would the drainage of a pleural effusion count as treatment?
If a patient is not planned to have active anticancer treatment (e.g. chemotherapy) then this should count - as a palliative care treatment
In other circumstances it will not count.

4.18 In lung cancer would a mediastinoscopy count as first treatment?
No, this would not count as start of treatment

4.19 If a patient has a non small cell lung cancer and has to be stented can this be classed as a first treatment?
Yes this would be recorded as the start of cancer treatment.

Head and Neck

4.20 Would dental clearance count as start of treatment in oral cancer?
No, this would not count as start of treatment. An adjustment to the waiting time can be made if the dental clearance means the patient is unfit for radiotherapy and so the radiotherapy treatment is delayed (see section 8.10).

4.21 Head & neck patients often require the insertion of a PEG (Percutaneous Endoscopic Gastrostomy) prior to surgery or radiotherapy, would this count as the start of a first treatment?

This procedure enables patients nutrition prior to the start of active treatment. In this case the

period they are unfit for the treatment should be an adjustment, but the insertion of the PEG is not the treatment itself. If a patient requires nutrition via a PEG to make them fit for active treatment a medical suspension may be recorded.

4.22 Would a hemi-thyroidectomy count as start of treatment in patients diagnosed with Thyroid cancer?
Yes, hemi-thyroidectomy is considered as start of treatment.

Urology

4.24 How do we monitor patients with bladder cancer?
Cancer registries do not record carcinoma in situ or pTa transitional cell carcinoma as 'cancer' as they are regarded as non invasive. Patients with these histological diagnoses are therefore not counted for the purposes of the 31 and 62 day targets. (Grade 3 pTa are registered in ICD10 as in-situ tumours (D09.0) and grade 1 and 2 as borderline (D41.4))

For bladder cancer diagnoses, the TURBT counts as the first definitive treatment provided it is carried out with the intention of debulking rather than just carrying out a biopsy of the cancer. TURBT remains the first definitive treatment even for patients who require further treatment such as cystectomy or radiotherapy.

A TUR biopsy of a bladder cancer or a biopsy of metastatic disease will not count as first definitive treatment.

If a patient has completed the standard investigations for haematuria (i.e. normal cystoscopy and normal upper tract imaging) and no malignancy has been identified then a 'benign' diagnosis can be made and these patients will not be included in the 62 day target. However if monitoring or further tests are planned (e.g. because of abnormal urine cytology or equivocal upper tract imaging) then monitoring for the 62 day target cannot be stopped until these are complete and a benign cause is diagnosed.

4.25 What counts as first definitive treatment for Upper Tract Transitional Cell Carcinoma (TCC)?
First definitive treatments include:-
• Radical surgery (e.g. nephroureterectomy)
• Local excision (open or endoscopic)
• Chemotherapy
• Palliative therapy
• Surveillance

4.26 How do we monitor patients with prostate cancer?
Patients with a raised PSA or clinically suspected prostate cancer who are referred via the suspected cancer referral will continue to be monitored until cancer is diagnosed and the first definitive treatment commenced or an unequivocal benign diagnosis is made. In practice there still remain some unclear areas.

If a patient has a raised PSA and the prostate biopsy shows benign tissue or PIN only, provided no immediate re-biopsy is planned then monitoring ceases. However, if the suspicion of cancer remains (e.g. a very high PSA, suspicious histology or inadequate tissue obtained at the first biopsy) and a further immediate biopsy is planned despite the benign first biopsy the patient continues to be monitored.

Once a patient has been told that the diagnosis is benign even if continued assessment of the PSA is recommended, the patient is no longer tracked as a potential 62 day patient whether they are discharged or not.

For patients who have locally advanced or metastatic disease, first definitive treatment will usually be hormone therapy or watchful waiting.
For patients who apparently have localised disease and are suitable for curative treatment a pelvic MR scan may be indicated (see para 8.10 for guidance on stopping the clock).
Once a patient is given a number of treatment options, they may ask for time to think before selecting their preference. The clock stops while the clinician is waiting for the patient to decide (this is generally regarded as good practice). However the clock continues while the patient is waiting to see various specialists to discuss the different options e.g. surgeon, radiotherapist or brachytherapist.

First definitive treatment options include:-
• Radical surgery
• Radical radiotherapy
• Definitive treatment with new technology
• For those patients who have neo-adjuvant hormone therapy, the date of starting hormone therapy is taken as the first definitive treatment.
• Active monitoring
• Watchful waiting
If these options are chosen it is important to note the decision date clearly in the patient's case sheets for the monitoring team.

4.27 In prostate cancer would a TURP count as first treatment?
The guidance has been reviewed after further advice from urologists.
A TURP may be performed on known prostate cancer patients to palliate symptoms (where it could be regarded as de-bulking surgery).
In other patients a TURP may be carried out for benign disease and incidentally diagnose and treat prostate cancer. In both cases this will count a start of treatment.

4.28 How do we track a suspected cancer referral patient who refuses altogether to have a TRUS biopsy but the clinician continues to review?
The TRUS biopsy will potentially diagnose the patient and by refusing altogether to have a TRUS the patient has removed themselves from the 62 day pathway. If cancer is subsequently diagnosed then the patient will be monitored under the 31 day target.
Where a patient delays a TRUS biopsy an adjustment should be made, and tracking as a potential 62 day patient should continue.

4.29 What counts as first definitive treatment for kidney cancer?
First definitive treatments include;-
• Surveillance
• Radical surgery
• Local excision (nephron sparing surgery)
• Ablation using new technology
• Immunotherapy
• Palliative care

4.30 What counts as first definitive treatment for testis cancer?
First definitive treatments include
• Orchidectomy
• Chemotherapy
• Palliative care

4.31 What counts as first definitive treatment for penile cancer?
First definitive treatments include
• Debulking operation e.g. circumcision, excision biopsy
• Radical surgery e.g. amputation, excision inguinal lymph node metastases

• Radiotherapy
• Chemotherapy
• Palliative care

Carcinoma in situ is not classed as invasive and so is not included in cancer waiting times data

Gynae

4.19 What would count as the date of first treatment in Gynaecological Cancer?

- Date of admission for surgery (or date of admission as emergency if proceeds to surgery during that admission). A cone biopsy should count as first treatment in early cervical cancer as it is a curative / definitive treatment for stage 1a disease. A diagnostic loop biopsy in more advanced cases would not usually be called a "cone" biopsy.

- Open and Close surgery - Where a patient has a major laparotomy for (usually) ovarian cancer the intention is de-bulking (not diagnosis) and so will count as start of treatment.

- Date of first radiotherapy / chemotherapy where these are first treatments

- Date of first hormonal therapy where this is used as primary treatment (eg endometrial cancer in frail patients or very young patients with low grade disease)

- Date of “treatment enabling” intervention forming part of the planned “treatment package” (eg ureteric stenting for advanced cervical cancer)

- Date of palliative intervention (e.g. colostomy or stenting) where no specific anticancer therapy is planned

- Date of the first assessment by a member of the Specialist Palliative Care team for patients who do not receive any anticancer treatments. Diagnosis does not need to be confirmed by histology / cytology for inclusion into statistics.

- “Active Monitoring”: for patients who receive symptomatic support but who do not receive any specific anticancer treatment / intervention and are not referred to a SPC team – rare in gynae oncology

4.33 How do we record the wait for a patient with ovarian cancer who requires the drainage of Ascites prior to being fit for chemotherapy?
In this situation a medical suspension would apply for the period the patient is medically unfit for the chemotherapy.

Upper GI

4.34 Would the insertion of a pancreatic stent count as start of treatment for pancreatic cancer?
After discussions with national leads it has been agreed that the **previous guidance needs to be amended.**
If the planned first treatment is resection for pancreatic or related cancers (ampullary, duodenal and distal bile duct), but subsequently the patient requires a stent due to a delay to having the surgery then stenting will not count as start of treatment. Many clinicians agree that patients with mild obstructive jaundice (a serum bilirubin below 200 micromol/l) do not require bilary stenting before resection, if surgery and imaging are planned within 7-10 days. If this is the agreed clinical practice locally then stenting for these patients will not count as start of treatment.

If the planned first treatment is to insert a stent in order to resolve jaundice before the patient has a resection or the patient starts chemotherapy stenting will count as start of treatment.

4.35 Should gastrointestinal stromal tumours (GISTs) be recorded for cancer waits?
GISTs that are described as malignant, invasive or as having metastases are coded to the relevant C code for the part of GI tract involved and are thus included in the cancer waits. GISTs not otherwise specified are coded as borderline using the relevant D code and are not recorded for cancer waits.

4.36 Would a jejunostomy count as start of treatment?
The jejunostomy would not count as start of treatment as it is a procedure to insert a feeding tube. However if a patient is medically unfit while they recover from the procedure before start of treatment (e.g. chemotherapy) it is appropriate to make an adjustment and to suspend the patient for the period they are unfit.

Brain/CNS

4.21 When a patient with a Brain tumour is given Dexamethasone would this count as first treatment?
Dexamethasone will only count if the patient is only being cared for palliatively and no other anti-cancer treatment is offered.

4.38 Should treatment of Von Hippel-Lindau syndrome be recorded on cancer waits?
No, this is a benign condition and so is outside the monitoring of cancer waiting times.

4.39 Which grades of brain tumour do we report for cancer waiting times?
Grade 3 and 4 tumours are considered malignant and should be reported for cancer waits. Grade 1 and 2 tumours are benign and so should not be recorded for cancer waits

Skin

4.22 In skin cancer are Intraepidermal carcinomas, Lentigo malignas or bowen's disease included in the monitoring of cancer waiting times targets to treatment?

No. All these conditions are classified as carcinoma in-situ of the skin and so are outside the scope of diagnoses monitored for cancer waiting times. Full details of the diagnosis codes covered in cancer waiting times are available in the core data definitions document.

Complex pathways

4.23 What are the complex pathways/clinical exceptions and how should this be recorded?

For a very small number of patients, there will be good clinical reasons for their care pathway not to be completed within the 31/62 days. For reasons this will vary according to individual patients and the type of cancer. Such clinical exceptions should continue to be recorded on the cancer access database, and on waiting list, although they will end up breaching the standard times. It has been agreed by the Network Tumour Groups it is acceptable for these few cases to breach the standard.

For the 62 day pathway, patients may attend for diagnosis test which prove inconclusive, leaving uncertainty as to whether they have cancer or not. If is best practice for these patients to remain within the hospital system, as repeated tests over a period of time may be required before a definitive diagnosis can be made. However, the term ‘clinical exception’ cannot be applied simply because a patient requires a series of multiple diagnostic tests, for which there are long waiting times, thus a lung cancer patient who requires several staging tests is not a “clinical exception”.

The 31 day target does not cover the diagnostic phase of the pathway and so there are fewer reasons why a patient is likely to take longer than 31 days between decision to treat and the start of their treatment.

The following are a few examples of circumstances which might be categorized as clinical exceptions:

Gynaecology - There will be a few patients coming through less obvious pathway such as those presenting with a pleural effusion who turn out to have an ovarian carcinoma. Patients presenting with endometrial hyperplasia who require repeat biopsies, may also be clinical exceptions as there is diagnostic uncertainty.

Haematology - Patients with lymphoma who have solitary mediastinal (also see lung cancer) or abdominal lymph node disease.

Head and Neck - Patients with in-situ carcinoma and those presenting with an isolated lump in the neck from an unknown primary site.

Lower GI - Those patients presenting with a rectal or colonic polyp with a focus of invasive carcinoma.

Lung Cancer - Patients presenting with pulmonary nodules or shadowing of an uncertain nature that require follow-up prior to eventual diagnosis of lung cancer.

Upper GI - Patients presenting with high grade dysplasia or carcinoma in-situ.

Urology - An inconclusive trans-rectual ultrasound biopsy for suspected prostate cancer will be repeated, but there needs to be a time delay before the patient can be retested to allow the patient to recover.

The above is not intended to be an exhaustive list or clinical exceptions but instead to provide an indication of the type of patient that could be classified as such. It should be noted that the situation described above are such that the rules for adjustments and medical or social suspensions (stopping the clock) cannot be applied to them.

Part 5 - What is the “FIRST DIAGNOSTIC TEST”?

5.1 This section provides a list of first major diagnostic tests. The first major diagnostic test is the test which will move the level of suspicion of cancer from "possible/probable" (based on history, clinical examination or blood count) to "highly probable/certain". This list is not exhaustive and so should be used as a guide to help teams in recording this data.

Primary tumour type	**First major diagnostic test likely to be one of the following**
Breast	Mammogram, Ultrasound, Needle Biopsy
Lung	Bronchoscopy, CT scan or MRI
Colorectal	Barium Enema, Flexible Sigmoidoscopy, Rigid Sigmoidoscopy, Colonoscopy, biopsy, ultrasound for abdominal mass, CT, digital rectal exam, MRI
Upper GI	Barium Meal/Swallow or Gastroscopy
Urology	I.V.U., flexible cystoscopy, trans-rectal ultrasound. P.S.A., Ultrasound
Gynaecology	OVARY: Ultrasound Scan or Ca 125(usually), CT scan (in some cases) CERVIX: Biopsy VULVA: Biopsy, Vulvoscopy ENDOMETRIUM: Vaginal Ultrasound, Endometrium Assessment/Sampling, Hysteroscopy
Haematology	Full Blood Count, Bone Marrow, Node Biopsy or CT scan
Skin	Biopsy
Head and Neck	Upper airways endoscopy, biopsy, CT scan, MRI
Brain	CT or MRI scan

The date of the first diagnostic test is recorded in the field
CLINICAL INTERVENTION DATE (FIRST DIAGNOSTIC TEST)
The date of the first diagnostic test must be after the patient has been referred to secondary care.

Part 6 - When should a new record be created?

6.1 A new record is required for each new cancer care spell. This appendix provides definitions of a cancer care spell for breast, lung and skin cancers. The definitions of cancer care spells for other tumour types are being agreed through the development of the National Cancer Dataset and will be available in subsequent versions of the Dataset document (which will be made available on the Health and Social Care Information Centre website).

6.2 In general, recurrence of cancer at the same site is considered to be part of the same care spell (so it does not require a new record) but it would be the subject of a new care plan for its management. The treatment standards in the Cancer Control Programme only apply to first definitive treatment of newly diagnosed cancers.

6.3 Breast Cancer (see exceptions below)

A new Cancer Care Spell for breast cancer should be started for:

- different histology
- different laterality

So, simultaneous bilateral breast tumours with the same histology would result in two Cancer Care Spells, one for the right breast and one for the left breast.

Multi-focal tumours (i.e. discrete tumours apparently not in continuity with other primary cancers originating in the same site or tissue) would result in one Cancer Care Spell (unless they have different histology and/or different laterality).

6.4 Lung (see exceptions below)

A new Cancer Care Spell for lung cancer should be started for:

- Any tumour with a different histology, irrespective of ICD-10 code or laterality
- A tumour with a different three-character ICD-10 code, except in cases where this is considered to be recurrence of the original primary tumour
- A tumour with different laterality except in cases where this is considered to be recurrence of the original primary tumour

However, a single lesion of one histological type is considered a single primary (i.e. one Cancer Care Spell), even if the lesion crosses site boundaries above. Differences in histological type refer to differences in the first three digits of the morphology code.

So, simultaneous bilateral lung tumours with the same histology (excluding metastases) would result in two Cancer Care Spells, one for the right lung and one for the left lung.
Multi-focal tumours (i.e. discrete tumours apparently not in continuity with other primary cancers originating in the same site or tissue) would result in one Cancer Care Spell (unless they have different histology and/or different laterality) – unless these were considered to be metastatic from the primary tumour.

6.5 Skin Cancer

There are particular rules for recording skin cancers within the Cancer Dataset, which apply when collecting skin cancer data for monitoring of Cancer Waiting Times. For full details please see the Cancer Data Manual. **Please note that data on the treatment of basal cell carcinomas is not required for the cancer waiting system as they are not covered by the cancer waiting times targets to treatment (see core data definitions document for further details).**

For Squamous Cell Carcinoma – Most patients have a single lesion at presentation, but a significant number will get more primaries over a period of time. Only one cancer care spell (i.e. one record) should be recorded for all these Squamous Cell Carcinomas.

For Kaposi's sarcoma – A new cancer care spell should be started for each Kaposi sarcoma diagnosed.

Malignant Melanoma – A new cancer care spell should be started for each Malignant Melanoma diagnosed.

Cutaneous Lymphomas - A new cancer care spell should be started for each cutaneous lymphoma diagnosed.

6.6 Exceptions

The Cancer Waiting Times database works on the basis of a single dataset record for a given Cancer Referral Decision Date or a given Decision to Treat date. Hence there are rare occasions when the database cannot record both cancer care spells:

1. If a patient is referred by the GP for two different suspected cancers **on the same date,** only the first of these can be recorded.
2. If a patient is urgently referred for suspected cancer and is diagnosed with two separate cancers (which both relate to the **same Cancer Referral Decision Date),** only the cancer first treated can be recorded on this record. Where the decision to treat date for these cancers is different, treatment data for the second cancer should be recorded as a new record and information recorded from the date of decision to treat to date of first definitive treatment (start date).
3. If the decision to treat date **is the same date** for 2 separate cancers only the first of these cancers can recorded.

Part 7 – Data and the Database

There is currently no single system available regionally which will link the patients pathway across organisations. The aim in the mid to long term is to identify an IT system which is complimentary to all the existing IT systems within Northern Ireland and will enable the collection of information through a single data entry method. It is intended the collection of information to asses the timeliness of treatment should form part of the information collection process which is required to ensure effective clinical decision making and the audit of clinical outcomes.

It is recognised a number of Trusts have already established cancer patient databases which are used for the clinical decision making and audit for the cancer multi-disciplinary team. In the short term it is intended these should be developed by Trusts to allow the collection of the data items included in the core data definitions document.

A core data definitions document has been developed which lists all the information which is required to monitor the cancer patient access standard. Trust should ensure the databases are able to collect each of the listed information.

7.1 If the Trust does not have a database, what database is available?

The Cancer Registry has recognised the key forum for the collection of cancer patient treatment is the multi-disciplinary team and has developed a cancer patient database, including a cancer staging tool. A number of cancer multi-disciplinary team meetings are already using the Cancer Registry database to support the collection of cancer patient information and to facilitate timely decision-making. The Cancer Registry database will be made available to each Trust for local implementation.

7.2 What support is available for the database?

A training programme for the databases will be provided. Any supplementary IT support required will be provide from within Trust IT support staff. Any significant errors within the Cancer Registry database should be notified directly to the Clinical MDM Support Consultant, Dr Lisa Ranaghan Telephone 028 9063 2573

7.2 How will non-mandatory data recorded on the database be used?

Mandatory data on the database are required to monitor the cancer plan targets. In addition the database supports collection of a small number of additional data items that the Cancer Services Collaborative have shown are useful to support service improvement. All non mandatory data items will only be available for local use.

The core data definitions document clearly explains the data to be collected.

Only the trust(s) who manage the care of individual patients will be able to download patient identifiable information.

7.3 Will trusts be able to update data on patients for which there is an existing record on the database?

Yes. The database allows records to be automatically updated through the Cancer Multi-disciplinary Team meeting.

7.4 For which patients can we record CANCER REFERRAL DECISION DATE?

This may only be recorded on the database for Urgent Suspected Cancer Referrals from for suspected cancer. The Cancer Referral Decision Date and Health and Care Number together form the unique record identifier within the database for these records (see para 7.9).

7.5 Which data items within the database are required to monitor the Cancer plan Targets?

The table in Appendix A of the core data definitions document shows which data items are required for monitoring the Cancer Access Standards. The table splits up data required for the access standard and treatment data, as patients may be treated in a different organisation to where they are first seen.

"Trust where first seen if urgent GP referral for suspected cancer" - The M's show the data required for ALL suspected cancer referrals to allow reporting against the suspect cancer GP red flag referrals . i.e. A trust reporting the suspect cancer referrals must ensure all the M's are complete for each record. Other data is optional or not applicable.

"Trust where patient receives first definitive treatment for cancer following a referral other than an urgent GP referral for cancer" - The M's show the data required on all cancer patients who do not come through the suspect cancer red flag GP referral route for monitoring the one month diagnosis (decision to treat) to treatment target. The Trust who delivers the first definitive treatment must ensure this data is complete. Other data is optional or not applicable.

"Trust where patient receives first definitive treatment for cancer following an urgent GP referral for suspected cancer". The M's show the data required on all cancer patients who come through the 'red flag' GP suspect cancer rule to enable monitoring of the one month diagnosis (decision to treat) to treatment target and the two months urgent referral to treatment target. The Trust who delivers the first definitive treatment must ensure this data is complete. These patients will already have the data from the first column recorded on them within the database. Other data is optional or not applicable.

7.6 Why are some of the options on SOURCE OF REFERRAL FOR OUTPATIENTS not available on the database?

The source of referral relates to the initial referral into secondary care and so should relate to the DATE FIRST SEEN. Some of the options are not available on the database in order to protect the integrity of this data and to discourage trusts further down the pathway overwriting this data.

7.7 Which MDT discussion should be recorded on the database?

As stated in the Cancer Control Programme, the care of all patients should be formally reviewed by a specialist team. This will be either through direct assessment or through formal discussion with the team by the responsible clinician. This will help ensure that all patients have the benefit of the range of expert advice needed for high quality care.

In line with the manual of cancer services, the date of MDT meeting in which the patient's treatment plan is agreed should be recorded on the database.

(Standard 2A-136 " The Core MDT, at their regular meetings should agree and record individual patient's treatment plans. A record is made of the treatment plan … including the multidisciplinary planning decision".)

7.8 How should the new codes for cancer status be used?

Cancer Status codes and descriptions

1	Suspected cancer
3	No new cancer diagnosis identified by the Trust
5	Diagnosis of new cancer confirmed – treatment not yet planned
6	Diagnosis of new cancer confirmed - NHS treatment planned
7	Diagnosis of new cancer confirmed - no NHS treatment planned
8	First treatment commenced (NHS only)

The purpose of item is to identify those urgent referrals for suspected cancer who require data to be recorded on first definitive treatment.

1 Suspected cancer

3 No new cancer diagnosis identified by the Trust
Use when benign or normal diagnosis or when a patient is diagnosed with a recurrence (see below).

5 Diagnosis of new cancer confirmed - treatment not yet planned
Use for patients with a new diagnosis of cancer, but where treatment is not yet planned.

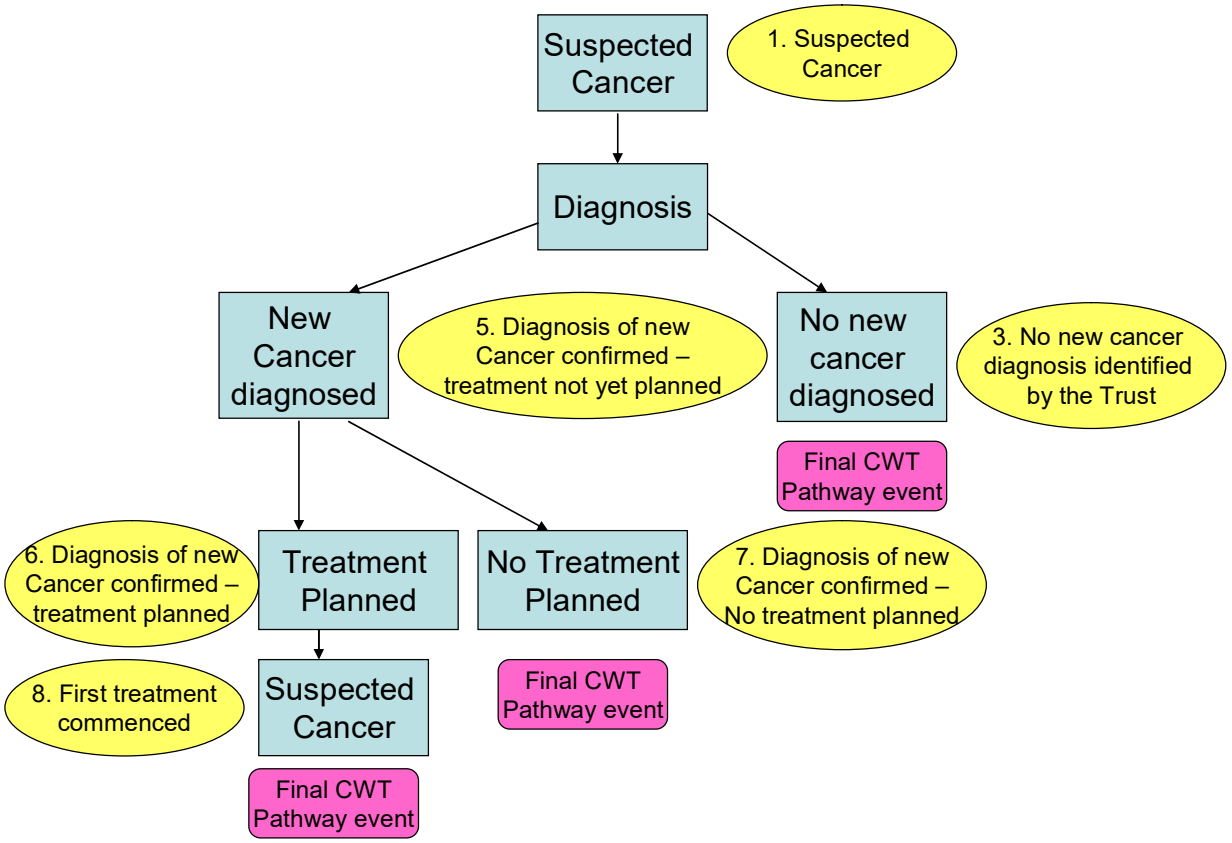
6 Diagnosis of new cancer confirmed - NHS treatment planned
Use for patients with a new diagnosis of cancer where NHS treatment is planned but has not yet commenced.

7 Diagnosis of new cancer confirmed - no NHS treatment planned
Use for patients with a new diagnosis of cancer where NHS treatment is not planned. Use this code when a patient dies before treatment, a patient refuses all treatment or a when a patient is first treated in an independent provider or the patient is first treated privately.

8 First treatment commenced (NHS only)
This code should be used when treatment under the NHS has commenced for a patient with a new diagnosis of cancer.

Patients diagnosed with a recurrence
The standards only apply to patients with a newly diagnosed cancer. Some patients have metastases at presentation and so the treatment may be to the metastatic site rather than the primary site.
The standards do not apply to a patient receiving treatment for a recurrence of cancer. Clearly good clinical practice involves treating patients with recurrence as soon as possible on the basis of clinical priority.
When a patient is diagnosed with a second new cancer, which is not a recurrence, then the targets will apply to the treatment of this cancer.

Cancer Status and the patient care pathway



7.9 How is the primary key for a record in the CWT -db defined?

(Option 1) H&C Number + "Cancer Referral Decision Date" - If the patient is referred as an Urgent Referral for Suspected Cancer - Option 1 will be used and the trust where they are first seen has the responsibility to create the record on the system.

(Option 2) H&C Number + "Decision To Treat Date" - If the cancer patient is **NOT** an Urgent referral for Suspected Cancer, Option 2 will be used and the trust where they are **treated** has the responsibility to create the record on the system.

To add further information to a suspect cancer referral record (I.e. treatment data) it is necessary to include the "Cancer Referral Decision Date" (and the NHS Number) in any subsequent upload records. This information ensures the database will identify the correct record.

This means that there needs to be local mechanisms in place to ensure that the "Cancer Referral Decision Date" is passed along the pathway if the patient crosses trust boundaries:

7.10 What data should be recorded on patient admitted as an emergency?

Some cancer patients are admitted as emergencies and remain as an inpatient until they receive their first treatment. When a patient receives surgery as the first treatment the START DATE(SURGERY) is defined to be the date of admission. In this example the DECISION TO TREAT DATE may be after the date of admission and hence the interval between decision to treat and start date is negative. These dates will be accepted by the database.

7.11 In what circumstances should we use the code "4 – patient choice" in the field WAITING TIME ADJUSTMENT REASON (FIRST SEEN)?

This code should only be used if a patient referred by their GP as a suspected cancer makes it clear that they do not want an appointment within 14 days before an offer is made. The patient will be excluded from the reports generated on the CWT-db to monitor the Two Week Standard. However data on the patients waiting time should be uploaded onto the CWT-db, as this will be required for monitoring the Urgent Referral to treatment target if the patient is diagnosed with cancer.

Where a patient turns down an appointment offered within 14 days the code "2 – patient cancellation" should be used (for example the patient declines as they are on holiday on the date offered). The patient should be offered another appointment within 14 days of the cancelled appointment.

7.12 How do we record suspect cancer patients that are admitted as emergencies before they are seen?

When a suspected cancer patient is admitted as an emergency before they are seen. The emergency admission is the referral into the system and effectively supersedes the original referral. Where a patient is admitted for another condition the original suspected cancer referral still stands.

7.13 How do we record new cases of cancer cases where there is no pathology available?

It is well recognised that some patients with cancer never have microscopic verification (i.e. histology or cytology). This is particularly the case for internal cancers such as pancreatic and for elderly patients with lung cancer who are deemed unfit for bronchoscopy. In these cases diagnosis is made on non-microscopic information such as radiological investigations. For practical purposes if a patient has been told they have cancer and/or have received treatment for cancer the relevant primary diagnosis code should be used.

7.14 How should we record ICD10 code on Chronic Lymphocytic Leukaemia?

Chronic Lymphocytic Leukaemia should be reported using the 3-digit code C91. The CWT-db requires all acute leukaemia's to four digits in order to identify these cases separately to monitor the 2001 treatment target, but in other cases of leukaemia the ICD10 code is only required to 3 digits.

Decision to Treat

7.15 Why is “decision to treat date” used to monitor the 31 day target?

Date of diagnosis is already well defined for cancer registration purposes. In some cancers it is common for the diagnosis to take place AFTER first treatment. For example in testicular cancer, orchidectomy is counted as the first definitive treatment, although definitive diagnosis will be obtained from this operation. The start date for monitoring this target should be one that is meaningful for patients. The decision to treat date is the date of the consultation in which the patient and clinician agree the treatment plan for first treatment. If the first treatment requires an admission (e.g. Surgery) this date is recorded on hospital PAS systems, as the "Date of decision to admit" (used for calculation of waiting list statistics). A decision to treat is dependent on the agreement of the patient and so may not be on the day of the MDT meeting.

7.16 What is the date of decision to treat for chemotherapy or radiotherapy?

Oncologists have agreed that the "decision to treat date" is the date the oncologist sees the patient and agrees that the patient is suitable for treatment and that the patient agrees the treatment plan.

7.17 Can a decision to treat be made with a patient prior to completing all staging tests?

Normally staging tests are completed prior to making a decision to treat. As stated above if first treatment requires an admission (e.g. Surgery) this date is recorded as “Date of Decision to admit” on hospital PAS systems and is used for measuring elective inpatient waiting times and should also be used for cancer waiting times.

7.18 What date is the decision to treat for brachytherapy in prostate cancer?

In order to determine whether the prostate is suitable for brachytherapy a volume study has to be performed. The date of the decision to treat will be the date of the consultation where the treatment is agreed after the volume study has been completed.

Part 8 – Guidance on Adjustments for Cancer Waiting Times

8.1 There will be guidance issued which will explain the recording waiting times for the purposes of calculating inpatient waiting list and waiting time central returns.

8.2 This existing guidance also applies to the recording of waiting times in the cancer access standards database. This note provides some specific examples of adjustments in the cancer pathway.

8.3 In line with current guidance on waiting times an adjustment to the waiting time of a patient is applicable in the following circumstances.

Patient cancelled an outpatient appointment
Patient Did Not Attend (DNA) an outpatient appointment
Patient defers an admission
Suspension for patient reasons (often referred to as social suspension)
Suspension for medical reasons

8.4 Patient cancelled an outpatient appointment

~ If this is the first outpatient appointment the clock restarts from the date the patient informs the Trust that they wished to cancel their appointment the adjustment is the number of days from date of decision to refer to date of appointment the patient refuses. (i.e. clock is reset)
For example if the referral is received on the 1 May and the appointment is offered for the 10th May, and the patient cancels it on the 5th May, this should take 5 days off your waiting time.

If this is a follow-up appointment the adjustment is calculated as the number of days from the date the patient informs the Trust that they wished to refuse the appointment.
Note: If the provider cancels the appointment then there is no affect on the waiting time.

8.5 Patient Did Not Attend (DNA) an outpatient appointment

~ If this is the first outpatient appointment the clock restarts from the date of the appointment the patient did not attend or the date on which they informed the Trust that they wished to cancel their appointment. The adjustment is the number of days from date of decision to refer to date of DNA. (i.e. clock is reset)
If this is a follow-up appointment the adjustment is calculated as the number of days from the date the patient was last seen to the date of appointment the patient did not attend.

8.6 Patient defers admission

~ Patient is offered a reasonable date for admission but refuses. Provided the admission date was a reasonable one (i.e. there was a sufficient amount of notice and the provider took account of personal circumstances) this is described as a self-deferral. In such a case the waiting time is adjusted by the number of days from date of decision to treat to the date the admission was scheduled to take place.

Example

A patient is contacted by the trust and offered an admission date for surgery to treat their breast cancer. At this time they declare that they are unable to attend on this date as they have booked a holiday. This is a patient deferral. In this case the period between the admission date they declined and the decision to treat date is to be removed by an adjustment.

Note: if the provider cancels the admission then there is no affect on the waiting time. (e.g. the 31 day target waiting times is calculated from the original decision to treat date)

8.7 Suspension for patient reasons (often referred as social suspensions)

The clock stops when

When a patient has other commitments they wish to pursue prior to treatment or investigation (e.g. Holiday)

When a patient requests a period of time to think (e.g. to decide on treatment options)

When a patient requests a second opinion before making a decision on treatment. (The clock does not stop if the clinician requires a second opinion)

Suspensions must be clearly recorded in the patient notes

The position of any patient suspended must be reviewed regularly.

The clock does not stop

When a patient chooses a treatment with a longer waiting time (e.g. radiotherapy rather than surgery)

A patient should not be suspended once an admission date has been agreed, unless the date is later than normal due to the need to resolve other medical problems prior to treatment.

8.8 Examples of social suspensions

A patient with cancer is seen by the oncologist and is suitable for a clinical trial. The patient is given the details and told he/she needs to make a choice about whether or not they wish to take part in the trial. This two-step process is good practice in terms of informed consent. Whilst taking the time to make the decision, the patient will be classed as suspended for patient reasons as he/she is technically unavailable for treatment. The clock starts again as soon as the patient has told the oncologist of their decision.

Note: Allowing patients time to consider treatment options is part of good clinical practice and is not confined to clinical trials.

A young patient is advised that potentially curative treatment involves significant risk of serious side effects (which may include peri-operative death). The patient wishes to be referred for a second opinion to see if they might avoid these outcomes but yet still achieve cure. The patient is suspended for patient reasons as they have made themselves unavailable for treatment whilst seeking a second opinion.

A patient is discussing their care-plan with a clinician and states (before any offer of an admission date is made) that they would like to take the holiday they have booked prior to treatment starting. As no offer of a TCI date had been made by the trust this can be classified as a suspension for patient reasons. The period which the patient has made themselves unavailable should be adjusted out of the calculated waiting time.

8.9 Suspension for medical reasons

The clock stops when

When a patient is unavailable for admission for a period of time due to another medical condition that needs to be resolved

When a patient is unavailable for a diagnostic or staging test or treatment due to another medical condition that needs to be resolved (e.g. reduce weight)

Suspensions must be clearly recorded in the patient notes

The position of any patient suspended must be reviewed regularly.

The clock does not stop

When the trust is unable to offer treatment within the required timescales.

For a patient who requires repeat biopsies or scans because of uncertainty the first time round.

In patients for whom there is genuine clinical uncertainty about the diagnosis and the clinician elects to observe the patient over (say) a three month period.

A patient should not be suspended once an admission date has been agreed, unless the date is later than normal due to the need to resolve other medical problems prior to treatment

8.10 Examples of suspension for medical reasons

Some cancer patients will have co-morbidities, which will require investigation and/or treatment prior to administering cancer treatment. For example a cancer patient with angina may be referred for a cardiology opinion prior to treatment. In this case the clock will only stop if the cardiology opinion is that the patient is medically unfit for cancer treatment. If the opinion is that the patient is fit for cancer treatment then the clock does not stop. Hence the clock does not stop whilst an opinion on the co-morbidity is being sought. A similar example would be where a patient with mouth cancer requires dental extraction prior to ommencement of radiotherapy treatment – the clock would stop while the patient was not fit for treatment following the extraction, but not whilst they were waiting for the extraction.

Patients with severe frailty/cachexia related to the cancer. A patient who requires intensive nutritional support (e.g. through intravenous feeding or through nasogastric feeding) before they are fit for surgery. The clock stops for the period the patient is medically unfit for surgery, with the start date of this period of suspension being defined as the date when a medical opinion as to their being unfit for treatment was received.

A patient with cancer also has COPD. He/she is technically suitable for surgical resection but considered in need of a medical opinion (in this case usually a respiratory physician). The respiratory physician confirms the patient is medically unfit for the surgery at that time (clock stops at this point) (see above) and wishes to institute a changed therapeutic regime to optimise their respiratory function before surgery. The patient is suspended until medically fit for the surgery.

In prostate cancer following a transrectal ultrasound-guided biopsy there may be swelling of the prostate gland. This makes interpretation of MRI scans unreliable. Many clinicians would advocate that there should be a planned interval of up to 4 weeks between biopsy and MRI, as the gland swelling means the patient is medically unfit for the scan and so a medical suspension is appropriate. Where this is agreed in local clinical protocols and if the clinician agrees this with the patient, then an adjustment can be made to the waiting time for the period that the patient is unfit to progress to the scan (i.e. where the MRI is requested after biopsy the clock can be stopped from date of MRI request until the date that is a maximum of 4 weeks after the biopsy). The patient notes need to make it clear that a medical suspension was necessary. Of course this must not be used to mask delays to MRI scans or subsequent delays to surgery.

In the absence of conclusive research regarding the optimum time interval from TRUS biopsy to radical prostate surgery, it has been agreed through clinical consensus that there could

be a period of up to six weeks, depending on clinical judgement, between TRUS biopsy and radical prostate surgery. If this is agreed in local clinical protocols the patient should only be medically suspended for the period they are unfit (i.e. from the date it is agreed they will have radical surgery until the date 6 weeks after biopsy).

If a cancer is found on barium enema a CT cannot be performed for up to 10 days as barium sulphate cannot be penetrated by X-Ray. A medical suspension may be recorded for the period the patient is unfit (following the decision that the patient requires a CT) if no other diagnostic activities can be carried out in this period and a CT scan was available within 10 days.

Some patients diagnosed with primary liver cancer (Hepatoma) have an organ transplant as their first treatment. A patient should be suspended for the period that matched organs are not available.

8.11 Can we make an adjustment for radiographic investigations in menstruating females?
The Royal College issued guidance a few years ago indicating that, while the 28 day rule was satisfactory for most radiographic investigations, in menstruating females, the 10 day rule was safer for high dose investigations particularly barium enema and CT of the abdomen and pelvis (i.e. the procedure should be performed in the first 10 days of the menstrual cycle). Many departments also apply the 10 day rule for barium studies of the small bowel. Where this delays a patients investigation a medical suspension may be applied for the time the patient is unfit for the test.

8.12 How do we monitor a patient who agrees a treatment and then a week later changes their mind and wishes to receive a different treatment altogether?
The patient will have to agree a new decision to treat and hence the 31 day target clock is reset. For the 62 day target it is appropriate to remove the period from decision to treat to the date of cancellation and should be coded as a self-deferral.

8.13 How do we monitor a patient that refuses altogether the diagnostic test that may diagnose cancer but continues to be cared for by the trust?
In effect the patient, by refusing the diagnostic test, has taken them self off the 62 day pathway. The trust can not deliver on a patient who is not prepared to "be on the pathway". If the patient agrees at a later stage to have the test and is subsequently diagnosed with cancer, they should be monitored against the 31 day standard.

8.14 How do we monitor a patient that turns up for their diagnostic test but then refuses the test and has to be re-booked at a later date?
If the trust has done everything possible to avoid this happening (e.g. the patient is fully informed about what to expect) then the patient can be considered as having been self-deferred (or patient cancellation) and so an adjustment may be made.

8.15 How are adjustments to waiting times made?
There are three adjustment fields within the Cancer Waiting Times Database (CWT-Db) to record adjustment values depending on which point on the referral to treatment pathway the adjustment is appropriate.
WAITING TIMES ADJUSTMENT (FIRST SEEN) – To record adjustment (in days) between referral received date and date first seen.

WAITING TIMES ADJUSTMENT (DECISION TO TREAT) – To record adjustment (in days) between date first seen and date of decision to treat.

WAITING TIMES ADJUSTMENT (TREATMENT) – To record adjustment (in days) between date of decision to treat and start date of treatment.

If an adjustment is recorded a user is also required to give the reason for adjustment (using the fields WAITING TIME ADJUSTMENT REASON (FIRST SEEN), WAITING TIME ADJUSTMENT

REASON (DECISION TO TREAT), and WAITING TIME ADJUSTMENT REASON (TREATMENT)

Please Note: A comment in the delay reason comment field will **not** result in a patient's waiting time being adjusted. The system requires the adjustment fields above to be completed in order to calculate an adjusted waiting time.

8.16 Examples of adjusting a patients waiting time

Example A: The patient and surgeon agreed first definitive treatment of surgery on 01/11/2002. The date of admission for this surgery was 25/11/2002, but the patient defers treatment. The patient is then admitted on 09/12/2002 for the surgery.
DECISION TO TREAT DATE (SURGERY) = 01/11/2002
START DATE (SURGERY HOSPITAL PROVIDER SPELL) = 09/12/2002
WAITING TIME ADJUSTMENT (TREATMENT) = 25/11/2002 – 01/11/2002 = 24 days
The database will then calculate the waiting time for the decision to treat to treatment target which will be reported as 14 (START DATE (SURGERY HOSPITAL PROVIDER SPELL) - DECISION TO TREAT DATE (SURGERY) - WAITING TIME ADJUSTMENT (TREATMENT))

If however, the patient cancels on the 20/11/02 the waiting times will be adjusted and calculated as 20/02/02-01/02/07 = 11 days

Example B: A GP decides to refer a patient under the suspected cancer referral standard on 03/02/2003 and the referral is received on the 04/02/2003 and the patient is given an appointment for 11/02/2003. The patient cancels this appointment on the 07/02/2003 and is given another appointment for 18/02/2003, which the patient attends.
CANCER REFERRAL RECEIVED DATE = 04/02/2003
DATE FIRST SEEN = 18/02/2003
WAITING TIME ADJUSTMENT (FIRST SEEN) = 18/02/2003 – 04/02/2003 = 3 days
The database will calculate the waiting time from the above information and the reported waiting time will be 11 days (DATE FIRST SEEN - CANCER REFERRAL RECEIVED - WAITING TIME ADJUSTMENT (FIRST SEEN))

Example C: The patient above (who was first seen on 18/02/2003) cancels their follow-up appointment on 23/02/2003. This is an adjustment of 5 days from the date the patient cancels or DNAs. The patient is given another appointment for 04/03/2003, which the patient attends. The consultant and patient agree the first definitive treatment of surgery on 11/03/2003.
Date Last Seen = 18/02/2003
WAITING TIMES ADJUSTMENT (DECISION TO TREAT)
= Cancelled follow-up appointment – Date last seen
= 23/02/2003 – 18/02/2003 = 5 days

Example D: If the patient in examples B and C is admitted for the surgical treatment on 07/04/2003 then the waiting time from urgent referral to treatment is calculated as follows.
Waiting time from urgent referral to first treatment
= START DATE (SURGERY HOSPITAL PROVIDER SPELL) - CANCER REFERRAL RECEIVED DATE – WAITING TIME ADJUSTMENT (FIRST SEEN) - WAITING TIME ADJUSTMENT (DECISION TO TREAT) – WAITING TIME ADJUSTMENT (TREATMENT). This is when they cancel on the 25th Feb.
= 07/04/2003 – 04/02/2003 –(3 +7) – 10 = 52 days

References

http://www.dh.gov.uk/PolicyAndGuidance/HealthAndSocialCareTopics/Cancer/CancerArticle/fs/ en?CONTENT_ID=4001800&chk=dpRNWQ

- HSC 2001/012 - Cancer Waiting Times: Achieving the NHS Cancer Plan Waiting Times Targets, Department of Health.
- HSC 2002/005 - Cancer Waiting times: Guidance on Making and Tracking Progress on Cancer Waiting Times
- Achieving the two week standard: Questions and Answers
- Cancer Waiting Targets – A guide

http://www. performance.doh.gov.uk/cancerwaits/

- Cancer Waiting Times Data

http://www. nhsia.nhs.uk/cancer/pages/waiting//documentation.asp

- The user manual for the Cancer Waiting Database (including CSV upload format for multiple records)
- System security document

http://www. nhsia.nhs.uk/nhais/pages/products/vaprod/openexe/

- User Access form for Cancer Waiting Times System

www. n hsia. n hs. u k/dscn

- DSCN 22/2002 – National Cancer Waiting Times Monitoring
- DSCN 31/2003 – Extension of Active Monitoring to all tumour sites
- DSCN 15/2004 – Cancer Waiting Times – First Definitive Treatment
- DSCN 27/2004 – Cancer Waiting Times - Cancer Status

www. nocancerwaits.org

- Information and slide packs from National Briefing and Cancer Waits executive delivery days
- Information on 27th June 2005 National Briefing
- **Materials for clinicians**
  - The ABC of Cancer Waits
  - The "one page guide" of key definitions for MDTs.
  - Power point slide pack

http://www.cancerimprovement.nhs.uk/scripts/default.asp?site_id=26&id=5620

- ***Applying High Impact Changes to Cancer***
- ***The "How to" Guide: Achieving Cancer Waiting Times***

Discussion Forum

The discussion forum is designed to give the opportunity for those interested in cancer access standards information to discuss ideas or share good practice. This discussion forum is located on the <> web site<>?
To check out the discussion forum please visit:
www.dhsspsweb site

Willis, Lisa

From: Corrigan, Martina
Sent: 19 February 2013 14:19
To: O'Brien, Aidan; McCorry, Monica
Cc: Reddick, Fiona; Carroll, Ronan; Trouton, Heather
Subject: RE: Urology referrals

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Aidan

Please see below list of outstanding letters that are with you for triage, can you please let me know when these will be returned to Mandeville so that they can appoint these patients if necessary.

Thanks

Martina

** Monica, can you please bring to Aidan's attention please? **

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 USI
Email: Personal Information redacted by USI

From: Carroll, Ronan
Sent: 19 February 2013 12:55
To: Corrigan, Martina; Trouton, Heather
Cc: Reddick, Fiona
Subject: FW: Urology referrals
Importance: High

Heather/Martina
Please see below – all help greatly appreciated Ronan

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

From: Montgomery, Angela
Sent: 19 February 2013 12:50
To: Carroll, Ronan
Cc: Graham, Vicki; McQuaid, Julieann
Subject: Urology referrals
Importance: High

Ronan

The below referrals are currently with Mr O'Brien for triage. Julie had escalated most of them last week but we still have not received them back. Can you please escalate these?

SURNAME

INITIAL

HOSP. NUMBER

REFERRAL DATE

Personal Information redacted by USI

A

Personal Information redacted by USI

05/02/13

Personal Information

R

Personal Information redacted by USI

06/02/13

Personal Information

T

Personal Information redacted by USI

05/02/13

Personal Information

J

Personal Information redacted by USI

05/02/13

Personal Information

A

Personal Information redacted by USI

05/02/13

Personal Information redacted by USI

S

Personal Information redacted by USI

07/02/13

Personal Information redacted by USI

K

Personal Information redacted by USI

07/02/13

Personal Information redacted by USI

C

Personal Information redacted by USI

07/02/13

Personal Information redacted by USI

G

Personal Information redacted by USI

07/02/13

Personal Information redacted by USI

J

Personal Information redacted by USI

08/02/13

Personal Information redacted by USI

M

Personal Information redacted by USI

13/02/13

Personal Information redacted by USI

C

Personal Information redacted by USI

12/02/13

Personal Information redacted by USI

R

Personal Information redacted by USI

15/02/13

Personal Information redacted by USI

A

Personal Information redacted by USI

12/02/13

Personal Information redacted by USI

T

Personal Information redacted by USI

12/02/13

Personal Information redacted by USI

G

Personal Information redacted by USI

12/02/13

Personal Information redacted by USI

M

Personal Information redacted by USI

13/02/13

Personal Information redacted by USI

Personal Information redacted by USI

13/02/13

Personal Information redacted by USI

Personal Information redacted by USI

13/02/13

Personal Information redacted by USI

J

Personal Information redacted by USI

14/02/13

Thanks

Angela Montgomery
Cancer Services Co-Ordinator
Tel. No. (Personal Information redacted by USI

Southern Health and Social Care Trust

POLICY FOR THE SAFEGUARDING, MOVEMENT & TRANSPORTATION OF PATIENT/CLIENT/STAFF/TRUST RECORDS, FILES AND OTHER MEDIA BETWEEN FACILITIES

Lead Policy Author & Job Title:	Catherine Weaver – Head of Information Governance
Directorate responsible for document:	**Performance & Reform**
Issue Date:	TBC
Review Date:	**March 2023**

Policy Checklist

Policy name:	Policy for the safeguarding, movement and transportation of Patient/Client/Staff/Trust Records, Files and other media between facilities.
Lead Policy Author & Job Title:	Catherine Weaver – Head of Information Governance
Director responsible for Policy:	Aldrina Magwood
Directorate responsible for Policy:	**Performance & Reform**
Equality Screened by:	Claire Graham
Trade Union consultation?	Yes ☒No ☐
Policy Implementation Plan included?	Yes ☐ No ☒
Date approved by Policy Scrutiny Committee:	TBC
Date approved by SMT:	TBC
Policy circulated to:	Directors and Information Governance Committee
Policy uploaded to:	Sharepoint

Version Control

Version:	Version 2.4
Supersedes:	Version 2.3

Version History

Version	Notes on revisions/modifications and who document was circulated or presented to	Date	Lead Policy Author
V2.4	Amendments to include updated Good Management, Good Records (GMGR) 2021	02032021	Catherine Weaver

POLICY FOR THE SAFEGUARDING, MOVEMENT & TRANSPORTATION OF PATIENT/CLIENT/STAFF/TRUST RECORDS, FILES AND OTHER MEDIA BETWEEN FACILITIES

1.0 INTRODUCTION

1.1 The aim of this policy is to ensure that staff safeguard all confidential information while travelling from one facility/location to another during the course of their working day.

1.2 This may include confidential information contained within work diaries, notebooks, case papers, patient/client notes, Trust documents, 'lap top' computers etc.

1.3 This may also include from time to time the necessity to store confidential information overnight in staff members own home.

1.4 All Trust staff are bound by a common law duty of confidentiality. (See 9.0)

1.5 It is the responsibility of all staff to familiarise themselves and to implement practice of the contents of this policy.

2.0 GUIDING PRINCIPLE

2.1 The DHPSS Code of Practice on Protecting the Confidentiality of Service User Information (January 2012) states that "staff working within health and social services have an ethical and legal obligation to protect the information entrusted to them by users of the services."

2.2 Staff must notify their line managers immediately on suspicion of loss of any confidential information.

2.3 Line Managers must inform/notify Information Governance Team of any loss and contact Catherine Weaver, Head of Information Governance, Ferndale, Bannvale Site Gilford.
Personal Information redacted by USI Tel: Personal Information redacted by USI

2.4 Managers must ensure staff, are aware that disciplinary action may be taken when it is evident that a breach in confidentiality has occurred as a result of a member of staff's neglect in ensuring the safeguarding of confidential information.

3.0 TRACKING / TRACING RECORDS

3.1 Managers must ensure that effective systems are in place for tracking the location of files/records/documentation containing confidential information. The system in place by managers/service leads should be

appropriate to the type of confidential information concerned (e.g. a card index system may be appropriate to a small department, tracking sheet for outpatient type clinics while large scale libraries may benefit from a computerised tracking system – e.g. PAS/Clinical Manager. Detailed guidance on tracking/tracing systems should be documented in departmental procedures relating to records management/ transportation and should take into account relevant professional standards where such exist. The following points should be incorporated into Departmental guidelines:

- A clear record of the files which have been removed from the designated storage area, date removed, by whom and reason should be maintained;
- Files should be logged out to the borrower, who will be responsible for them whilst out of their designated storage;
- The tracking/tracing system should be updated by the borrower if the files are passed on, prior to being returned to the storage area;
- The minimum number of files required for the purpose should be removed;
- Should staff need to store records/information in their own home they need to ensure that they are stored in a safe place and cannot be accessed by unauthorised people;
- A system for following up outstanding returns should be implemented;
- Responsibility for ensuring the availability of the files should be assigned to one individual/supervisor within the Department.

4.0 MOVEMENT OUTSIDE THE WORK BASE

4.1 Movement of patient/client/staff records off-site may be required for a variety of reasons, e.g.

- To facilitate care or treatment at a different Trust facility;
- To facilitate care or treatment at a different facility outside of the Trust;
- To facilitate patient/service user access;
- Recruitment, selection and other H.R. functions;
- For domiciliary visits;
- To meet legal or statutory requirements;
- Delivery of drugs/specimens;
- Disciplinary Investigations;
- For home working
  (In some circumstances, records may be stored at the patient's home e.g. maternity notes, domiciliary care records and NISAT assessments etc. Confidentiality of the records stored in the client's home is the responsibility of the client/family members and they should be informed of their responsibility in this matter by the professional involved).

5.0 SAFEGUARDING OF PATIENT/CLIENT/STAFF RECORDS TRANSPORTED BETWEEN FACILITIES/LOCATIONS

5.1 It is recommended that employees should avoid taking confidential information outside the work base wherever possible. However, it is accepted that there are certain circumstances where this will be necessary or unavoidable**. Departmental procedures should detail the level of authorization required for the removal of files from Trust premises** or from one Trust premise to another.

5.2 Records should be transported in sealed boxes or sealed pouches when being transported between Trust sites and locations within the Southern Trust area.

5.3 All records should be prepared and tracked from the current location to the new location on PAS, Clinical manager or manual tracking system (or other relevant administration system) to ensure traceability at all times.

5.4 Transport boxes are used by health records departments. Each box is security sealed using the tamper evident seals by health records staff and collected from the health records department on a daily basis by Trust transport staff.

5.5 Charts must be securely transferred by SHSCT transport vans or on occasion, staff personal cars. Charts should never be left in a vehicle on view to the public and must be stored in the locked boot when being transported.

5.6 Transport boxes used for health records are delivered to the health records department at each site, emptied in health records department and charts left for delivery onto final internal destination by portering staff.

5.7 If it appears that security seals have been tampered with, this should be reported to your Line Manager immediately and must be reported as per Adverse Incident reporting procedure. If a loss of data occurs, this must also be reported immediately to Catherine Weaver, Head of Information Governance, Ferndale, Bannvale Site, Gilford [redacted]
Personal Information redacted by USI

5.8 Records should be returned to their original hospital site as soon as possible after use.

6.0 TRANSPORTATION OF ORIGINAL PATIENT/CLIENT/STAFF RECORDS WITHIN TRUST FACILITIES / AROUND HOSPITAL SITES

6.1 TRANSPORTATION OF RECORDS FOR CLINICS

6.1.1 All records should be tracked from the current location to the new location on PAS/other administration system or manual tracking as necessary to ensure traceability at all times.

6.1.2 Records are to be transported using the appropriate trolleys to and from wards, clinics and departments. If taking records in your car these should be stored in the locked boot of the car and never left unattended in the vehicle.

6.1.3 Smaller quantities of records not requiring a trolley should be sealed within an envelope, marked private and confidential and clearly marked with the recipient's name and the destination address.

6.1.4 Records being transported from clinical areas to medical staff/secretarial offices must at all times be covered appropriately ensuring patients' personal details are concealed.

6.1.5 Trolleys containing casenotes or any other patient information should never be left unattended.

6.1.6 Staff preparing records for transport must ensure:

- Bundles of records are no larger than 8 inches.
  The records are well secured to ensure that they cannot fall out of the bundle and patient details cannot be viewed.
- The records are clearly labelled indicating the recipient and the delivery destination.
- The records are appropriately tracked out and returned when no longer required.

6.1.7 If a patient is being transferred to theatres or another ward an appropriate member of staff should accompany the patient and will be responsible for the transfer of the patient's record.

6.1.8 Records are not to be given to patients or their relatives to take to another department. If it is absolutely necessary, the record must be placed in a sealed envelope which is fully addressed.

6.2 TRANSPORTATION OF COPY RECORDS BETWEEN DEPARTMENTS FOR PROCESSING EXTERNAL REQUESTS e.g. SUBJECT ACCESS REQUESTS

In order to facilitate the processing of requests for records received from patients / clients / external agencies, some transfer of **copy** records is necessary between Departments. Copies of records should be sealed within an envelope, marked confidential and clearly marked with the recipient name and destination address.

7.0 TRANSPORTATION OF ORIGINAL RECORDS OUTSIDE OF THE SOUTHERN TRUST

7.1 This policy advises that original health records are **not** sent outside the Trust except in strictly defined circumstances. The exceptional circumstances include case notes accompanying patients who are transferred to another hospital out of hours or records requested by the Court. Staff must follow CREST guidelines. (See 9.0)

7.2 Where original or copy case notes are sent via external mail, high grade envelopes or tamper proof envelopes must be used to provide adequate protection for the contents, and they must be sent via special delivery or registered mail with sender details on the postage franking if not already included.

7.3 In exceptional circumstances where original records are required for court, a copy of the records must be made and the Staff Member must ensure that the original records have been returned. Staff Member must record details of person requesting records so that they can be contacted to ensure return.

7.4 If health records held in electronic format are being sent by post, then the data must be password protected and password sent separately following Trust procedure. (e.g. sending data such as a diagnostic tests or images etc. on a CD via special delivery or courier).

7.5 If a Courier service is being used, then it is essential to confirm that the Courier service has tracking systems in place, including recorded delivery and traceability of packages.

In these circumstances and for other personal information sent by external mail the addressing must be accurate, and the senders name and address must be given on the reverse of the envelope.

8.0 TRANSPORT AND STORAGE FOR DOMICILIARY VISITS

- Client records are to be transported in a secure transport briefcase/bag.
- During transport client records are to be kept in the boot of the car and out of sight in a briefcase or a secure transport bag.
- Professional to decide with Line Manager on individual case whether it is best to bring only records pertaining to the client into their home and other client records to be kept in a secure transport briefcase/bag in the boot of car.
- Records should be returned to base when visit is complete as soon as possible.
- Staff should not leave portable computers, medical notes or mobile data devices (e.g. Dictaphones, PDAs, digital cameras) that are used to store patient records/patient identifiable information in unattended cars or in easily accessible areas. Staff should store all files and portable equipment under lock and key, when not actually being used.
- Staff should not normally take health/client records home and where this cannot be avoided, procedures should be place to safeguard that information effectively. If records are being held by staff member's home overnight then they must be kept in a secure place. The responsibility for the records is held by the staff member.

9.0 RELATED POLICIES/MANUALS INCLUDE:

1. Code of Practice on Protecting the Confidentiality of Service User Information. Privacy Advisory Committee (NI) (January 2012) http://www.dhsspsni.gov.uk/confidentiality-consultation-cop.pdf

2. Records Management Policy, Southern Health & Social Care Trust (March 2021).

3. Records Management Procedures, Southern Health & Social Care Trust (January 2015).

4. Records Retention and Disposal Schedule, DHSSPSNI January 2021. gmgr-disposal-schedule.pdf (health-ni.gov.uk)

5. Data Protection Requests Flowchart (GDPR) Southern Health & Social CareTrust (May2018). GDPR SAR Flowchart

6. Protocol for the Inter Hospital Transfer of Patients and Their Records.

Clinical Resource Efficiency Support Team (CREST) (August 2006) ISBN: 1-903982-23-5

7. Guidance for Social Work and clinical staff responses to: Subject Access Requests, PSNI Form 81 Requests & Litigation Cases
Subject Access Guidance

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

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

June 2021.

Content	Page Numbers

1.0 Background and Context

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

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

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

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

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

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

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

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

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

The panel requested additional information from the Trust as follows:

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

3.0 Methodology

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

- 27th May 2021
- 17th June 2021.

4.0 Terms of Reference 1

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.0 Terms of Reference 2

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.0 Terms of Reference 3

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

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

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

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

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

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

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

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

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

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

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

7.0 Terms of Reference 4

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

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

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

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

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

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

Southern Health and Social Care Trust

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RESPONSE TO STAGE 1 GRIEVANCE

MR A O'BRIEN
CONSULTANT UROLOGIST (Retired)

November 2018 (additional submission July 2020)

26 October 2020

STAGE 1 GRIEVANCE PANEL
Dr Aisling Diamond, Deputy Medical Director, SHSCT
Shirley Young, HR Associate, HSC Leadership Centre (Chair)

CONTENTS

1 BACKGROUND

1.1 Mr O'Brien raised a Grievance on 27 November 2018 supplemented by written papers/evidence. In advance of the Stage 1 grievance hearing, he made an additional written submission on 23 July 2020 relating to post-November 2018 events and additional information available to him regarding the matters in his November 2018 submission.

1.2 Dr Aisling Diamond and Shirley Young were asked to form a Stage 1 grievance panel under the Trust's Grievance Procedure. Mr O'Brien had retired by the time the grievance was heard on two occasions, 30 July and 7 August 2020.

1.3 Given the volume of papers, information presented and the need to speak to a range of employees referenced, the panel sought, and Mr O'Brien agreed to, an initial extension of the usual response time limits. It was agreed that the time limit for the panel's formal response be extended by three weeks until Friday 28 August 2020.

1.4 As a consequence of diary availability and the challenges noted at 1.3 above, Mrs Young wrote to Mr O'Brien on 25 August 2020, changing the time limit for the panel response to Friday 18 September 2020. This deadline was subsequently altered on two further occasions before the deadline for this report of Monday, 26 October 2020.

1.5 The matters raised in this grievance have been extensive and complex and they cover a significant timeframe and therefore the panel's formal response is in report format rather than the usual letter style.

1.6 Summary of Stage 1 Grievance

1.6.1 Mr O'Brien set his concerns in the following summary provided at the outset of his written submissions:

- *"the acts and omissions of senior managers within the SHSCT re handling of concerns about my administrative practices. I believe that the actions and failures of the Trust amount to breaches of Trust Policies and Procedures and a breach of my contract of employment* ***(*Section 2 of this response*)***

- *Additionally, I am formally lodging a grievance against the decision dated 1 October 2018 of the Case Manager to classify the case as a case of misconduct"* **(Section 3 of this response)**

- In July 2020, he added other matters, namely, *"delayed handling of my grievance", "additional concerns (i) events before so December 2016, (ii) An Unfocused Trawl, (iii) Private Patients ", Duty of clinical care update"* **(Section 4 of this response)**

1.7 This response will deal with each in turn.

2 ***"The acts and omissions of senior managers within the SHSCT re handling of concerns about my administrative practices. I believe that the actions and failures of the Trust amount to breaches of Trust Policies and Procedures and a breach of my contract of employment."***

2.1 To achieve an of understanding of the detail and chronology of Mr O'Brien's concerns we have organised our response in this section as follows[1]:

- March 2016 to December 2017 **(Section 2.2)**
- January 2017 to June 2018 **(Section 2.3)**
- July 2018 to November 2018 **(section 2.4)**

2.2 MARCH 2016 TO DECEMBER 2016

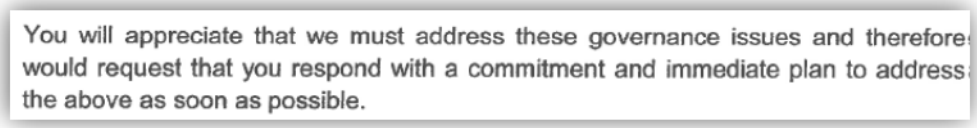
2.2.1 This time frame reflects the period between a formal letter to Mr O'Brien on 23 March 2016 and the decision to launch of the formal Maintaining High Professional Standards[2] (MHPS) investigation in December 2016.

2.2.2 **The facts established are set out at 2.2.3 to 2.2.23 below**

2.2.3 Mr Mackle, then Associate Medical Director, held a meeting with Mr O'Brien on 23 March 2016. Mr Mackle was accompanied by Martina Corrigan, Head of ENT & Urology services. A letter summarising the issues from the meeting was given to Mr O'Brien signed by Mr Mackle and Ms Trouton, Assistant Director of Acute Services (Appendix 1).

2.2.4 Mr Mackle and Mrs Corrigan are of the view that Mr O'Brien ought not to have been in any doubt that the reason for meeting him and, supplementing it with a letter, was to seek a response from Mr O'Brien to the concerns raised and, for his part, he would provide comment on the issues raised from his own perspective.

2.2.5 The letter communicated that action from Mr O'Brien was required in all aspects of the letter and not just about patient notes. The following is an extract from the letter of 23 March 2016 (Appendix 1):


You will appreciate that we must address these governance issues and therefore would request that you respond with a commitment and immediate plan to address the above as soon as possible.

2.2.6 There is no evidence of any response with a commitment of plan or any comment from Mr O'Brien between March 2016 and the Oversight

[1]These differ from how Mr O'Brien organised and presented his information but in the panel's opinion it reflects how it organized its decision making.

[2] *Maintaining High Professional Standards in the Modern HPSS A framework for the handling of concerns about doctors and dentists in the HPSS* (Department of Health, Social Services & Public Safety - November 2005

Committee meeting on 13 September 2016. Neither is there any evidence of active follow-up from managers who had the authority to do so.

2.2.7 Mr Mackle stepped down from his role as Associate Medical Director on 30 April 2016. It was not until 13 September 2016 that the concerns about Mr O'Brien were a subject of a meeting of the Oversight Committee (see notes at Appendix 2) and were now escalated from direct line management. A decision was made at this meeting that an informal MHPS investigation should be launched.

2.2.8 Mr O'Brien expressed concern at his grievance that proper MHPS provisions had not been followed when Mr Mackle and Mrs Corrigan met him in March 2016. He says in his November 2018 submission:

> The letter is not described as a formal letter. It does not refer to the Trust Guidelines. It does not state on the face of the letter that it was issued pursuant to any Trust policy or procedure. It does not refer in any way to any suggestion of misconduct or even to a performance issue. Neither expressly nor impliedly can it be interpreted as a formal warning, or any form of disciplinary sanction. Nor could misconduct or lack of performance be inferred from the letter. In fact, the letter starts by stating, "*We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as Consultant Urologist*".

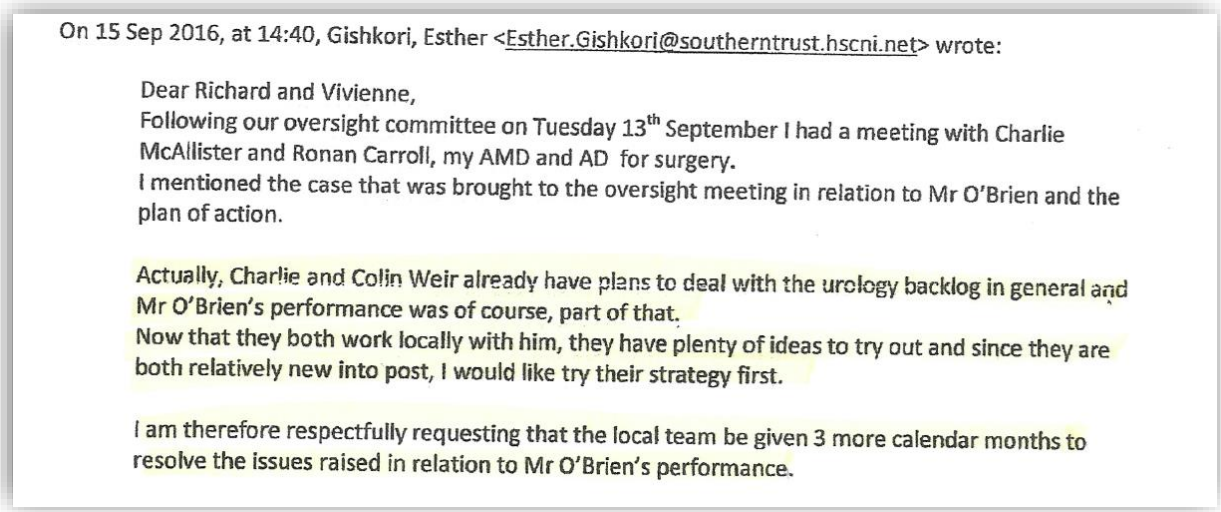
> The Trust Guidelines describe how concerns about a Practitioner should be handled. Paragraph 1.5 provides that:
>
> 1.5 This Guidance, in accordance with the MHPS framework, establishes clear processes for how the Southern Health & Social Care Trust will handle concerns about it's doctors and dentists, to minimise potential risk to patients, practitioners, clinical teams and the organisation. Whatever the source of the concern, the response will be the same, i.e. to:
>
> a) Ascertain quickly what has happened and why
> b) Determine whether there is a continuing risk
> c) Decide whether immediate action is needed to remove the source of the risk
> d) Establish actions to address the underlying problem

> If the letter of 23rd March 2016 is raising a concern about my performance as opposed to a concern about management, then that concern falls squarely within the definition above. **Yet the Trust Guidelines were completely ignored.**

2.2.9 Mr O'Brien also logged his concern about the Trust's response to National Clinical Assessment Service (NCAS)[3] advice and input in September 2016 (Appendix 3). He considered that the Trust's information to Dr Fitzpatrick to be inaccurate and these inaccuracies informed Dr Fitzpatrick's response.

[3] The NHS National Clinical assessment Service is at the time of writing became known as NHS Resolution – Practitioner Performance Advice. For the purposes of this response, we have retained the name NCAS throughout.

2.2.10 Ms Gishkori (then Director of Acute Services) was part of the Oversight Committee. Following the meeting on 13 September 2016, Ms Gishkori asked Dr Wright to amend the plan so that her clinical management team could have the opportunity to put in an alternative plan of their choice in place (Appendix 2 Notes of Oversight Committee 13 September 2016 and Appendix 4 email trail Miss Gishkori to Dr Wright):



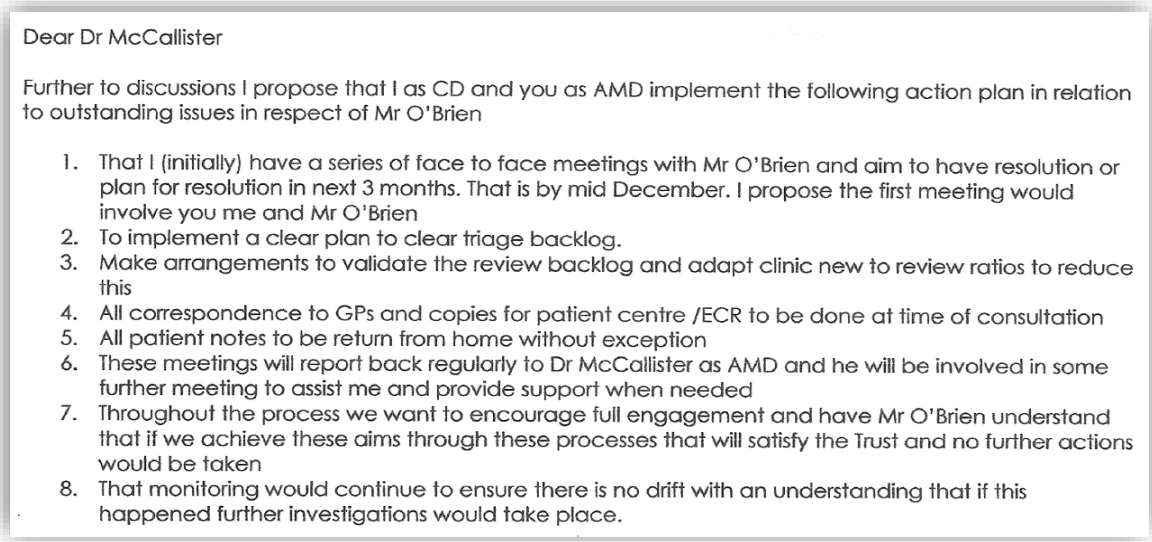
On 15 Sep 2016, at 14:40, Gishkori, Esther <Esther.Gishkori@southerntrust.hscni.net> wrote:

Dear Richard and Vivienne,
Following our oversight committee on Tuesday 13th September I had a meeting with Charlie McAllister and Ronan Carroll, my AMD and AD for surgery.
I mentioned the case that was brought to the oversight meeting in relation to Mr O'Brien and the plan of action.

Actually, Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr O'Brien's performance was of course, part of that.
Now that they both work locally with him, they have plenty of ideas to try out and since they are both relatively new into post, I would like try their strategy first.

I am therefore respectfully requesting that the local team be given 3 more calendar months to resolve the issues raised in relation to Mr O'Brien's performance.

2.2.11 Mr Colin Weir (who took up the role of Clinical Director in June 2016) developed a plan with Dr McAllister and set the details out in an email of 16 September 2016 (full email trail at Appendix 5). The following is an extract sent by Mr Weir to Dr McAllister:



Dear Dr McCallister

Further to discussions I propose that I as CD and you as AMD implement the following action plan in relation to outstanding issues in respect of Mr O'Brien

1. That I (initially) have a series of face to face meetings with Mr O'Brien and aim to have resolution or plan for resolution in next 3 months. That is by mid December. I propose the first meeting would involve you me and Mr O'Brien
2. To implement a clear plan to clear triage backlog.
3. Make arrangements to validate the review backlog and adapt clinic new to review ratios to reduce this
4. All correspondence to GPs and copies for patient centre /ECR to be done at time of consultation
5. All patient notes to be return from home without exception
6. These meetings will report back regularly to Dr McCallister as AMD and he will be involved in some further meeting to assist me and provide support when needed
7. Throughout the process we want to encourage full engagement and have Mr O'Brien understand that if we achieve these aims through these processes that will satisfy the Trust and no further actions would be taken
8. That monitoring would continue to ensure there is no drift with an understanding that if this happened further investigations would take place.

2.2.12 The next meeting of the Oversight Committee was on 12 October 2016 (notes are contained at Appendix 6). The following extract is relevant:

Mr A O'Brien

Mrs Gishkori reported that Mr O'Brien was going for planned surgery in November and was likely to be off for a considerable period. It was noted that Mr O'Brien had not been told of the concerns following the previous Oversight Committee. It was also noted that a plan was in place to deal with the range of backlogs within Mr O'Briens practice during his absence.

Mrs Gishkori gave an assurance that, when Mr O'Brien returned from his period of sick leave, that the administrative practices identified by the Oversight Committee would be formally discussed with him, to ensure there was an appropriate change in behaviour. It was agreed that this would be kept under review by the Oversight Committee.

2.2.13 By September 2016, Mr O'Brien is correct that no one had spoken to him about the intentions of any new plan from Mr Weir and Dr McAllister, supported by Ms Gishkori.

2.2.14 It is a fact therefore that, since March 2016, there had been no practical inputs to respond to the concerns from any manager or Mr O'Brien. This means that Dr Wright, Medical Director, and the Oversight Committee, by 12 October 2016, had no assurance that matters were progressing in any planned way or that there was no ongoing risk. The committee had intended that these circumstances would be reviewed at its October 2016 meeting.

2.2.15 It is correct that Mr O'Brien made arrangements with Ms Corrigan about the return of files from his home.

2.2.16 It is also a fact that, at the time of the meeting on 12 October 2016, Mr O'Brien was scheduled to have surgery in November 2016 and would be on sick leave for a period thereafter.

2.2.17 The Oversight Committee decided to keep the matters relating to Mr O'Brien under review. Its next meeting was held on 22 December 2016 (notes attached at Appendix 7).

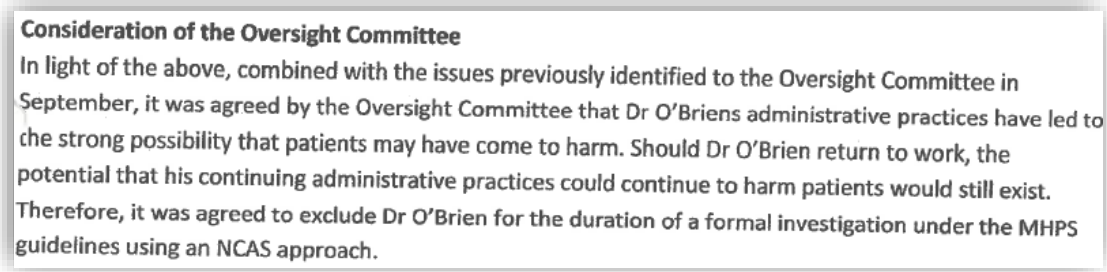
2.2.18 At this meeting, the following extract is relevant:

Dr Boyce summarised an ongoing SAI relating to a Urology patient who may have a poor clinical outcome due to the lengthy period of time taken by Dr O'Brien to undertake triage of GP referrals. Part of this SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason. It was noted as part of this investigation that Dr O'Brien had been undertaking dictation whilst he was on sick leave.

2.2.19 The new fact at this meeting on 22 December 2016 in relation to Mr O'Brien was that there was a Serious Adverse Incident (SAI). The committee was also provided with further update on more detail of

alleged administrative deficiencies – patient notes allegedly being held at Mr O'Brien's home and a number of undictated clinics (see notes at Appendix 7).

2.2.20 On consideration of these updates, the Oversight Committee made the following decision on 22 December 2016 (Appendix 7):



Consideration of the Oversight Committee

In light of the above, combined with the issues previously identified to the Oversight Committee in September, it was agreed by the Oversight Committee that Dr O'Briens administrative practices have led to the strong possibility that patients may have come to harm. Should Dr O'Brien return to work, the potential that his continuing administrative practices could continue to harm patients would still exist. Therefore, it was agreed to exclude Dr O'Brien for the duration of a formal investigation under the MHPS guidelines using an NCAS approach.

2.2.21 Mr O'Brien drew the grievance panel's attention to discrepancies in the notes of this meeting. These were that (i) the notes referred to a "formal" MHPS process being in place in September 2016 and (ii) that the decision on 22 December 2016 planned a meeting with Mr O'Brien on 30 December 2016.

2.2.22 The reference in the notes of 22 December 2016 is incorrect when it states "*formal*" - the notes of 13 September 2016 clearly state that an "*informal"* process was in place (see Appendix 2). Mrs Toal, Director of HR, who attended the Oversight Committee meetings confirmed that an informal process was in place and the note in December is an error. The author of the notes, Mr Gibson, also acknowledges this as an error.

2.2.23 Mr O'Brien's told us that the meeting planned with Dr Wright on 3 January 2017 was brought forward at this request to 30 December 2016.

2.2.24 **The panel findings on issue at 2.2 are set out in 2.2.23 to 2.2.46 below**.

2.2.25 There was no evidence before the panel that Mr O'Brien responded to or engaged in the concerns raised by Mr Mackle in March 2016 and summarized in his and Ms Trouton's letter of 23 March 2016 (Appendix 1)

2.2.26 Mr O'Brien expressed a view at the outset of his grievance hearing that it was disproportionate to move from the March 2016 meeting with Mr Mackle to formal MHPS processes in December 2016. This is not correct and there were attempts to move the concerns forward. These were delayed within the Directorate (2.2.10 to 2.2.20 above). We accept that Mr O'Brien was not aware of them at the time.

2.2.27 In relation to Mr Weir's input, Mr O'Brien suggests that any delay in speaking to him was because Mr Weir had been told (possibly by Mr O'Carroll) that he should not speak with Mr O'Brien. The possibility of this "instruction" only exists in the context of a decision to move to a formal investigation in December 2016 when it would have been inappropriate for Mr Weir to discuss the process with Mr O'Brien outside of his assigned role of Case Investigator. It does not explain any absence of contact by Mr Weir as Mr O'Brien's Clinical Director before then.

2.2.28 Mr Mackle clearly stated in March 2016 that there were matters of concern about Mr O'Brien's practice. It was, in our opinion, in Mr O'Brien's interests, to participate in examining this matter or refuting it for the record.

2.2.29 Mr O'Brien also stated there was an agreed plan with Mrs Corrigan relating to his return of files. This is correct but, in our opinion, this was an agreement about the process of returning charts that ought not to have been at Mr O'Brien's home. This is separate from any investigation into how and why the files were at this home and his explanation of that. The fact that some files were returned did not replace the need to seek Mr O'Brien's response to them being at his home in the first place.

2.2.30 Based on the emails at 2.2.10 and 2.2.11 above (and at Appendices 4 and 5), it is the panel's view that Dr Wright and the Oversight Committee had a reasonable basis for assurance in September 2016 that Ms Gishkori and her team would have actions in place on which progress could be reported at the next meeting of the Oversight Committee in October 2016.

2.2.31 However, this did not prove to be the case. Miss Gishkori updated the Oversight Committee on 12 October 2016 that no communication had taken place with Mr O'Brien:

Mr A O'Brien

Mrs Gishkori reported that Mr O'Brien was going for [redacted] and was likely to be off for a considerable period. It was noted that Mr O'Brien had not been told of the concerns following the previous Oversight Committee. It was also noted that a plan was in place to deal with the range of backlogs within Mr O'Briens practice during his absence.

2.2.32 By December 2016, nine months had passed since Mr Mackle's intervention in March 2016. There were now significant matters of context:

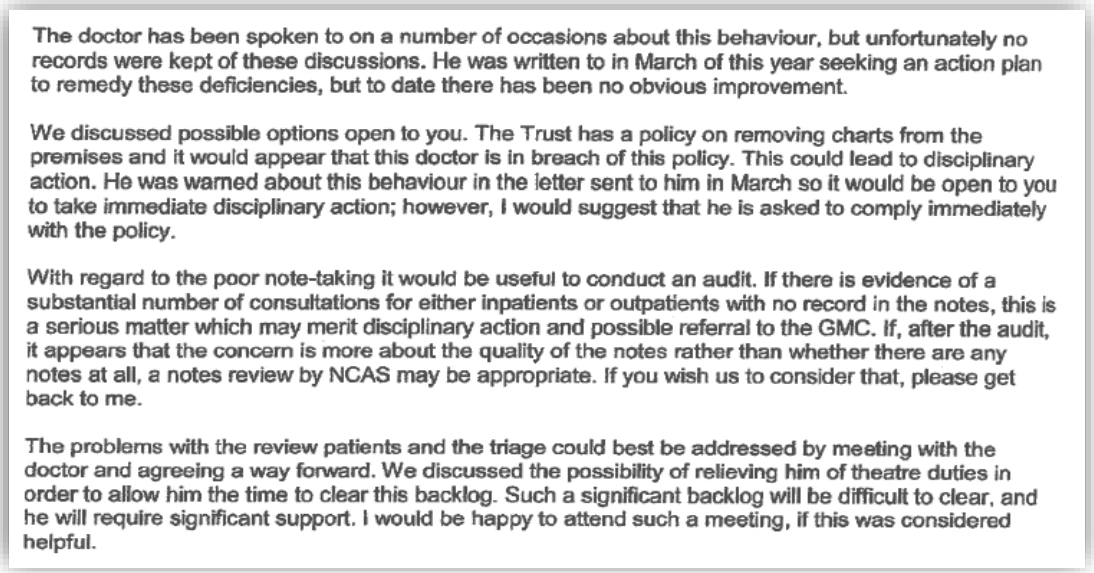
- the absence of assurances about progress made to manage and attend to the concerns
- the Serious Adverse Incident
- the information provided on the quantum of the alleged performance matters.

It is our opinion that Dr Wright, Medical Director, and the Oversight Committee were entitled to seek and escalate the required assurances. In the absence of active compliance by any party with earlier Oversight Committee plans in September and October 2016 in response to concerns going back to March 2016, we find that it is reasonable and by this stage, proportionate, that this matter was escalated to a formal MHPS investigation.

2.2.33 With regard to Mr O'Brien's comments on the advice from NCAS and its context in Trust decision-making, we established the following:

- NCAS wrote to the Trust on 13 September 2016 following a telephone discussion with Mr Gibson about Mr O'Brien on 7 September 2016 (Appendix 3). The Oversight Committee met on 13 September 2016 and there is no factual evidence from the notes whether the NCAS letter was presented or discussed at the meeting or Mr Gibson's summary of it.

- An extract from Dr Fitzpatrick's letter states:



The doctor has been spoken to on a number of occasions about this behaviour, but unfortunately no records were kept of these discussions. He was written to in March of this year seeking an action plan to remedy these deficiencies, but to date there has been no obvious improvement.

We discussed possible options open to you. The Trust has a policy on removing charts from the premises and it would appear that this doctor is in breach of this policy. This could lead to disciplinary action. He was warned about this behaviour in the letter sent to him in March so it would be open to you to take immediate disciplinary action; however, I would suggest that he is asked to comply immediately with the policy.

With regard to the poor note-taking it would be useful to conduct an audit. If there is evidence of a substantial number of consultations for either inpatients or outpatients with no record in the notes, this is a serious matter which may merit disciplinary action and possible referral to the GMC. If, after the audit, it appears that the concern is more about the quality of the notes rather than whether there are any notes at all, a notes review by NCAS may be appropriate. If you wish us to consider that, please get back to me.

The problems with the review patients and the triage could best be addressed by meeting with the doctor and agreeing a way forward. We discussed the possibility of relieving him of theatre duties in order to allow him the time to clear this backlog. Such a significant backlog will be difficult to clear, and he will require significant support. I would be happy to attend such a meeting, if this was considered helpful.

2.2.34 Mr O'Brien suggested that this advice from NCAS is not appropriate because it is factually incorrect, i.e. he says that no such action plan existed with which he had to comply. It is correct that Mr O'Brien was not "*warned*" on 23 March 2018, but he was made aware of the concerns about the charts and was asked to demonstrate his commitment and participate in a plan. If we accept that Dr Fitzpatrick believed Mr O'Brien

to have been "warned" then his advice in that context being that the Trust could "take immediately disciplinary action" in relation to the charts at home that advice may have been correct. The Trust did not take any immediate disciplinary action. Therefore, there is no detriment in practice to Mr O'Brien and we have no evidence that Dr Fitzpatrick was misled.

2.2.35 The implication is that Dr Fitzpatrick was wrongly informed on purpose. This relates to the matters initially discussed at 2.2.3 to 2.2.5 above and to the letter of 23 March 2016 at Appendix 1.

2.2.36 To set this in context we refer again to Mr Mackle and Ms Trouton's letter of 23 March 2016 in which they also stated:

> We need assurances that there are no patients contained within this backlog that are Cancer Surveillance patients. We are aware that you have a separate oncology waiting list of 286 patients; the longest of whom was to have been seen in September 2013. Without a validation of the backlog we have no assurance that there are not clinically urgent patients on the list. Therefore we need a plan on how these patients will be validated and proposals to address this backlog.

> You will appreciate that we must address these governance issues and therefore would request that you respond with a commitment and immediate plan to address the above as soon as possible.

2.2.37 It is not correct that Mr O'Brien did not know that he had to respond. He did not do so. It is our opinion that the NCAS advice was delivered in the context of the issues facing the Trust. The use of the word "warned" in Dr Fitzpatrick's letter is misleading as there was no official warning in place but as stated above, Mr O'Brien was aware of the criticisms of him that needed a response.

2.2.38 With regard to Mr O'Brien's comments on policies and procedures, it is our opinion that the MHPS process is the appropriate mechanism to address matters like this about a doctor's alleged performance especially where no actions planned earlier had been implemented.

2.2.39 Mr O'Brien expressed a view in his grievance that there were viable alternatives to MHPS processes during 2016[4]. This was the case in March, but by October 2016 nothing had been implemented. It was not Mr O'Brien's fault, that matters were not progressed at this point by the clinical team. They were not progressed. This lead credibly to Dr Wright's decision on 22 December 2016 to move matters into a formal MHPS process.

[4] Section 2.3.2 (page 8) of Mr O'Brien's November 2018 submission

2.2.40 Mr O'Brien is correct about errors in the notes of the Oversight Committee meeting of 22 December 2016 (see 2.2.21 to 2.2.23 above). It is our view that the suggestion that the meeting notes were not formally written up until later has credibility. On balance, we consider it to have been the case that the notes, were not written up immediately, given the Christmas and New Year breaks. They were, in our opinion likely to have been written up in the current typed format much later.

2.2.41 It is our opinion that neither the errors nor the date the notes were written did anything but reflect the outcome of the meeting and the decision to progress to a formal MHPS investigation. Dr Wright, by the time of 22 December 2016, was then minded to formalise the Trust response regarding the alleged concerns about Mr O'Brien. He could only reasonably have escalated this from an informal stage already in place so the reference to "formal" is indeed an error.

2.2.42 Mr O'Brien told us that the meeting with Dr Wright to discuss the decision to move to the formal MHPS process was initially arranged for 3 January 2017 and it was brought forward to 30 December 2016 at Mr O'Brien's request. It is factually correct that on 28 December 2016, Mrs Toal wrote to Ms Hainey in HR asking her to accompany Dr Wright at a meeting with Mr O'Brien "this Friday" (30 December 2016). We cannot say with certainty whether a January 2017 date had already been discussed direct with Mr O'Brien and he had subsequently sought to change it by 28 December 2016 when Mrs Toal wrote her email. Either way, we see no significant issue to our findings here of impact on Mr O'Brien other than it may have been he who instigated the meeting being brought forward. We agree that it was better to do so rather than meet on his first day back at work.

2.2.43 The Trust Guidelines state that a role of the Oversight Committee is to "monitor progress"[5]. It is reasonable that, having not being assured of informal progress at its September and October 2016 meetings and then the December 2016 meeting, and with the potential of additional concerns arising from a Serious Adverse Incident, the Committee endorsed a formal approach with immediate effect.

2.2.44 It is concerning that the December 2016 notes did not reflect earlier "informal" action correctly in retrospect. In the context of our comment above at 2.2.43 about the legitimacy and reasonableness of progressing the concerns formally, it is clear from Dr Wright's actions following the meeting that invoking a formal process was the clear plan.

[5] Section 2.5 *Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance* (September 2010)

2.2.45 Dr Wright's roles as Medical Director and General Medical Council Responsible Officer include significant responsibilities to the public about a practitioner's fitness to practise which should not be underestimated. This is interlinked with his role in the MHPS Framework to deal with performance concerns.

2.2.46 We note the level of non-compliance with the Oversight Committee's plans by managers/clinicians and also Mr O'Brien's non-engagement or his motivation to enquire about the concerns raised with him, even to dispute them. We have no evidence of his input in this regard. **It is our decision that by the time matters were discussed on 22 December 2016 at the Oversight Committee, the opportunity for a viable informal approach no longer existed and the Committee endorsed the decision to address them formally under the MHPS Framework. This was a reasonable response in accordance with processes and the grievance is not upheld.**

2.3 JANUARY 2017 TO JUNE 2018

2.3.1 This timeframe reflects the period covering the formal MHPS investigation until it reported on 21 June 2018. It also relates to Mr O'Brien's submission that there were variations to Trust policies and procedure to the extent that his contract of employment was breached.[6]

2.3.2 **The facts established are set out at 2.3.3 to 2.3.14 below**:

2.3.3 It is Mr O'Brien's contention that policies and procedures were not applied correctly in his case and this was a breach of his contract on the part of the Trust.

2.3.4 As well as his contract of employment, he also referred to:

- *Maintaining High Professional Standards in the Modern HPSS A framework for the handling of concerns about doctors and dentists in the HPSS* (Department of Health, Social Services & Public Safety - November 2005 *(referred to as MHPS Framework or MHPS in this response)*

- *Trust Guidelines for Handling Concerns about Doctors' and Dentists' Performance* – September 2010 *(referred to Trust guidelines in this response)*

2.3.5 We are in no doubt that the MHPS Framework is the overarching document and contractual process that applies to handling concerns about doctors employed in Health & Social Care (HSC) in Northern

[6] Section 2 heading on page 3 of Mr O'Brien's November 2016 submission

Ireland. It is our opinion that it cannot be set aside nor an alternative put in place because to do so would be outside of national terms and conditions of service.

2.3.6 Having read and considered the Trust Guidelines, our opinion is that it describes the operational processes within which the MHPS Framework is applied. It is not an alternative to the MHPS Framework nor is it a substitute for the primary process to attend to concerns about doctors.

2.3.7 Mr O'Brien is correct that there are gaps in the Trust's compliance with the requirements of these processes.

2.3.8 In relation to the stated timescales, MHPS sets out very precise requirements:

- *"the Case Investigator should, other than in exceptional circumstances, complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 working days*[7]*"*

2.3.9 From the date of the Case Conference on 26 January 2017 which confirmed that there was a case to answer, to the date of submission of Dr Chada's (Case Investigator) report on 12 June 2018 and then issued to him on 21 June 2018, 73 weeks had passed.

2.3.10 We therefore examined this timeline and any explanations for the passage of time. A timeline summary for the formal investigation provided by the investigators is included at Appendix 8. We also shared this document with Mr O'Brien and considered his comments on it.

2.3.11 To assist us in understanding the grievance aspects relating to procedural delay of the MHPS investigation itself, we also set out a calendar for 2017 and up to June 2018 (Appendices 9 and 10).

2.3.12 Mr O'Brien referred to other matters. At page 4 of his November 2018 grievance submission he said that "… *the Trust was always aware that the volume of work was overwhelming. It is clear from the witness statements provided in the investigation my administrative backlog was known to Trust managers for a very considerable periods of time*". This is the case and the backlog in Urology was known.

2.3.13 In his grievance, Mr O'Brien also expressed his concern that excessive time was spent in "*scoping*" the investigation and its terms of reference. He also said that there is a lack of clarity on what "*scoping*" is

[7] Paragraph 37 on page 10 of MHPS

2.3.14 Mr O'Brien further expressed his concern to us that on the one hand, the investigation was delayed significantly but when it came to his required response, the Trust was disinclined to extend any flexibility on the timeline for his responses.

2.3.15 **The panel findings on issues at 2.3 are set out in 2.3.17 to 2.3.44 below**

2.3.16 Having stated that MHPS Framework is the underlying contractual process, we are of the view that whatever practical challenges there are in its operation, its overarching intention is to resolve matters in a timely way, even before the Framework in invoked. It is our view that Mr O'Brien's lack of engagement and absence of evidence of him working with his employer before the formal MHPS investigation commenced contributed significantly to the decisions that later escalated the process to a formal MHPS context. With professional and meaningful engagement input from Mr O'Brien it is plausible that events may never had needed to be escalated and all the later delays in the investigation subsequently avoided.

2.3.17 The initial plans in March 2016 were not implemented by any clinical manager. It is credible that, when Mr Mackle ceased to be Clinical Director, that progression of the concerns raised with Mr O'Brien were not prioritised after Mr Mackle ceased his role as Clinical Director. Mr Haynes became the new Associate Medical Director, and Mr Colin Weir became the new Clinical Director in June 2016. Mr Weir intended to design a new local approach by September 2016 (2.2.11 above). There is no evidence that, as the Directorate representative at the Oversight Committee, Ms Gishkori had taken steps to check the status of Mr Mackle's intervention before she attended the 13 September 2016 meeting of the Oversight Committee or ensure that responsive action was taken to the later plan she proposed to Dr Wright as an alternative in September 2016 (2.2.10 above). This allowed Mr O'Brien's non-engagement to go unchecked and give rise further delay

2.3.18 Mr O'Brien's suggested that the letter to him of 23 March 2016 did not require his attention. We do not consider this to be the case as the letter's closing remark (Appendix 1), clearly describes the action required of Mr O'Brien. He presented no evidence of his response to the request made of him and therefore progress was stalled:

> You will appreciate that we must address these governance issues and therefore would request that you respond with a commitment and immediate plan to address the above as soon as possible.

2.3.19 Mr O'Brien also states that this letter of 23 March 2016 fell outside the required Trust Guidelines.

> If the letter of 23rd March 2016 is raising a concern about my performance as opposed to a concern about management, then that concern falls squarely within the definition above. **Yet the Trust Guidelines were completely ignored.**

2.3.20 We do not accept this. From the notes of the meeting of the Oversight Committee an "*informa*l" MHPS approach was only commenced in September 2016, not before. It is our opinion that in March 2016, Mr Mackle's intention was to draw Mr O'Brien's attention to alleged performance issues and this was in advance of entering an MHPS process. This does not make the letter itself informal and we can understand, from our consideration of the later delays, that Mr Mackle may have considered the letter to be best followed up in writing at this time.

2.3.21 We did not understand the term "scoping" that Mr O'Brien told us the Trust said that it was carrying out before the terms of reference were issued. A "*Screening Process*" is referenced in the Trust Guidelines at its Appendix 1 on page 8 of the document. This may have been what was meant by "scoping" but we cannot be clear. In any event the time taken was lengthy, irrespective of definition.

2.3.22 Mr O'Brien commented in his grievance on the letter of 23 March 2016 (see 2.2.8 - the first extract) saying that "*it does not refer in any way to a suggestion of misconduct or even to a performance issue*".

> The letter is not described as a formal letter. It does not refer to the Trust Guidelines. It does not state on the face of the letter that it was issued pursuant to any Trust policy or procedure. It does not refer in any way to any suggestion of misconduct or even to a performance issue. Neither expressly nor impliedly can it be interpreted as a formal warning, or any form of disciplinary sanction. Nor could misconduct or lack of performance be inferred from the letter. In fact, the letter starts by stating, "*We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as Consultant Urologist*".

2.3.23 This comment is unfounded as the letter indicates in the second sentence in the extract, from the 23 March 2016 letter, below that there is an issue:

> We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as a Consultant Urologist. However, there are a number of areas of your clinical practice causing governance and patient safety concerns that we feel we need to address with you.

The letter goes on to describe these and give examples (Appendix 1).

2.3.24 Mr O'Brien stated that concerns should be raised with a practitioner's clinical manager and he is correct[8]. Mr Mackle fell into this category as Associate Medical Director.

2.3.25 Mr O'Brien is also correct that there are no notes of earlier interventions with any other clinical manager before the meeting with Mr Mackle on 23 March 2016. However, is not unusual in practice that managers of all professions choose to express early concerns before they escalate them and decide that no note is necessary and that this is proportionate at this point. This is a judgment call. On balance, and in the context of everything we have examined in this grievance process, it is our view that it is credible that Mr Mackle may have been aware of previous discussions about these matters and there was no evidence of attention to them by any party, so he have decided to hold the meeting.

2.3.26 On balance, we do not consider it likely that Mr Mackle chose to have this meeting and issue a letter as a first response within the department and it was credibly an escalation of earlier unrecorded concerns. We consider that such an approach would have been fair to Mr O'Brien in the first instance. However, after 23 March 2016, Mr Mackle had ensured that Mr O'Brien could not indicate his unawareness of the alleged concerns and that there remained an opportunity to resolve these.

2.3.27 When MHPS is invoked it is a clear process and it states that when even deciding if an informal process should be applied it says:

- *"… it is necessary to decide whether an informal approach can address the problem or whether a formal investigation is needed. This is a difficult decision and should not be taken alone but in consultation with the Medical Director and Director of HR, taking advice from NCAS or Occupational Health Service (OHS) where necessary)* (MHPS paragraph 15 page 10)

2.3.28 In March 2016, it is our finding that Mr Mackle discussed this matter outside of the MHPS Framework and matters had not yet got to the stage of being discussed within the context of the MHPS extract above. There is no detriment to Mr O'Brien in doing this. He could reasonably be said to have neglected to take advantage of this opportunity to engage in early resolution or provide actual assurances that there was no basis to the concerns by becoming involved in active dialogue with a genuine view to this resolution.

2.3.29 Mr O'Brien stated at page 8[9] of his November 2018 submission that "*MHPS recognises the importance of seeking to address clinical performance issues through remedial action including retraining rather*

[8] Trust Guidelines section 2.2.
[9] Second paragraph at top of page 8 of Mr O'Brien's November 2018 submission

than solely through formal action". The implication is that in not doing so, The Trust has breached his contract.

2.3.30 We do not find this to be the case. First, this assumes that the matters were clinical in nature, and there is no common ground on this matter. Dr Khan, Case Manger under MHPS, considers this to be a matter of conduct unrelated to clinical skill (this is covered in Section 3 of this report). Secondly, any resolution, clinical, or otherwise under MHPS assumes a principle of co-operation. It is our view that Mr O'Brien was persistent in his non-engagement in any process that suggested any potential for shortcoming in his role. He only engaged when he had concerns about the Trust and in this regard, he expects timely responses from them that were not reciprocated by him. Mutuality is key. In there being no common ground and, in the absence of Mr O'Brien's acknowledgement that there was the potential for an issue to be addressed from the Trust's perspective, it is not solely a failure or breach on the Trust's part that any "*remedial action*" could succeed in the one-way process that existed.

2.3.31 We noted from Mr O'Brien's submission in his November 2018 submission[10] that his workload pressures were known (to the Trust) and we inferred that he meant this backlog to be mitigation of the position in which he found himself. Our findings on this are:

- Mitigation of allegations and findings in an investigation which leads to a disciplinary process, is for that formal process and only for a disciplinary panel to consider

- In our opinion, mitigation will be only relevant where allegations are factually correct and serves to provide an explanation and context.

- None of these above is relevant to the grievance process and we cannot comment on whether it may have featured or not in a disciplinary hearing that never happened. If it had taken place and Mr O'Brien was subsequently dissatisfied with the outcome and mitigation was not considered in his view, that would be appropriately raised in a formal appeal within the disciplinary process. It is not something that this grievance panel can decide upon.

2.3.32 The MHPS Framework sets out specific timescales for the Formal investigation process i.e. *"The Case Managers should, other than in exceptional circumstances, complete the investigation within 4 weeks of appointment and submit their report to the Case Manager within a further 5 working days."* In our calendars at Appendices 9 and 10, we have set out information collated from the investigators and from Mr O'Brien in his written submissions, at the grievance hearing and in his response to seeing the panel comments sent to us. The key dates on which issues are of most significant dispute to Mr O'Brien,

[10] Page 4 section 2.3 of his November 2018 submission Mr O'Brien states in reference to his workload, "*This was always known to the Trust and the Trust was always aware that the volume of work was overwhelming*."

(after he had seen the investigators' timeline) are set out in the table below **(NB the next section relates to the timeframe for the formal MHPS investigation only that is relevant to this Section, 2.3):**

DATES	MR O'BRIEN'S COMMENTS	INVESTIGATORS'/GRIEVANCE PANEL'S COMMENTS
A. January to March 2017	*"It took approximately 10 weeks before the Terms of Reference were even provided to Mr O'Brien. This delay is unconscionable"*	There was a significant delay in providing the Terms of Reference to Mr O'Brien.
B. April, May & June 2017	"*there is no explanation provided as to why the Case Investigator took 3 months to interview all of these witnesses. It does not feel reasonable …"*	*Dr Chada said in response "… three months were required to interview people given I had a busy full-time clinical job and had duties and responsibilities in my tole as Associate Medical Director." She does point out that that they attempted to meet with Mr O'Brien having heard from witnesses but their statements had not been returned, "but having better understood the issues which we wished to raise with Mr O'Brien"*
	"Mr O'Brien did not receive any of the statements made by these witnesses by the time of his first interview on 3 August 2017…. The complete list was only provided to Mr O'Brien on 28 September 2017"	
	"Mr O'Brien did not meet once with Dr Chada to discuss the investigation even though it is stated in MHPS to be best practice for the Case Investigator to meet with the practitioner first."	This is not a requirement.

C. 14 June 2017, 19 June 2017 & 5 July 2017		
D. 3 August 2017		

E. 6 November 2017		
F. 15 February to 2 April 2018	” “ ’ ’ ’	’ ’ ’

[11] Refers to the meeting held on 3 August 2017
[12] “*entries*” means the comments made by investigators on their investigation timeline

	MR O'BRIEN'S COMMENTS	INVESTIGATORS'/GRIEVANCE PANEL'S COMMENTS
G. Other remarks from Mr O'Brien	*"There is significant imbalance in the way that time is provided to the investigators on the one hand and Mr O'Brien on the other. Statements from witnesses in March to June 2017 were not provided to Mr O'Brien until October and November 2017. This delay is not considered noteworthy by the investigators. However, where Mr O'Brien required extra time, this became a subject of criticism."*	See **F.** above and our comment in **F.** below.
	"It is also worth noting that the Investigator's report was not in fact completed for almost another three months when finally provided on 21 June 2018. Mr O'Brien then provided his full response by 10 July 2018 having been given a 24-hour extension. Then there was almost another three-month delay until the Case Manager provided his determination on 1 October 2018."	This is factually correct and not disputed. See section 2.4 which covers this period.

2.3.33 The investigators provided us with emails having been sent Mr O'Brien's comments of 25 September 2018. These ae in Mr O'Brien's possession as they were emails to him and he responded to them. It is our intention to eradicate the sense of imbalance between the parties' perspectives and we have set out our findings on each of the above points as follows:

A. The Terms of Reference can only be formally finalised when the preliminary enquiries have been completed and the case conference held (in this case it was held on 26 January 2017). It was therefore almost seven weeks, not ten, before Mr O'Brien was provided with these on 16 March 2017. However, this is too long and we would expect that some early consideration of these could have taken place in preparation and thereby finalised much more quickly. There has been much confusion about preliminary drafts of terms of reference (a draft had been prepared for Dr Wright's information for the December 2016 meeting), screening and scoping. None of which explains the delay on an input that is clearly the responsibility of the Trust. We do not find evidence whereby we could safely conclude that this was motivated by some sense of purposeful dishonesty and was unscrupulous as is suggested by Mr O'Brien's contention that it was "*unconscionable*". This is his view but it is not our finding.

B. We accept Dr Chada's explanation that this investigation had to be managed within her job plan and her roles. It is credible that in trying to seek diary availability with Mrs Hynds and then each of the 13 witnesses was challenging. It is not that unlike what Mr O'Brien said about his commitments preventing him from moving onwards. The difference from Dr Chada's perspective is that we have evidence of active progression on her part despite diary availability. Although, regrettably, over a period of 13 weeks, there is evidence that Dr Chada did set aside time and did meet all 13 witnesses by 5 June 2017.

While we find the overall period to do this took much longer than it ought to have, it cannot be categorised as impacting negatively on the investigation. The witnesses were essential to the investigation and there were actions happening over the period, albeit at a frequency that was not ideal where all the parties could have protected time from their jobs. This is not possible while maintaining services.

C. Investigators made attempts to meet Mr O'Brien in late June. While not attributing "blame" to Mr O'Brien, it was he who was unable to comply with the dates suggested. We understand that, like Dr Chada, these are related to work priorities. At one point, Mr O'Brien offered to meet on Saturday, 1 July 2017. Then in view of his work activity and the unavailability to his son (who accompanies him), he finally offered 31 July 2017. It is likely that Mr O'Brien's job plan was not made up entirely of Direct Clinical Care activities throughout July 2018 and we noted that he offered no alternative date in July, only 31 July 2017.

We observed that, immediately Mr O'Brien suggested 1 July 2017, a Saturday, and the investigators facilitated it, Mr O'Brien cancelled it saying, "*it would be better to defer the meeting to later in July."* We are concerned that Mr O'Brien was not demonstrating the sense of urgency that he now complains was lacking by the investigators.

D. See responses in **A**. and **B.** above.

E. Mr O'Brien asked for the process to be delayed for 2 months in November and December 2017 and we acknowledge that the investigators agreed with this proposal. However, the next actions sat also with Mr O'Brien (he wished to make comments on statements and his own inputs). Regrettably in his comment above these actions would *"be addressed in the new year".* Mr O'Brien suggests that all the remaining actions were on the part of the Trust, but he did have actions i.e. comments on witness statements. He was reminded of this on 22 February 2018 and as well as expressing some confusion on his actions, he stated *"I have not had time to attend to the process since November 2017".*

It suggests that Mr O'Brien considers that he has considerable authority to manage the timeframe of the MHPS investigation himself which is not the case. It is our opinion that both parties share responsibilities for <u>progression</u>.

Having said that, we fully accept that the pace required in such a complex investigation needs to be set by the investigators. However, date provision and availability need to be reciprocated and it was not until 2 April 2018 that Mr O'Brien submitted the outstanding inputs.

It is our finding that Mr O'Brien was not inclined to progress and he controlled this by his inaction. We observe with the benefit of hindsight now in 2020, that there ought to have been a more assertive management of Mr O'Brien even thought he would have been unlikely to have welcomed that. If he considered he "*had no time*" and valued faster progression of the matter with the certainty he expressed at his grievance, he ought to have asked if space could be created to allow him to progress his inputs.

Regrettably in this section we saw a similar pattern to the wasted time frame from 23 March 2016 onwards, i.e. Mr O'Brien appears to withdraw and then takes the view that he had no role in that delay.

F. Mr O'Brien appears to suggest that there were no actions from him in the period up until February 2018. This is not the case (see **E.** above and in the table). Having requested, and the panel agreeing, to exclude November and December 2017 for any actions from him, there was no curiosity from Mr O'Brien about how he could progress without a draft of his statement which he then said was essential to his comments. It appears to us that he lost interest in the investigation during this time and it was only when Mrs Hynds reminded him about outstanding matters on his part that he expressed that he had "*misunderstood the arrangements and commitments … and wondering why there had been such a long delay."*

In considering this grievance in its entirety, we do not find the lack of understanding on Mr O'Brien's part to be credible.

By February 2018, the required inputs were Mr O'Brien's i.e. to expedite his comments back to the Trust and to do this by 9 March 2018. Mr O'Brien was not able to meet this deadline because of work commitments. Mrs Hynds extended the deadline to 16 March 2018 and, on no receipt of comments on 16 March 2018, extended it to 26 March 2018. When this deadline was also missed by Mr O'Brien, it was extended to 29 March 2018 and finally to 30 March 2018. Mr O'Brien submitted his comment on 2 April 2018. These were available to the investigators on 4 April following the Easter Bank Holiday break.

Mr O'Brien stated at **F**. in the table above that this delay was because of him not being provided with his draft statement until 4 March 2018. We do not accept that Mr O'Brien was unable to reflect on matters raised at the meeting on 6 November and earlier, on 3 August 2017. While we do not need access to the investigation report and notes of meetings with Mr O'Brien (we cannot re-investigate the formal MHPS investigation itself), we do not find it credible that there were no matters put to him at

the meeting on which he needed to reflect and comment on. This is because he had sought time to do so. We do not accept that his response was solely dependent on him seeing how his statement was reflected to him in writing at the later date.

G. It is correct that from submitting his factual response to the draft report on 10 July 2018 to Dr Khan, the Case Manager, Dr Khan's decision on the report was not completed until 28 September 2018.

Our comments in relation to this timescale are made in Section 2.4 below (where we deal with this period until Mr O'Brien lodged this Grievance on 27 November 2018.

2.3.34 In our analysis of the facts relating to the timescale of the investigation itself, it took 350 working[13] days to complete. We then considered what accounted for the passage of time beyond what may have been considered reasonable at the outset of the investigation. In the way that it is not automatically appropriate to categorise all contribution to the extended timescale on Mr O'Brien's part as a "delay", it is also not appropriate to define all time on the part of investigators as a "delay" either. Both parties will have had to spend necessary time in their own analysis and that has to be understood as a necessity.

2.3.35 In this regard, our attempt to quantify and understand the passage of time in this case is not intended to pejorative, it is purely factual. Our view on the parties' contributions is set out separately from 2.3.36 below. It is essential in any investigation that there will be a certain amount of time that inevitably passes between scheduled interventions, for example, to read and comment on documents, set up meetings with witnesses, write up notes and draft documents. The blocks of time in the 350 working days that could not have been reasonably predicted or expected in this case are as follows:

- An investigation meeting scheduled for 28 June 2017 was changed at Mr O'Brien's request. A new date of 1 July 2017 was agreed but was immediately changed to 31 July 2017. This date was again, at Mr O'Brien's request, moved to 3 August 2017. This period accounted for 25 working days (7% of the 350 working days).

- The first formal MHPS meeting with Mr O'Brien was held on 3 August 2017 and it was 65 days later, on 3 November 2017, that the second meeting was held (18%)

- Mr O'Brien requested that he be allowed on concentrate on his workload and prepare for his appraisal in November and December 2017. From the date of his meeting with investigators on 6 November

[13] All weekends and bank/statutory holidays have been removed.

2017 (when he requested this) until end of December 2018, 76 working days were unused (21%).

- To make his response to matters on 6 November 2018 as he indicated he wished to do, from January 2018 until his response on 2 April 2018, a further 63 days had passed (18%)

- From receipt of the information from Mr O'Brien on 2 April 2018 until the Case Manager issued her report on 21 June 2018, there are 55 working days (15%)

2.3.36 These figures are concerning and we do not suggest that some of these could have definitely been shortened to one or two weeks. However, 79% of the time of the investigation was waiting for the next event to take place. It is our opinion, with the benefit of hindsight, that the setting up of the second meeting with Mr O'Brien ought to have been accelerated. It is also our opinion that Mr O'Brien's changes to dates and non-submission of responses was tolerated beyond what now looks reasonable. We understand that request for more time like these are commonly facilitated to avoid any unintended unfairness to Mr O'Brien in this case. But such facilitation did not have the intended effect of minimising any sense of unfairness and now in this grievance it has contributed to the extension of the timeframe and subsequent criticism of the Trust. This will always be a dilemma and matter of judgment for the Trust on a case by case basis because there is potential criticism either way. From our perspective, having seen significant lack of active engagement from Mr O'Brien from March 2016, more pressure on him to respond may have been appropriate.

2.3.37 We note that having conceded to three extensions to a deadline from 9 March 2018 otherwise the Case Investigator would proceed. She did not ignore his submission on 2 April 2018. Although late and she could have ignored it from a technical perspective, she did not.

2.3.38 It is our finding therefore that while there were periods of time that the Trust should have minimized, they did afford considerable leeway to Mr O'Brien.

2.3.39 On his receipt of the MHPS report on 21 June 2018, Mr O'Brien had to comment on the document and the facts. He sought more time to do so and the Trust did not willingly afford more additional time. It was an already protracted matter and a few days would not have had significant impact. However, they may have been mindful of his missing deadlines in the past and were disinclined to give more than a short extension.

2.3.40 Returning to the original catalyst for these processes, by December 2016, matters had lain in abeyance since March 2016, with no one, including Mr O'Brien, responding actively to the concerns raised about him. Mr O'Brien, as well as the Trust, had an interest in these matters

being closed one way or the other. At the point where this grievance was heard this year, Mr O'Brien continued to express a view that there is no basis for the allegations and he remains confident of that. However, from the Trust's perspective these matters could not be set aside just because of the passage of time. Mr O'Brien ought also to have attended to them and presented his evidence in the structured context of the conduct panel arising from the MHPS investigation which, by the time of the grievance, was the procedural way forward.

2.3.41 Mr O'Brien chose to present evidence to us at his grievance hearing that not only had the allegations no basis, in his view, the MHPS investigation report was flawed. This is outside of the remit of a grievance panel. The correct place for such evidence and challenge of the MHPS report is at the conduct panel hearing that was planned. Mr O'Brien presented much information to us and a high level of dispute of the content of the investigation in a forum that cannot appropriately deal with them. We explained that this was likely to be the case when we spoke to him at the grievance hearing. On balance, we consider that in not participating in a disciplinary process, Mr O'Brien has delayed proper attention to the matters and resolve them in line with the processes set out in the national terms and conditions and contractual arrangements. We are also critical of the Trust where they did not inform Mr O'Brien regularly about delays and revised timescales on their part.

2.3.42 Mr O'Brien has an entitlement to raise a grievance where he has a dispute with his employer. We note, however, the need for reciprocity in an employment contract and thereby Mr O'Brien has a responsibility to engage with and participate in his employer's use of formal processes too. This is the basis on which MHPS is intended to operate. Therefore, while we find delays existed in the investigation on the part of the Trust, when considered in their totality, they did not dispense with the expectation that Mr O'Brien ought to have complied with Trust processes at the outset In March 2016 and then during and when the lengthy investigation was completed in June 2018.

2.3.43 **Mr O'Brien's grievance about the duration of the investigation is not upheld. It does breach the 4 weeks for the investigation and the further 5 days for submitting the report. However, we consider that the "*exceptional circumstances*" do exist. While not excusing all delays in the process, on balance, there is a level of credible explanation for some of them. It does not in our view reach the threshold of a breach of his contract.**

2.4 JULY 2018 TO NOVEMBER 2018

2.4.1 **The facts established are set out at 2.4.2 to 2.4.4 below**

2.4.2 This timeframe reflects the period from Mr O'Brien's comments on the Case Investigator's formal MHPS report made on 10 July 2018, to the Case Manager's decision of 28 September 2018 and until Mr O'Brien lodged his grievance dated 27 November 2018 (20 weeks)

2.4.3 In section 2.3.33 above in the table at section G, we note Mr O'Brien's comments:

Mr O'Brien then provided his full response[14] by 10 July 2018 having been given a 24-hour extension. Then there was almost another three-month delay until the Case Manager provided his determination on 1 October 2018."

2.4.4 In his grievance Mr O'Brien set out his concerns about the delay in setting up his grievance and receiving documents he sought from the Trust.

2.4.5 **The panel findings on issue at 2.4 are set out in 2.4.5 to 2.4.7 below**

2.4.6 In speaking to Dr Khan, Case Manager, we do consider that he clearly reflected on the report and the MHPS options. However, we find that the 21 weeks he took to do so unnecessarily protracted the process. After such a lengthy investigation, Dr Khan's response where no exchanges with Mr O'Brien were required, should have been expedited. It required Dr Khan's analysis and reflection on the facts in the report and how it fitted with MHPS decision-making. **The timescale is not explained sufficiently but Mr O'Brien's grievance is not upheld to the extent that it breached his contract of employment**.

2.4.7 From Mr O'Brien's receipt of the Case Investigators decision on 28 September 2018 until he lodged his Grievance on 28 November 2018, the period is not overly long and he appears to have used the time to prepare his lengthy submission. This is not relevant to the grievance

[14] to the Case Investigator's MHPS report received on 21 June 2018

3 *"I am formally lodging a grievance against the decision dated 1 October 2018 of the Case Manager to classify the case as a case of misconduct."*

3.1 **The facts established are set out in 3.2 below**

3.2 The MHPS Framework states that there is a range of decisions open to the Case Manager, in this case, Dr Khan, when he has examined the report. These are set out at paragraph 38 page 12 of the Framework:

38. The report should give the Case Manager sufficient information to make a decision on whether:

- no further action is needed;
- restrictions on practice or exclusion from work should be considered;
- there is a case of misconduct that should be put to a conduct panel;
- there are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer;
- there are concerns about the practitioner's clinical performance which require further formal consideration by NCAS ;
- there are serious concerns that fall into the criteria for referral to the GMC or GDC;
- there are intractable problems and the matter should be put before a clinical performance panel.

3.3 **The panel findings on issue 3 are set out at 3.4 to 3.6 below**.

3.4 We spoke to Dr Khan as part of the grievance process and we also read his Case Manager's Report. We find that Dr Khan's response at that time was in line with the MHPS Framework requirements in 3.1 above and we are satisfied that he gave due consideration to the information available to him.

3.5 We are also satisfied that Dr Khan gave due consideration to whether a conduct or clinical approach was appropriate. At the time that he made this decision, it was reasonable for him to conclude that the matters before him were not concerns about Mr O'Brien's clinical skill or aptitude and a conduct approach was appropriate.

3.6 **This aspect of Mr O'Brien's grievance is not upheld.**

4 In July 2020, Mr O'Brien added other matters, namely, "*Delayed Handling of my Grievance", "Additional Concerns (i) events before 30 December 2016, (ii) an unfocused trawl, (iii) private patients", and Duty of clinical care update*"

4.1 Delayed Handling of my Grievance

4.1.1 **The facts established are set out in 4.1.2 to 4.1.4 below.**

4.1.2 Mr O'Brien's grievance is dated 27 November 2018 and the grievance hearing (day one) was held on 30 July 2020. This process took 103 weeks. We considered the period from November 2019 to April 2020 (say 25 weeks) when, because of industrial action and then the early days of the Covid-19 pandemic, much of the usual HR activity was set aside. However, even setting these events aside which significantly distracted from normal business, it still took approximately 78 weeks to arrange this grievance and we needed to examine this timeframe.

4.1.3 The Grievance Procedure states that the Trust will "*arrange for a grievance panel to hear the grievance normally within 20 working days or as soon as reasonably practicable. If it is not possible to hold the hearing within 20 working days the employee must be provided with an explanation for the delay by the Human Resources Department."*

4.1.4 In looking at the facts of this we considered the correspondence between Mr O'Brien and the Trust in his quest for additional information.

4.1.5 **The panel findings on issue 4.1. are set out at 4.1.6 to 4.1.17 below**.

4.1.6 There is no requirement in the grievance process, once invoked by the employee, to supply him/her with ongoing information. It is enough that they set out their concerns and it is then for the panel to seek out all evidence. While it is useful for the employee to provide some of the information in his own possession, he/she is not expected to do the research and trawl for other information. This is provided for in the Grievance Procedure, *"the Grievance Panel may also additional information/clarification in the pursuit of resolution of the grievance."*[15]

4.1.7 Unusually, for a grievance, Mr O'Brien told us that he had *"set out proposed actions that would allow the grievance process to commence with a first meeting …"*[16]. It is our understanding that it is the Trust who sets out the timetable and manages the process.

[15] Paragraph 6b of the Grievance Procedure
[16] Contained in Mr O'Brien's supplementary comments to the panel on 25 September 2020

4.1.8 Mrs Toal, Director of Human Resources, acknowledged receipt of Mr O'Brien's grievance on 14 December 2018 and in it she referred to *"arrangements being finalised to consider your grievance".* She also referred to information sought earlier by Mr O'Brien and that the Trust would endeavour to release it to him by 21 December 2018 and, if that were not possible, she would update him.

4.1.9 Further communication continued for some time:

- The Trust provided some documents by 22 December 2018 and sought an extension to provide the remaining papers by 11 January 2019

- Mr O'Brien and Mrs Toal exchanged further correspondence between 12 March 2019 and October 2019 when information was delivered to Mr O'Brien's secretary.

4.1.10 Our finding is, having examined correspondence, that the requests for more information by Mr O'Brien were considered by the Trust to be a condition of his attendance at his own grievance. In his letter to Mrs Toal of 12 March 2019 he says (when he requests further information for the Medical Protection Society - MPS:

> *"Following its receipt, you will be advised whether any further information is to be requested, and/or whether the grievance is to be amended."*

4.1.11 On 3 June 2019 Mr O'Brien wrote to Mrs Toal on 3 June 2019. In the first paragraph he refers to information connected to his grievance "*has still not been provided".* In Mrs Toal's response of 3 June 2019 (Appendix 12), she states *"once this information has been provided to you, I will be commencing your grievance process immediately to avoid further undue delay. Any additional requests for information or amendment to your grievance can be done so as it is progressed.".*

4.1.12 We have no evidence to indicate that Mr O'Brien did not agree that it was the case that his attendance at a grievance was conditional upon his receipt of information as set out, nor have we evidence that he corrected this if he did not agree.

4.1.13 We have no evidence to indicate that Mr O'Brien sought assurances about his grievance for the avoidance of any doubt that he may have had after the correspondence from Mrs Toal on 3 June 2019. We have experienced in this grievance Mr O'Brien's attention to dates and correspondence and we do not consider it likely that he believed that the Trust was the party that had not progressed the matter.

4.1.14 It is our opinion that the process stalled. Mr O'Brien sought extensive information and the Trust understood that until he no longer had outstanding information requests, he was not prepared to attend his grievance.

4.1.15 As before it is our opinion that after Mr O'Brien was provided information on 30 October 2019, the industrial action faced by all HSC employers and subsequently the Covid-19 pandemic while not related directly to Mr O'Brien's case, had the effect of all HSC HR departments having to redirect attention urgently to matters beyond normal business.

4.1.16 Finally, in this section, Mr O'Brien contended that a decision by the Medical Director to refer him to the General Medical Council (GMC) was related to him advising the Trust that he had instructed legal representation. Mr O'Brien provided no evidence on this beyond timing alone. It is therefore not possible for us to conclude safely on that basis that he is correct.

4.1.17 While there are significant delays in setting up Mr O'Brien's grievance, we have been able to explain them, at least to some extent, by examining the correspondence. We inferred from Mr O'Brien's submissions that this was deliberate on the part of the Trust and we do not find this to be the case. Unlike most other grievances, Mr O'Brien's had the attention of the Director of HR and she personally attended to much of the responses to him. **This aspect of the grievance is not upheld**.

4.2 Additional Concerns

(i) Events before 30 December 2016

4.2.1 All matters on which we wish to comment are included in section 2.2.

(ii) An unfocused trawl

4.2.2 Mr O'Brien pointed out that included in Dr Lynn's (NCAS) letter to Dr Wright of 29 December 2016, "*the investigation should not be an unfocused trawl".* **(Appendix 11)**

4.2.3 It is not possible nor is it appropriate for a grievance panel to reinvestigate the matters contained in the formal MHPS investigation. This includes seeking whether the matters considered by the investigators were relevant or not. This would have required some investigation on our part and judgment of the matter to decide whether the inclusion of any item was appropriate. While we would have preferred to attend to and address all matters raised by Mr O'Brien, it is beyond our remit in this matter. This is only appropriate in the context of the disciplinary hearing that was anticipated and Mr O'Brien

presenting his evidence there and his view that he has no case to answer.

(iii) Private Patients

4.2.4 Again, it is not possible nor is it appropriate for a grievance panel to reinvestigate the matters subject to the formal MHPS investigation. By doing otherwise in relation to private patients would have required re-investigation on our part and we cannot substitute the MHPS and disciplinary processes with our analysis or judgment on this. This is only appropriate in the context of the disciplinary hearing that was anticipated and Mr O'Brien presenting his evidence and his view that he has no case to answer in this regard

4.2.5 **In relation to the items in 4.2 (i) and (ii), these are beyond the panel's remit.**

4.3 Duty of Clinical Care

4.3.1 On examination of these matters, these are outside of the remit of a grievance panel because they raise concerns of a clinical nature.

4.3.2 For this reason, these will be passed on by Dr Diamond to the Trust's Medical Director, Dr O'Kane, to alert her formally to them and to decide on what, if any, next steps may be required.

5 Data Protection

5.1.1 Although not set out as a separate matter in his grievance, Mr O'Brien described some confidential matters that had been included in information sent to him that was in breach of Data Protection and confidentiality requirements. On examination, this appeared to be the case.

5.1.2 There are separate formal processes to deal with such alleged breaches and the panel forwarded details of these to the Trust so that they could be addressed within those policy requirements and dealt with, if required.

6 SUMMARY CONCLUSIONS

6.1 **Overall, we do not find Mr O'Brien's grievance upheld**.

6.2 Mr O'Brien referenced the MHPS Framework on many occasions in his submissions and at the grievance hearing. We consider that there were issues on the part of the Trust and Mr O'Brien himself that compromised the effective operation of the Framework the way it was intended. However, even though the Trust moved beyond timescales to the extent that they were, in effect, set aside, Mr O'Brien did not actively participate in an early resolution at the outset. This may have obviated the need to the subsequent investigation.

6.3 In the period after 23 March 2016 when Mr O'Brien did not respond, we are aware that it was not his fault that he did not know about the plans suggested by Ms Gishkori in September 2016. However, none of this takes away from the responsibilities of the Medical Director to have concerns examined and the time for informal resolution had passed by 22 December 2016.

6.4 As stated above, the delays in adhering to the timeframes in MHPS, while challenging and, from experience, seldom adhered to, the duration on this occasion was a concern. We also consider that the timeframe from submitting his grievance to it being heard was the subject of delay. We have explained in the sections above how we have taken account of some on the factors contributing to the timescales.

6.5 It is also our view that there were examples where Mr O'Brien's apparent focus solely on his own perspective contributed to the challenges facing his employer in attending to their concerns at an earlier stage which in turn created the escalating context that he faced. These delays, and the context in which they existed, did not mean that his contract was breached.

6.6 This also links to the fact that Mr O'Brien summarised the overall detriment to him by the time he got to his planned retirement i.e. not being able to stay beyond retirement because HR issues were remained without conclusion. This again is factually correct but our finding is also set in the context of his choices as set out in 6.2 above.

6.7 The correct way of addressing his views or veracity of the matters set out in the MHPS investigation report after Dr Khan decided it should go to a conduct panel, was for Mr O'Brien to participate. In line with the procedures he then could present his own evidence to a panel to support his view and have it fully considered. Mr O'Brien did not do this, he sought a grievance instead, some of which we were unable to consider because it was relevant to the purpose of the conduct panel and we could not re-investigate the MHPS investigation.

6.8 We find that, had Mr O'Brien met his obligations to engage meaningfully from March 2016, there was a chance of resolution and support to him, if it was required, outside of the formal MHPS process that ensued.

6.9 In relation to the concerns about Mr O'Brien which were the catalyst for this whole process, there are three key facts:

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

6.10 In examining these, it was, in our opinion, reasonable that Dr Wright was not assured of a viable alternative to the formal MHPS process in December 2016. All earlier intended interventions outside of the formal MHPS process had failed to deliver progress, let alone closure.

6.11 Overall, we inferred a suggestion that the actions and, in other cases, lack thereof, were deliberate and designed to cause distress to Mr O'Brien. We did not find evidence to support that level of allegation. However, we do appreciate that any formal employment process brings an inevitable anxiety to the parties.

***** END *****

APPENDICES

APPENDIX 1

Southern Health and Social Care Trust

23 March 2016

Mr Aidan O'Brien,
Consultant Urologist
Craigavon Area Hospital

Dear Aidan,

We are fully aware and appreciate all the hard work, dedication and time spent during the course of your week as a Consultant Urologist. However, there are a number of areas of your clinical practice causing governance and patient safety concerns that we feel we need to address with you.

1. **Untriaged outpatient referral letters**

There are currently 253 untriaged letters dating back to December 2014. Lack of triage means we do not know whether the patients are red-flag, urgent or routine. Failure to return the referrals to the Booking Centre means that the patients are only allocated on a chronological basis with no regard to urgency.

2. **Current Review Backlog up to 29 February 2016**

Total in Review backlog = 679

2013	41
2014	293
2015	276
2016	69

We need assurances that there are no patients contained within this backlog that are Cancer Surveillance patients. We are aware that you have a separate oncology waiting list of 286 patients; the longest of whom was to have been seen in September 2013. Without a validation of the backlog we have no assurance that there are not clinically urgent patients on the list. Therefore we need a plan on how these patients will be validated and proposals to address this backlog.

3. **Patient Centre letters and recorded outcomes from Clinics**

Consultant colleagues from not only Urology but also other specialties are frustrated that there is often no record of your consultations/discharges on Patient Centre or in the patients' notes. Validation of waiting lists has also highlighted this issue. If your

Surgical And Elective Division, Acute Directorate, Craigavon Area Hospital, 68 Lurgan Road, Portadown, Craigavon, Co Armagh BT63 5QQ Telephone: Personal Information redacted by USI

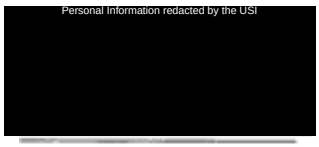
patient is reviewed at another Urology Clinic a new appointment slot is required due to the lack of documentation.
This lack of documentation combined with no record of clinic outcomes means further investigations/follow-up may not be organised by admin staff.

4. Patient Notes at home

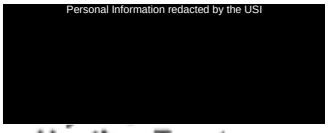
This has been an ongoing issue for years and needs addressed urgently. We request that all SHSCT charts that are in your home or in your car be brought to the hospital without further delay.

You will appreciate that we must address these governance issues and therefore would request that you respond with a commitment and immediate plan to address the above as soon as possible.

Yours sincerely,



Eamon Mackle
Associate Medical Director



Heather Trouton
Assistant Director

APPENDIX 2

Extract from notes of Oversight Committee 13 September 2016

Oversight Group H.
13 Sept 2016

AOB:

from EM & HT.

The oversight group was informed that a formal letter had been sent to AOB on 23/3/16 outlining a number of concerns about his practice. He was asked to develop a plan detailing how he was intending to address these concerns, however no plan had been provided to date and the same concerns continue to exist almost 6 months later. A preliminary investigation has already taken place on paper and in view of this, the following steps were agreed;

- Simon Gibson to draft a letter for Colin Weir and Ronan Carroll to present to AOB
- The meeting with AOB should take place next week (w/c 19/9/16)
- This letter should inform AOB of the Trust's intention to proceed with an informal investigation under MHPS at this time. It should also include action plans with a 4 week timescale to address the 4 main areas of his practice that are causing concern i.e. untriaged letters, outpatient review backlog, taking patient notes home and recording outcomes of consultations and discharges
- Esther Gishkori to go through the letter with Colin, Ronan and Simon prior to the meeting with AOB next week
- AOB should be informed that a formal investigation may be commenced if sufficient progress has not been made within the 4 week period

No mention of SG conversation with NCAS on 07.09.16 & NCAS advice.

ACTIONS:

1. **Simon Gibson to draft a letter for Colin Weir and Ronan Carroll to present to AOB next week**
2. **Esther Gishkori to meet with Colin Weir, Ronan Carroll and Simon Gibson to go through the letter and confirm actions required**

[redacted]

Handwritten notes are panel member's (Shirley Young) during deliberations

APPENDIX 3

National Clinical Assessment Service

NCAS
N I office
HSC Leadership Centre
The Beeches
12 Hampton Manor Drive
Belfast
Co Antrim
BT7 3EN

Tel: 028 90 690 791
Personal information redacted by USI

13 September 2016

PRIVATE AND CONFIDENTIAL
Sent by email only

Mr Simon Gibson
Assistant Director
Southern Health and Social Care Trust
Craigavon Area Hospital
68 Lurgan Road
Portadown
Craigavon
BT63 5QQ

NCAS ref: 18665 (Please quote in all correspondence)

Dear Mr Gibson

I am writing following our telephone discussion on 7 September. Please let me know if I have misunderstood anything as it may affect my advice.

You called to discuss a consultant urologist who has been in post for a number of years. You described a number of problems. He has a backlog of about 700 review patients. This is different to his consultant colleagues who have largely managed to clear their backlog.

You said that he is very slow to triage referrals. It can take him up to 18 weeks to triage a referral, whereas the standard required is less than two days.

You told me that he often takes patient charts home and does not return them promptly. This often leads to patients arriving for outpatient appointments with no records available.

You told me that his note-taking has been reported as very poor, and on occasions there are no records of consultations.

To date you are not aware of any actual patient harm from this behaviour, but there are anecdotal reports of delayed referral to oncology.

The doctor has been spoken to on a number of occasions about this behaviour, but unfortunately no records were kept of these discussions. He was written to in March of this year seeking an action plan to remedy these deficiencies, but to date there has been no obvious improvement.

We discussed possible options open to you. The Trust has a policy on removing charts from the premises and it would appear that this doctor is in breach of this policy. This could lead to disciplinary action. He was warned about this behaviour in the letter sent to him in March so it would be open to you to take immediate disciplinary action; however, I would suggest that he is asked to comply immediately with the policy.

With regard to the poor note-taking it would be useful to conduct an audit. If there is evidence of a substantial number of consultations for either inpatients or outpatients with no record in the notes, this is a serious matter which may merit disciplinary action and possible referral to the GMC. If, after the audit, it appears that the concern is more about the quality of the notes rather than whether there are any notes at all, a notes review by NCAS may be appropriate. If you wish us to consider that, please get back to me.

The problems with the review patients and the triage could best be addressed by meeting with the doctor and agreeing a way forward. We discussed the possibility of relieving him of theatre duties in order to allow him the time to clear this backlog. Such a significant backlog will be difficult to clear, and he will require significant support. I would be happy to attend such a meeting, if this was considered helpful.

Relevant regulations/guidance:

- Local procedures;
- General Medical Council Guide to Good Medical Practice;
- Maintaining High Professional Standards in the Modern HPSS (MHPS).

Review date:

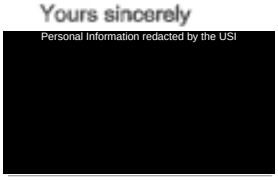
7 October 2016.

As it seems likely that further NCAS input will be required, we will keep this case file open and review the situation in about one month. If you require further advice in the meantime, please do not hesitate to contact me.

If you have any further issues to discuss, or any difficulties with these arrangements, please contact the Northern Ireland office on the direct line above.

I hope the process has been helpful to you.

Yours sincerely



Dr Colin Fitzpatrick
NCAS Senior Adviser

cc: Jill Devenney, Case Officer (N I)

Please ensure that any information provided to NCAS which contains personal data of any type is sent to us through appropriately secure means.

APPENDIX 4

Mallagh-Cassells, Heather

From: Wright, Richard
Sent: 16 September 2016 13:44
To: Toal, Vivienne
Subject: RE: meeting re Mr O'Brien.

Hi Vivienne. I had a meeting scheduled with Francis and Esther this am and this topic came up. Esther agreed in principle to provide the info requested and to ensure that there was a documented meeting with Mr OB outlining the implications of not getting this sorted within 3 months. Francis was keen to pursue this a under those circumstances but not to let it run further than the three months if still non compliant. Happy to discuss further. Richard

From: Toal, Vivienne
Sent: 16 September 2016 08:57
To: Wright, Richard; Gishkori, Esther
Subject: RE: meeting re Mr O'Brien.

Esther – I am conscious you go off on leave today; how do you wish to handle Richard's request below?

Vivienne

From: Wright, Richard
Sent: 15 September 2016 14:52
To: Gishkori, Esther
Cc: Toal, Vivienne
Subject: Re: meeting re Mr O'Brien.

Hi Esther. As director of the service naturally we have to listen to your opinion. Before I would consider conceding to any delay in moving forward with what was our agreed position after the oversight meeting I would need to see what plans are in place to deal with the issues and understand how progress would be monitored over the three month period.
Perhaps when we have seen these we could meet again to consider. regards Richard

Sent from my iPad

On 15 Sep 2016, at 14:40, Gishkori, Esther <[redacted]> wrote:

Personal Information redacted by USI

> Dear Richard and Vivienne,
> Following our oversight committee on Tuesday 13th September I had a meeting with Charlie McAllister and Ronan Carroll, my AMD and AD for surgery.
> I mentioned the case that was brought to the oversight meeting in relation to Mr O'Brien and the plan of action.
>
> Actually, Charlie and Colin Weir already have plans to deal with the urology backlog in general and Mr O'Brien's performance was of course, part of that.
> Now that they both work locally with him, they have plenty of ideas to try out and since they are both relatively new into post, I would like try their strategy first.
>
> I am therefore respectfully requesting that the local team be given 3 more calendar months to resolve the issues raised in relation to Mr O'Brien's performance.

Handwritten notes are panel member's (Shirley Young) during deliberations

I appreciate you highlighting the fact that this long running issue has not yet been resolved. However, given the trust and respect that Mr O'Brien has won over the years, not to mention his life-long commitment to the urology service which he built up singlehandedly, I would like to give my new team the chance to resolve this in context and for good. This I feel would be the best outcome all round.

Happy to discuss any time and I will of course brief the oversight committee of any progress we make.

Many thanks
Best
Esther.

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office Personal Information redacted by USI **Mobile** Personal Information redacted by USI
<image002.png> Personal Information redacted by USI

APPENDIX 5

From: Carroll, Ronan [mailto: Personal Information redacted by USI
Sent: 22 September 2016 15:41
To: McAllister, Charlie; Gishkori, Esther; Weir, Colin
Subject: RE: meeting re Mr O'Brien.
Importance: High

Charlie/Colin
So can I ask and offer some suggestions/solutions as to how we may monitor progress against the action listed below. The clock is ticking now toward December
Come back to me if you wish me to action anything/all

1. That I (initially) have a series of face to face meetings with Mr O'Brien and aim to have resolution or plan for resolution in next 3 months. That is by mid December. I propose the first meeting would involve you me and Mr O'Brien – At the first meeting obviously after the context of the meeting being explained the proposed plan/actions need to be shared with AOB and agreed
2. To implement a clear plan to clear triage backlog. – is this the outpatient referral letters, including RF's? How are you planning to monitor that this is cleared? I would propose with regard to the RF's that I would ask the cancer team to monitor the triage turnaround, with regard to outpatients I would ask Anita to put a process in place to monitor
3. Make arrangements to validate the review backlog and adapt clinic new to review ratios to reduce this – RBL validation – are we offering additional Pas for this to be done? If not, then something in his job plan will have to stop for this clinical validation to happen. Then when this task has been completed the remaining on the RBL can only be dealt by as your suggestion the template being adjusted, this has a lead in time of 6 weeks due to partial booking process. When this is implemented we will monitor the progress of AOBs RBL (I can have this run at anytime)
4. All correspondence to GPs and copies for patient centre /ECR to be done at time of consultation – I will speak to Anita to ensure AOBs secretary receives digital dictation following any consultation
5. All patient notes to be return from home without exception NA
6. These meetings will report back regularly to Dr McCallister as AMD and he will be involved in some further meeting to assist me and provide support when needed absolutely

7. Throughout the process we want to encourage full engagement and have Mr O'Brien understand that if we achieve these aims through these processes that will satisfy the Trust and no further actions would be taken
8. That monitoring would continue to ensure there is no drift with an understanding that if this happened further investigations would take place.

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by USI

From: McAllister, Charlie
Sent: 21 September 2016 11:55
To: Gishkori, Esther; Weir, Colin; Carroll, Ronan
Subject: RE: meeting re Mr O'Brien.

Hi Colin

Thank you very much for this. Apart from the fact that you spelt my name wrong (!) this is absolutely excellent and I agree completely. It would be important to do this in a positive/constructive/supportive role and that Mr O'Brien would be aware of this. I think that this approach will give the best chance to achieve this. And for improving the current situation.

Since I can't improve on this I am forwarding in toto.

Thanks

Charlie
From: Weir, Colin
Sent: 16 September 2016 14:41
To: McAllister, Charlie
Subject: Action Plan

Charlie
These are my initial thoughts. Anything to add? Change?

Dear Dr McCallister

Further to discussions I propose that I as CD and you as AMD implement the following action plan in relation to outstanding issues in respect of Mr O'Brien

1. That I (initially) have a series of face to face meetings with Mr O'Brien and aim to have resolution or plan for resolution in next 3 months. That is by mid December. I propose the first meeting would involve you me and Mr O'Brien
2. To implement a clear plan to clear triage backlog.
3. Make arrangements to validate the review backlog and adapt clinic new to review ratios to reduce this
4. All correspondence to GPs and copies for patient centre /ECR to be done at time of consultation
5. All patient notes to be return from home without exception
6. These meetings will report back regularly to Dr McCallister as AMD and he will be involved in some further meeting to assist me and provide support when needed
7. Throughout the process we want to encourage full engagement and have Mr O'Brien understand that if we achieve these aims through these processes that will satisfy the Trust and no further actions would be taken
8. That monitoring would continue to ensure there is no drift with an understanding that if this happened further investigations would take place.

Colin Weir FRCSEd, FRCSEng, FFSTEd
Consultant Surgeon | Honorary Lecturer in Surgery | AMD Education and Training | Clinical Director SEC
Southern Health and Social Care Trust

Secretary Jennifer [redacted] Personal Information redacted by USI

From: Gishkori, Esther
Sent: 15 September 2016 14:59
To: Weir, Colin; McAllister, Charlie; Carroll, Ronan
Subject: FW: meeting re Mr O'Brien.

FYI below.
.....and my response will be?

Esther Gishkori
Director of Acute Services
Southern Health and Social Care Trust
Office [redacted] Mobile [redacted] Personal Information redacted by USI
[redacted]

APPENDIX 6

I

Southern Health & Social Care Trust

Oversight Committee
12th October 2016

Present:
Dr Richard Wright, Medical Director (Chair)
Vivienne Toal, Director of HROD
Esther Gishkori, DAS

In attendance:
Simon Gibson, Assistant Director, Medical Director's Office
Malcolm Clegg, Medical Staffing Manager

Discussion:

N/A.

Mr A O'Brien

Mrs Gishkori reported that Mr O'Brien was going for planned surgery in November and was likely to be off for a considerable period. It was noted that Mr O'Brien had not been told of the concerns following the previous Oversight Committee. It was also noted that a plan was in place to deal with the range of backlogs within Mr O'Briens practice during his absence.

Mrs Gishkori gave an assurance that, when Mr O'Brien returned from his period of sick leave, that the administrative practices identified by the Oversight Committee would be formally discussed with him, to ensure there was an appropriate change in behaviour. It was agreed that this would be kept under review by the Oversight Committee.

APPENDIX 7

Southern Health & Social Care Trust

Oversight Committee
22nd December 2016

Present:
Dr Richard Wright, Medical Director (Chair)
Vivienne Toal, Director of HROD
Ronan Carroll, on behalf of Esther Gishkori, Director of Acute Services

In attendance:
Simon Gibson, Assistant Director, Medical Director's Office
Malcolm Clegg, Medical Staffing Manager
Tracey Boyce, Director of Pharmacy, Acute Services Directorate

Dr A O'Brien

Context
On 13th September 2016, a range of concerns had been identified and considered by the Oversight Committee in relation to Dr O'Brien. A formal investigation was recommended, and advice sought and received from NCAS. It was subsequently identified that a different approach was to be taken, as reported to the Oversight Committee on 12th October.

Dr O'Brien was scheduled to return to work on 2nd January following a period of sick leave, but an ongoing SAI has identified further issues of concern.

Issue one
Dr Boyce summarised an ongoing SAI relating to a Urology patient who may have a poor clinical outcome due to the lengthy period of time taken by Dr O'Brien to undertake triage of GP referrals. Part of this SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason. It was noted as part of this investigation that Dr O'Brien had been undertaking dictation whilst he was on sick leave.

Ronan Carroll reported to the Oversight Committee that, between July 2015 and Oct 2016, there were 318 letters not triaged, of which 68 were classified as urgent. The range of the delay is from 4 weeks to 72 weeks.

Action
A written action plan to address this issue, with a clear timeline, will be submitted to the Oversight Committee on 10th January 2017
Lead: Ronan Carroll/Colin Weir

Highlight is panel's (Shirley Young)

Issue two

An issue has been identified that there are notes directly tracked to Dr O'Brien on PAS, and a proportion of these notes may be at his home address. There is a concern that some of the patients seen in SWAH by Dr O'Brien may have had their notes taken by Dr O'Brien back to his home. There is a concern that the clinical management plan for these patients is unclear, and may be delayed.

Action

Casenote tracking needs to be undertaken to quantify the volume of notes tracked to Dr O'Brien, and whether these are located in his office. This will be reported back on 10th January 2017
Lead: Ronan Carroll

Issue three

Ronan Carroll reported that there was a backlog of over 60 undictated clinics going back over 18 months. Approximately 600 patients may not have had their clinic outcomes dictated, so the Trust is unclear what the clinical management plan is for these patients. This also brings with it an issue of contemporaneous dictation, in relation to any clinics which have not been dictated.

Action

A written action plan to address this issue, with a clear timeline will be submitted to the Oversight Committee on 10th January 2017
Lead: Ronan Carroll/Colin Weir

It was agreed to consider any previous IR1's and complaints to identify whether there were any historical concerns raised.
Action: Tracey Boyce

Consideration of the Oversight Committee

In light of the above, combined with the issues previously identified to the Oversight Committee in September, it was agreed by the Oversight Committee that Dr O'Briens administrative practices have led to the strong possibility that patients may have come to harm. Should Dr O'Brien return to work, the potential that his continuing administrative practices could continue to harm patients would still exist. Therefore, it was agreed to exclude Dr O'Brien for the duration of a formal investigation under the MHPS guidelines using an NCAS approach.

It was agreed for Dr Wright to make contact with NCAS to seek confirmation of this approach and aim to meet Dr O'Brien on Friday 30th December to inform him of this decision, and follow this decision up in writing.
Action: Dr Wright/Simon Gibson

The following was agreed:
Case Investigator – Colin Weir
Case Manager – Ahmed Khan

APPENDIX 8

4. Timeline of the Investigation

The dates below outline the key dates in respect of the background to the concerns and the management of the concerns under the Maintaining High Professional Standards (MHPS) Framework:

March 2016

On 23 March 2016, Mr Eamon Mackle, Associate Medical Director (Mr O'Brien's clinical manager) and Mrs Heather Trouton, Assistant Director (Mr O'Brien's operational manager) met with Mr O'Brien to outline their concerns in respect of his clinical practice. In particular, they highlighted governance and patient safety concerns which they wished to address with him.

Mr O'Brien was provided with a letter detailing their concerns and asking him to respond with an immediate plan to address the concerns. **(Appendix 1)**

Four broad concerns were identified:

- Untriaged outpatient referral letters

It was identified at that time that there were 253 untriaged referrals dating back to December 2014.

- Current Review Backlog up to 29 February 2016

It was identified at that time that there were 679 patient's on Mr O'Brien's review backlog dating back to 2013, with a separate oncology waiting list of 286 patients.

- Patient Centre letters and recorded outcomes from clinics

The letter noted reports of frustrated Consultant colleagues concerned that there was often no record of consultations / discharges made by Mr O'Brien on Patient Centre or on patient notes.

- Patient's hospital charts at Mr O'Brien's home

The letter indicated the issue of concern dated back many years. No numbers were identified within the letter.

April to October 2016

During the period April to October 2016, considerations were on-going about how best to manage the concerns raised with Mr O'Brien in the letter of 23 March 2016. It was determined that formal action would not be considered as it was anticipated that the concerns could be resolved informally. Mr O'Brien advised the review team he did not reply

to the letter but did respond to the concerns raised in the letter by making changes to his practice.

November 2016

Mr O'Brien was off work on sick leave from 16 November 2016 following surgery and was due to return to work on 2 January 2017.

An on-going Serious Adverse Incident (SAI) investigation within the Trust identified a Urology patient who may have a poor clinical outcome because the GP referral was not triaged by Mr O'Brien. The SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason.

December 2016

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

Information initially collated from the on-going SAI of Mr O'Brien's administrative practices identified the following:

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

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

28 December 2016

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

30 December 2016

Mr O'Brien was requested to attend a meeting on 30 December 2016 with Dr Richard Wright, Medical Director and Ms Lynne Hainey, HR Manager during which he was advised of a decision by the Trust to place him on a 4 week immediate exclusion in line with the Maintaining High Professional Standards (MHPS) Framework to allow for further preliminary enquiries to be undertaken. Mr O'Brien was accompanied by his wife, Mrs Marita O'Brien. **(Appendix 2)**

A letter was issued to Mr O'Brien in follow up to the meeting detailing the decision of immediate exclusion and a request for the return of all case notes and dictation from his home. The letter also advised Mr O'Brien that Dr Ahmed Khan had been appointed as Case Manager for the case and Mr Colin Weir was identified as the Case Investigator. **(Appendix 3)**

A note of the 30 December 2016 meeting was shared with Mr O'Brien. **(Appendix 4)**

03 January 2017

Mr O'Brien met with Mrs Martina Corrigan, Head of Service for Urology to return all case notes which he had at home and all undictated outcomes from clinics in line with the request made to him by Dr Wright on 30 December 2017.

20 January 2017

During the period of the 4 week immediate exclusion period notified to Mr O'Brien on 30 December 2016, Mr Colin Weir wrote to Mr O'Brien to request a meeting with him on 24 January 2017 to discuss the concerns identified and to provide an opportunity for Mr O'Brien to state his case and propose alternatives to formal exclusion. **(Appendix 5)**

23 January 2017

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

24 January 2017

The meeting between Mr Weir and Mr O'Brien took place on 24 January 2017 with Mrs Siobhan Hynds, Head of Employee Relations present. Mr O'Brien was accompanied to the meeting by his son, Michael O'Brien.

A note of the meeting was shared with Mr O'Brien. **(Appendix 6)**

26 January 2017

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

A preliminary report was provided for the purposes of this meeting. **(Appendix 7)**

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

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

These decisions were communicated to Mr O'Brien verbally by telephone following the case conference meeting on 26 January 2017.

6 February 2017

A letter was sent to Mr O'Brien on 6 February 2017 confirming the decisions from the case conference meeting on 26 January 2017 and notifying him of a meeting on 9 February 2017 to discuss the detail of the management plan and monitoring arrangements to be put in place on his return to work. **(Appendix 8)**

9 February 2017

Mr O'Brien attended a meeting with the Case Manager, Dr Ahmed Khan on 9 February to discuss the management arrangements that were to be put in place on his return to work following the immediate exclusion period. Mrs Siobhan Hynds and Mr Michael O'Brien were in attendance at the meeting. The action plan was accepted and agreed with Mr O'Brien at the meeting. **(Appendix 9)**

20 February 2017

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

January and February 2017

During January and February 2017, Mr O'Brien made a number of representations to Dr Richard Wright, Medical Director and Mr John Wilkinson, Non-Executive Director in respect of process and timescale. In considering the representations made, it was decided that Mr Colin Weir should step down as Case Investigator prior to the commencement of the formal investigation. Dr Neta Chada, Associate Medical Director and Consultant Psychiatrist was appointed as Case Investigator.

16 March 2017

The terms of reference for the formal investigation were shared with Mr O'Brien along with an initial witness list. **(Appendix 10)**

April, May and June 2017

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

Name	Job Title	Date
Mrs Martina Corrigan	Head of Service	15 March 2017
Mr Michael Young	Consultant Urologist	23 March 2017
Mrs Claire Graham	Head of Information Governance	03 April 2017
Mr Ronan Carroll	Assistant Director	06 April 2017
Mr Eamon Mackle	Consultant Surgeon	24 April 2017
Mr Anthony Glackin	Consultant Urologist	3 May 2017
Ms Anita Carroll	Assistant Director	19 May 2017
Mr Colin Weir	Clinical Director	24 May 2017
Mr Mark Haynes	Consultant Urologist	24 May 2017
Ms Noeleen Elliott	Personal Secretary	24 May 2017
Mrs Helen Forde	Head of Health Records	05 June 2017
Mrs Heather Trouton	Assistant Director	05 June 2017
Mrs Katherine Robinson	Referral & Booking Centre Manager	05 June 2017

14 June 2017

Dr Chada, Case Investigator wrote to Mr O'Brien requesting to meet with him on 28 June 2017 for the purpose of taking a full response in respect of the concerns identified. **(Appendix 24)**

19 June 2017

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

05 July 2017

Mr O'Brien advised the date of 31 July was not suitable and a date of 3 August 2017 was agreed.

03 August 2017

A first investigation meeting was held with Mr O'Brien in order to seek his response to the issues of concern. **(Appendix 25)**

At the meeting on 3 August 2017 it was agreed that a response would not be taken in respect of term of reference number 4 in respect of private patients until patient information requested by Mr O'Brien had been furnished to him. It was agreed that a further meeting date would be arranged for this purpose once all information had been provided. Mr O'Brien's responses to the remaining terms of reference were gathered.

16 October 2017

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

06 November 2017

A second investigation meeting was held with Mr O'Brien in order to seek his response to the issues of concern in respect of term of reference 4. **(Appendix 26)**

At the meeting of 6 November 2017, Mr O'Brien advised Dr Chada that he wished to make comment on both his first statement and also the witness statements provided to him. He further advised that his priority for November and December was completion of his appraisal and that he would not be able to provide his comments during this period. It was agreed his timescales would be facilitated.

15 February 2018

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

22 February 2018

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

In view of the timeframe to date, Mr O'Brien was asked to provide comments by 9 March 2018 rather than 31 March 2018.

16 March 2018

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

26 March 2018

No comments were received from Mr O'Brien.

29 March 2018

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

30 March 2018

No comments were received from Mr O'Brien.

2 April 2018

Comments on the statements from the meetings of 3 August and 6 November were received from Mr O'Brien. Mr O'Brien also queried requested amendments to notes of meeting on 30 December 2016 and 24 January 2017.

In the interests of concluding the investigation report without further delay, all comments from Mr O'Brien have been considered and are appended with the relevant documents.

APPENDIX 9

2017

January

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KEY		Trust actions		Mr O'Brien

/contd overleaf

Calendar 2017/ contd

24 January 2017	Meeting - Mr Weir & Mr O'Brien to discuss concerns and opportunity to comment on them
26 January 2017	Management Case Conference - formal MHPS investigation agreed and Mr O'Brien informed (by telephone)
27 January 2017	Mr O'Brien's exclusion from work ceased
30 January - 17 February 2017	Mr O'Brien on sick leave
06 February 2017	Letter to Mr O'Brien notifying him of meeting on 9 February 2017
09 February 2017	Meeting - Dr Khan & Mr O'Brien (return to work action plan agreed)
20 February 2017	Mr O'Brien returned from sick leave
16 March 2017	Terms of Reference of MHPS formal investigation given to Mr O'Brien
3, 6 & 24 April 2017	Investigation meetings with witnesses x 13
3, 19 & 24 May 2017	
5 & 14 June 2017	
14 June 2017	Case investigator wrote to Mr O'Brien asking to meet on 28 June 2017
19 June 2017	Mr O'Brien requested to reschedule 28 June 2017 meeting to ensure he could be accompanied (agreed)
28 June 2017	Investigation meeting scheduled with Mr O'Brien (postponed at Mr O'Brien's request)
29, 30 June & 1 July 2017	Alternative dates suggested to Mr O'Brien - 31 July 2017 was agreed
05 July 2017	Mr O'Brien advised that date was not suitable and 3 August 2017 agreed as an alternative
03 August 2017	First meeting held with Mr O'Brien by Case Manager under formal MHPS framework (Private Patients issues and Terms of Reference item 4) postponed until next meeting.
16 October 2017	Date for second meeting with Case Manager agreed for 6 November 2017
06 November 2017	Second meeting with Case Manger
7 November - 29 December 2017	Mr O'Brien asked that his other priorities (work pressures and appraisal take priority over this time - agreed by investigators)

APPENDIX 10

2018

January

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February

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March

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April

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KEY | **Trust Actions** | **Mr O'Brien**

CASE INVESTIGATION 2018 - Key Dates

3 January to 30 March 2017	Mr O'Brien's comments from Novermber are outstanding
15 February 2018	Mr O'Brien had not yet provided comments he had wanted to make after 6 November 2017 meeting - update sought from him (Ms Hynds email 15 February 2018)
22 February 2018	Further update sought from Mr O'Brien (Ms Hynds email of 22 February 2018). Mr O'Brein responded to email expressing misunderstanding and that he was waiting for response from Trust. Requests note of the meeting of 6 November 2018 and any other documentation. He suggested that a timeframe for his response is 31 March 2018.
23 February 2018	Email response to Mr O'Brien from Ms Hynds - will send thorugh notes of 6 November 2017. Comments that on 6 November 2018, it was Mr O'Brien who had wished to make comment on previous notes and recipt of November notes (which were a reflection of his written submission) should not have held up the comments that he wished to make. Ms Hynds ought an ealrlier deadline of 9 March 2018.
09 March 2018	Deadline set for comments by investigators (not met)
16 March 2018	Comments not provided by Mr O'Brien and another deadline sought of 26 March 2018
26 March 2018	New deadline for comments from Mr O'Brien - none received
29 March 2018	Final opportunity given to Mr O'Brien to provide the outstanding comments that he wished to make of 12.00 noon on 30 March 2018
30 March 2018	Deadline not met by Mr O'Brien
02 April 2018	Comments received from Mr O'Brien and queries
12 June 2018	Dr Chada, Case Investigator, completed her report.
21 June 2018	Final report issued to Mr O'Brien

APPENDIX 11

National Clinical Assessment Service

NCAS
NHS Litigation Authority
2nd Floor, 151 Buckingham Palace Road
London
SW1W 9SZ

Website: www.ncas.nhs.uk

General Enquiries and Advice Line: 020 7811 2600
Direct Fax: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

29 December 2016

SENT VIA EMAIL ONLY

PRIVATE AND CONFIDENTIAL

Dr Richard Wright
Medical Director
Southern Health And Social Care Trust
68 Lurgan Road
Portadown
BT63 5QQ

NCAS ref: 18665 (Please quote in all correspondence)

Dear Dr Wright

Further to our telephone conversation on 28 December 2016, I am writing to summarise the issues which we discussed for both of our records. Please let me know if any of the information is incorrect.

In summary, this case which my colleague Dr Fitzpatrick had previously discussed with Mr Gibson, involves Dr 18665, a senior consultant urologist about whom there have been increasing performance concerns. The allegations are of poor record keeping, and slowness of triaging referrals and arranging reviews. Dr 18665 is also reported to have removed a very substantial numbers of charts from the Trust's premises without bringing them back; despite requests that these be returned many charts remain outstanding. Dr 18665's colleagues have, on occasions, seen patients for whom there have been no notes. Dr 18665 is currently on sick leave, but has indicated that he is returning to work in January 2017.

A recent Serious Adverse Incident (SAI) has caused concern that there is potential for patients to be harmed by the ongoing situation. You are awaiting the report of the SAI but on the information available to date, you feel the Trust will need to undertake a formal investigation of Dr 18665. The Trust is also considering exclusion.

As you are aware, the concerns about Dr 18665 should be managed in line with local policy and the guidance in Maintaining High Professional Standards in the Modern HPSS (MHPS). We discussed that as the information to date - no noted improvement despite the matter having been raised with Dr 18665 - suggests that an informal approach (as per paragraphs 15-17 of Section I of MHPS) is unlikely to resolve the situation, a more formal process is now warranted.

Any formal investigation should be undertaken to robust and specific Terms of Reference (ToR) and in line with the guidance in paragraphs 28-40 of MHPS Section II. The Case Manager should write to Dr 18665 as per paragraph 35 informing him of the name of the Case Investigator and Designated Board Member; any objections by Dr 18665 to the appointment of nominated individuals should be given serious consideration. The investigation should not be an unfocused trawl of Dr 18665's work but we discussed that if there are concerns that patients may not have received appropriate treatment, or that there are patients with inadequate records, then this could be managed separately with an audit/ look back to ensure that patients have received the appropriate standard of care. We noted that further preliminary information (such as from the SAI and taking account of Dr 18665's comments) may be helpful in deciding the scope of the investigation and therefore the ToR.

As well as being outwith the Trust's Information Governance policies, the allegations, if upheld, may mean that the legislation (DPA) has been breached, and once more information is available you may wish to take further advice on this. Paragraphs 20 and 21 of the GMC's Good Medical Practice also set out standards for record keeping including a requirement that records are kept in line with data protection duties.

Dr 18665 is due to attend Occupational Health to ascertain whether he is fit for work; if he is not, we noted that there would be no need at this time to consider exclusion but you may then wish to ask the Occupational Physician whether/when Dr 18665 would be fit to participate in an investigative process.

If Dr 18665 is deemed fit for work, we discussed the criteria for formal exclusion, and the option of an interim immediate exclusion for a maximum of 4 weeks (as per paragraphs 18-27 of Section I MHPS). The latter would allow for further information to be collated and to take account of Dr 18665's comments about the allegations, before deciding whether there are reasonable and proper grounds for formal exclusion such as a concern that the presence of the practitioner in the workplace would be likely to hinder the investigation. I note that there had been a concern expressed previously about a record missing for 2 years inexplicably appearing on a secretary's desk. In line with paragraph 22 of Section II MHPS, there is an obligation to inform other organisations, including the private sector, of any restriction or exclusion of a practitioner and a summary of the reasons for it.

Dr 18665 should be encouraged to contact his defence organisation/ BMA for help and advice. He may also benefit from staff support such as counselling, at what is likely to be a stressful time for him. Dr 18665 should be told of the involvement of NCAS and you are welcome to share this letter with him if you think this would be helpful.

As discussed, and as Dr 18665 may be excluded, NCAS will keep this case open and I will review it with you in approximately 1 month. Please call in the interim if you have any queries.

Relevant regulations/guidance:

- Local procedures
- General Medical Council Guide to Good Medical Practice
- Maintaining High Professional Standards in the Modern HPSS (MHPS)

Review date:

27 January 2017

If you have any further issues to discuss, or any difficulty with these arrangements, please contact Case Support on the direct line above.

I hope the process has been helpful to you.

Yours sincerely

Personal Information redacted by the USI

Grainne Lynn
NCAS Adviser

cc Case Support Team

APPENDIX 12

D

Southern Health
and Social Care Trust

Quality Care - for you, with you

STRICTLY PRIVATE & CONFIDENTIAL

Mr Aidan O'Brien
Personal Information redacted by USI

& also via e-mail Personal Information redacted by USI
Personal Information redacted by USI

3 June 2019 **Our Ref:** VT/hm-c

Dear Mr O'Brien

INFORMATION REQUEST 3

I write further to your correspondence of 12 March 2019 enclosing a request for information.

The enclosed information request is extensive in nature and will require significant time and resources within the Trust to compile together.

Your information request has been sent to the relevant named individuals within the Trust and a process is on-going to gather the requested information. I have asked a member of my Employee Relations team to co-ordinate the information from the various Trust staff named in your correspondence and it will be shared with you as it is gathered.

All reasonable efforts are being made to gather the requested information however within your request there are elements which are much too wide and not properly defined. I therefore ask for you to refine and clarify the specifics of your request as highlighted by me on the attached document and return to me as soon as possible.

Once this information has been provided to you, I will be commencing your grievance process immediately to avoid any further undue delay. Any additional requests for information or amendment to your grievance can be done so as it is progressed.

I look forward to hearing from you.

Yours sincerely,

Personal Information redacted by the USI

VIVIENNE TOAL (MRS)
Director of Human Resources
& Organisational Development

Att.

Trust HQ, Craigavon Area Hospital, 68 Lurgan Road, PORTADOWN, Craigavon BT63 5QQ,
Personal Information redacted by USI Personal Information redacted by USI

Southern Health and Social Care Trust

Quality Care - for you, with you

Strictly Confidential

Maintaining High Professional Standards Formal Investigation

Case Manager Determination

Dr Ahmed Khan, Case Manager

1.0 Case Manager Determination following Formal Investigation under the Maintaining High Professional Standards Framework in respect of Mr Aiden O'Brien, Consultant Urologist

Following conclusion of the formal investigation, the Case Investigator's report has been shared with Mr O'Brien for comment on the factual accuracy of the report. I am in receipt of Mr O'Brien's comments and therefore the full and final documentation in respect of the investigation.

2.0 Responsibility of the Case Manager

In line with Section 1 Paragraph 38 of the MHPS Framework, as Case Manager I am responsible for making a decision on whether:

1. No further action is needed
2. Restrictions on practice or exclusion from work should be considered
3. There is a case of misconduct that should be put to a conduct panel
4. There are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer
5. There are concerns about the practitioner's clinical performance which require further formal consideration by NCAS (re-named as Practitioner Performance Advice)
6. There are serious concerns that fall into the criteria for referral to the GMC or GDC
7. There are intractable problems and the matter should be put before a clinical performance panel.

3.0 Formal Investigation Terms of Reference

The terms of reference for the formal investigation were:

1. (a) To determine if there have been any patient referrals to Mr A O'Brien which were un-triaged in 2015 or 2016 as was required in line with established practice / process.

   (b) To determine if any un-triaged patient referrals in 2015 or 2016 had the potential for patients to have been harmed or resulted in unnecessary delay in treatment as a result.

(c) To determine if any un-triaged referrals or triaging delays are outside acceptable practice in a similar clinical setting by similar consultants irrespective of harm or delays in treatment.

(d) To determine if any un-triaged patient referrals or delayed tri-ages in 2015 or 2016 resulted in patients being harmed as a result.

2. (a) To determine if all patient notes for Mr O'Brien's patients are tracked and stored within the Trust.

   (b) To determine if any patient notes have been stored at home by Mr O'Brien for an unacceptable period of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties.

   (c) To determine if any patient notes tracked to Mr O'Brien are missing.

3. (a) To determine if there are any undictated patient outcomes from patient contacts at outpatient clinics by Mr O'Brien in 2015 or 2016.

   (b) To determine if there has been unreasonable delay or a delay outside of acceptable practice by Mr O'Brien in dictating outpatient clinics.

   (c) To determine if there have been delays in clinical management plans for these patients as a result.

4. To determine if Mr O'Brien has seen private patients which were then scheduled with greater priority or sooner outside their own clinical priority in 2015 or 2016.

5. To determine to what extent any of the above matters were known to line managers within the Trust prior to December 2016 and if so, to determine what actions were taken to manage the concerns.

4.0 Investigation Findings

In answering each of the terms of reference of the investigation, the Case Investigator concluded:

1. (a) It was found that Mr O'Brien did not undertake non-red flag referral triage during 2015 and 2016 in line with the known and agreed process that was in place. In January 2017, it was found that 783 referrals were un-triaged by Mr O'Brien. Mr O'Brien accepts this fact.

(b) It was found that there was the potential for 783 patients to have been added to the incorrect waiting list. A look back exercise of all referrals by other Consultant Urologists determined that of the 783 un-triaged referrals, 24 would have been upgraded to red-flag status, meaning the timescales for assessment and implementation of their treatment plans was delayed. All un-triaged referrals were added to Trust waiting lists based on the GP referral assessment.

(c) It was found that all other Consultant Urologists undertook triage of all referrals in line with established practice.

(d) It was found that of the 24 upgraded patient referrals, 5 patients have a confirmed cancer diagnosis. All 5 patients have been significantly delayed commencing appropriate treatment plans.

2. (a) It was found that in January 2017 Mr O'Brien returned 307 sets of patient notes which had been stored at his home. Mr O'Brien accepts that there were in excess of 260 patient notes returned from his home in January 2017.

   (b) The notes dated as far back as November 2014. It was found that Mr O'Brien returned patient notes as requested and he asserts therefore there was no impact on patient care.

   (c) It was found that there are 13 sets of patient notes missing. The Case Investigator was satisfied these notes were not lost by Mr O'Brien.

3. (a) It was found that there were 66 undictated clinics by Mr O'Brien during the period 2015 and 2016. Mr O'Brien's accepts this.

   (b) It was accepted by Mr O'Brien that he did not dictate at the end of every care contact but rather dictated at the end of the full care episode. This is not the practice of any other Consultant Urologist. The requirements of the GMC is that all notes / dictation are contemporaneous.

   (c) There are significant waiting list times for routine Urology patients. It is therefore unclear as to the impact of delay in dictation as the patients would have had a significant wait for treatment. The delay however meant that the actual waiting lists were not accurate and the look back exercise to ensure all patients had a clear management plan in place was done at significant additional cost and time to the Trust.

6. It has been found that Mr O'Brien scheduled 9 of his private patient's sooner and outside of clinical priority in 2015 and 2016.

7. Concerns about Mr O'Brien's practice were known to senior managers within the Trust in March 2016 when a letter was issued to Mr O'Brien regarding these concerns. The extent of the concerns was not known. No action plan was put in place to address the concerns. It was found that a range of managers, senior managers and Directors within the Acute Service Directorate were aware of concerns regarding Mr O'Brien's practice dating back a number of years. There was no evidence available of actions taken to address the concerns.

Other findings / context

Other important factors in coming to a decision in respect of the findings are:

Triage

1. Mr O'Brien provided a detailed context to the history of the Urology service and the workloads pressures he faced. Mr O'Brien noted that he agreed to the triage process but very quickly found that he was unable to complete all triage. Mr O'Brien noted that he had raised this fact with his colleagues on numerous occasions to no avail. Mr O'Brien accepts that he did not explicitly advise anyone within the Trust that he was not undertaking routine or urgent referral triage. Mr O'Brien did undertake red-flag triage.

2. It was known to a range of staff within the Directorate that they were not receiving triage back from Mr O'Brien. A default process was put in place to compensate for this whereby all patients were added to the waiting lists according to the GP catergorisation. This would have been known to Mr O'Brien.

3. Mr Young is the most appropriate comparator for Mr O'Brien as both have historical long review lists which the newer Consultants do not have. Mr Young managed triage alongside his other commitments. Mr Young undertook Mr O'Brien's triage for a period of time to ease pressures on him while he was involved in regional commitments.

Notes

1. There was no proper Trust transport and collection system for patient notes to the SWAH clinic in place.

2. There was no review of notes tracked out by individual to pick up a problem.

3. Notes were returned as requested by Mr O'Brien from his home.

4. It was known that Mr O'Brien stored notes at home by a range of staff within the Directorate.

Undictated clinics

1. Mr O'Brien's secretary did not flag that dictation was not coming back to her from clinics. Mr O'Brien's secretary was of the view that this was a known practice to managers within the Directorate.

2. Mr O'Brien indicated that he did not see the value of dictating after each care contact.

3. Mr O'Brien was not using digital dictation during the relevant period and therefore the extent of the problem was not evident.

5.0 Case Manager Determination

My determination about the appropriate next steps following conclusion of the formal MHPS investigation:

- There is no evidence of concern about Mr O'Brien's clinical ability with patients.

- There are clear issues of concern about Mr O'Brien's way of working, his administrative processes and his management of his workload. The resulting impact has been potential harm to a large number of patients (783) and actual harm to at least 5 patients.

- Mr O'Brien's reflection on his practice throughout the investigation process was of concern to the Case Investigator and in particular in respect of the 5 patients diagnosed with cancer.

- As a senior member of staff within the Trust Mr O'Brien had a clear obligation to ensure managers within the Trust were fully and explicitly aware that he was not undertaking routine and urgent triage as was expected. Mr O'Brien did not adhere to the known and agreed Trust practices regarding triage and did not advise any manager of this fact.

- There has been significant impact on the Trust in terms of its ability to properly manage patients, manage waiting lists and the extensive look back

exercise which was required to address the deficiencies in Mr O'Brien's practice.

- Mr O'Brien did not adhere to the requirements of the GMC's Good Medical Practice specifically in terms of recording his work clearly and accurately, recording clinical events at the same time of occurrence or as soon as possible afterwards.

- Mr O'Brien has advantaged his own private patients over HSC patients on 9 known occasions.

- The issues of concern were known to some extent for some time by a range of managers and no proper action was taken to address and manage the concerns.

This determination is completed without the findings from the Trust's SAI process which is not yet complete.

Advice Sought

Before coming to a conclusion in this case, I discussed the investigation findings with the Trust's Chief Executive, the Director of Human Resources & Organisational Development and I also sought advice from Practitioner Performance Advice (formerly NCAS).

My determination:

1. No further action is needed

Given the findings of the formal investigation, this is not an appropriate outcome.

2. Restrictions on practice or exclusion from work should be considered

There are 2 elements of this option to be considered:

a. A restriction on practice

At the outset of the formal investigation process, Mr O'Brien returned to work following a period of immediate exclusion working to an agreed action plan from

February 2017. The purpose of this action plan was to ensure risks to patients were mitigated and his practice was monitored during the course of the formal investigation process. Mr O'Brien worked successfully to the action plan during this period.

It is my view that in order to ensure the Trust continues to have an assurance about Mr O'Brien's administrative practice/s and management of his workload, an action plan should be put in place with the input of Practitioner Performance Advice (NCAS), the Trust and Mr O'Brien for a period of time agreed by the parties.

The action plan should be reviewed and monitored by Mr O'Brien's Clinical Director (CD) and operational Assistant Director (AD) within Acute Services, with escalation to the Associate Medical Director (AMD) and operational Director should any concerns arise. The CD and operational AD must provide the Trust with the necessary assurances about Mr O'Brien's practice on a regular basis. The action plan must address any issues with regards to patient related admin duties and there must be an accompanying agreed balanced job plan to include appropriate levels of administrative time and an enhanced appraisal programme.

b. An exclusion from work

There was no decision taken to exclude Mr O'Brien at the outset of the formal investigation process rather a decision was taken to implement and monitor an action plan in order to mitigate any risk to patients. Mr O'Brien has successfully worked to the agreed action plan during the course of the formal investigation. I therefore do not consider exclusion from work to be a necessary action now.

3. There is a case of misconduct that should be put to a conduct panel

The formal investigation has concluded there have been failures on the part of Mr O'Brien to adhere to known and agreed Trust practices and that there have also been failures by Mr O'Brien in respect of 'Good Medical Practice' as set out by the GMC.

Whilst I accept there are some wider, systemic failings that must be addressed by the Trust, I am of the view that this does not detract from Mr O'Brien's own individual professional responsibilities.

During te MHPS investigation it was found that potential and actual harm occurred to patients. It is clear from the report that this has been a consequence of Mr O'Brien's conduct rather than his clinical ability. I have sought advice from Practitioner

Performance Advice (NCAS) as part of this determination. At this point, I have determined that there is no requirement for formal consideration by Practitioner Performance Advice or referral to GMC. The Trust should conclude its own processes.

The conduct concerns by Mr O'Brien include:

- Failing to undertake non red flag triage, which was known to Mr O'Brien to be an agreed practice and expectation of the Trust. Therefore putting patients at potential harm. A separate SAI process is underway to consider the impact on patients.

- Failing to properly make it known to his line manager/s that he was not undertaking all triage. Mr O'Brien as a senior clinician had an obligation to ensure, this was properly known and understood by his line manager/s.

- Knowingly advantaging his private patients over HSC patients.

- Failing to undertake contemporaneous dictation of his clinical contacts with patients in line with GMC 'Good Medical Practice'.

- Failing to ensure the Trust had a full and clear understanding of the extent of his waiting lists, by ensuring all patients were properly added to waiting lists in chronological order.

Given the issues above, I have concluded that Mr O'Brien's failings must be put to a conduct panel hearing.

4. **There are concerns about the practitioner's health that should be considered by the HSS body's occupational health service, and the findings reported to the employer.**

There are no evident concerns about Mr O'Brien's health. I do not consider this to be an appropriate option.

5. **There are concerns about the practitioner's clinical performance which require further formal consideration by NCAS (now Practitioner Performance Advice)**

Before coming to a conclusion in this regard, I sought advice from Practitioner Performance Advice.

The formal investigation report does not highlight any concerns about Mr O'Brien's clinical ability. The concerns highlighted throughout the investigation are wholly in respect of Mr O'Brien's administrative practices. The report highlights the impact of Mr O'Brien's failings in respect of his administrative practices which had the potential to cause harm to patients and which caused actual harm in 5 instances.

I am satisfied, taking into consideration advice from Practitioner Performance Advice (NCAS), that this option is not required.

6. There are serious concerns that fall into the criteria for referral to the GMC or GDC

I refer to my conclusion above. I am satisfied that the concerns do not require referral to the GMC at this time. Trust processes should conclude prior to any decision regarding referral to GMC.

7. There are intractable problems and the matter should be put before a clinical performance panel.

I refer to my conclusion under option 6. I am satisfied there are no concerns highlighted about Mr O'Brien's clinical ability.

6.0 Final Conclusions / Recommendations

This MHPS formal investigation focused on the administrative practice/s of Mr O'Brien. The investigation report presented to me focused centrally on the specific terms of reference set for the investigation. Within the report, as outlined above, there have been failings identified on the part of Mr O'Brien which require to be addressed by the Trust, through a Trust conduct panel and a formal action plan.

The investigation report also highlights issues regarding systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate. The report identifies there were missed opportunities by managers to fully assess and address the deficiencies in practice of Mr O'Brien. No-one formally assessed the extent of the issues or properly identified the potential risks to patients.

Default processes were put in place to work around the deficiencies in practice rather than address them. I am therefore of the view there are wider issues of concern, to be considered and addressed. The findings of the report should not solely focus on one individual, Mr O'Brien.

In order for the Trust to understand fully the failings in this case, I recommend the Trust to carry out an independent review of the relevant administrative processes

with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review should look at the full system wide problems to understand and learn from the findings.

Southern Health and Social Care Trust

Admin Review Processes

Introduction

This review of administrative processes followed a formal investigation into concerns about an individual Consultant under the Maintaining High Professional Standards Framework (MHPS). The main concerns highlighted concern over the Consultant's way of working, their administrative processes and their management of workloads.

The MHPS Case Manager made a number of recommendations one of which was a recommendation that in order for the Trust to understand fully the failings in the case, the Trust should *'carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. It recommended that the review should look at the full system wide problems to understand and learn from the findings'.*

The formal MHPS investigation focused on four main areas of concern::

1. Non-triage of GP and other consultant referrals
2. Non-dictation on patients who had attended outpatient clinics
3. Hospital notes being stored off Trust premises, namely the Consultant's home
4. The Consultant was found to have scheduled his private patient's sooner and outside of clinical priority.

The table below:

- highlights and describes the issues of concern
- identifies the gaps that led to the concerns raised
- advises on the policies and processes now in place
- describes the ongoing risks/ flaws
- explains the escalation process for non-adherence

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Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
1. Triage	Pre 2014 Due to the delayed triage of referrals, the decision was taken to add to the OP waiting list the referral at the clinical priority that the GP had assigned. .	2014-2017 For routine and Urgent GP referrals, non-adherence and non-enforcement of the IEAP, resulted in referrals not being returned within the appropriate timeframe, which then resulted in a lost opportunity to either upgrade or downgrade urgent/routine referrals	2017-current The introduction of e-Triage on 27/3/17 enabled referrals to be monitored with respect to the triage process. The revised triage process (draft) detailed in the word document below is based on the current IEAP also addresses these issues of timely and appropriate triaging TRIAGE PROCESS April 21.docx	Current Consultant-to-Consultant referrals (including outside of Trust) are not currently manged through e-Triage so there is still a risk that these could be delayed. Remaining specialties that still do not use e-Triage are being addressed Services not using eTriage.docx	Consultant to Consultant referrals to be added to e-Triage and the PDF SOP to be updated Consultant to Consultant Re Remaining specialties to be added to e-Triage The triage process continues to be monitored weekly and needs to be complied to and enforced where necessary	After 7 days Non- triage of urgent and routine referrals is escalated by the Referral & Booking Centre to the Operational Support Lead for the Clinical Area After 21 days OSL to escalate to Lead Clinician and HOS and copy Assistant Director of Functional & Support Services After 28 days HOS escalates to AD & AMD to address. After 35 days AD & AMD escalates to Director of Acute

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
2. Undictated Clinics	Some patients not having a letter dictated following an outpatient consultation resulting in no outcome recorded on PAS.	There is no system or process that provides assurance that each outpatient consultation generates an outpatient outcome letter	All Medical staff must understand that a letter is required for every outpatient attendance.	A limitation with the G2 system is that it simply records speech and generates a letter. However G2 is unable to correlate the letter dictated against the outpatient attendance.	The Trust has been working on the G2/PAS interface. This major piece of work required integration with the help of BSO. It is now in 'live' mode and is being piloted by one consultant with positive feedback. This will provide the Trust with more assurance around the dictation of outpatient clinics. A policy and guidance document needs to be developed and circulated to all Medical Staff to reiterate that a letter must be done for all outpatient attendance including for patients who do not attend. Update typing SOP to highlight that when a letters is not dictated for a patient that the secretary raises with	When the secretary is typing the clinics she must escalate to the Consultant by e mail and cc service administratorif there are any letters missing on Digital Dictation. If no response After 7 days This is escalated to the Service Administrator. After 14 days Service Administrator to escalate to Lead Clinician and HOS After 21 days HOS escalates to AD & AMD to address.

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
2. Undictated Clinics					the consultant and line manager in the first instance. Secretaries need to do a check and balance after every clinic checking that every pt has a letter dictated. Secretaries to stipulate on their backlog reports if they know of any undictated clinics/letters Monthly typing reports require to be produced and shared throughout all divisions At Junior doctor changeover inductions, the importance of timely and accurate dictating of all outpatients they have reviewed must be highlighted to them.	After 28 days AD & AMD escalates to Director of Acute

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
3. Hospital Notes	Patient's hospital records electronically casenote tracked to a consultant and a location.	When patients hospital records were required same not in the tracked location At a time health records did complete IR1 forms but were advised to stop , by the Director at that time.	Current tracking system is a function on Patient Administrative System (PAS) Missing Charts are investigated and an IR1 form is completed if not found	There is currently no system which identifies that a chart is not where it is tracked to other than manual searches.	Any missing notes need to have an IR1 raised to highlight the problem. These should be reported to the respective areas. All staff managing patient notes should be reminded of the need for accuracy on PAS when tracking notes and patient records should be returned to file as soon as possible. All consultants need to be reminded regularly that all charts are tracked in their name and that it is their responsibility to ensure the notes are kept in the location that the notes are tracked to. Business Case for IFit which is an electronic	Service Administrators to do spot-checks of offices and highlight any issues of charts being stored beyond a reasonable time period IR1's to be monitored by the head of health records and to escalate to the AD FSS Division for repeat 'Borrower' missing notes and any concerns over a particular consultant should be escalated to Clinical

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
					tracking system using barcode technology (as used in other Trusts in NI) to be considered for funding until the NI Electronic Patient Record replaces paper records under the Encompass Project This had been previously submitted and approved but no funding identified.	Director/AMD and AD
4. Private Patients	Patients who had been initially reviewed privately were added to the waiting list in a non-chronological manner	No monitoring of patients seen privately where they are entered onto the waiting list	This is governed by the Private Patient policy	It relies on the integrity of the consultant to comply with the private patient policy.	Revise the policy for paying patients in the Trust and share with all clinical teams. Guide-to-Paying-Patients-Southern-Trust- Data Quality Release notice for recording of	Secretaries have been given the codes to use to add private patients to the waiting list . A report is now on business objects for private patients added to waiting lists ~~and this is sent to~~ the private patient officer ~~to~~ reconciles and chases up

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
					private patient activity on PAS to be shared amongst clinical teams. 0023-18 PAS OP REFERRRAL PRIVATE	missing forms . ~~When secretaries are adding patients who were previously a private patient, to the waiting list they should ensure that Consultant has completed the appropriate forms and~~ After 7 days the private patient officer If forms haven't been received by Private Patient Office this is escalated to the HOS/CD. After 14 days HOS escalates to AD & AMD to address. After 21 days

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
						AD & AMD escalates to Medical Director

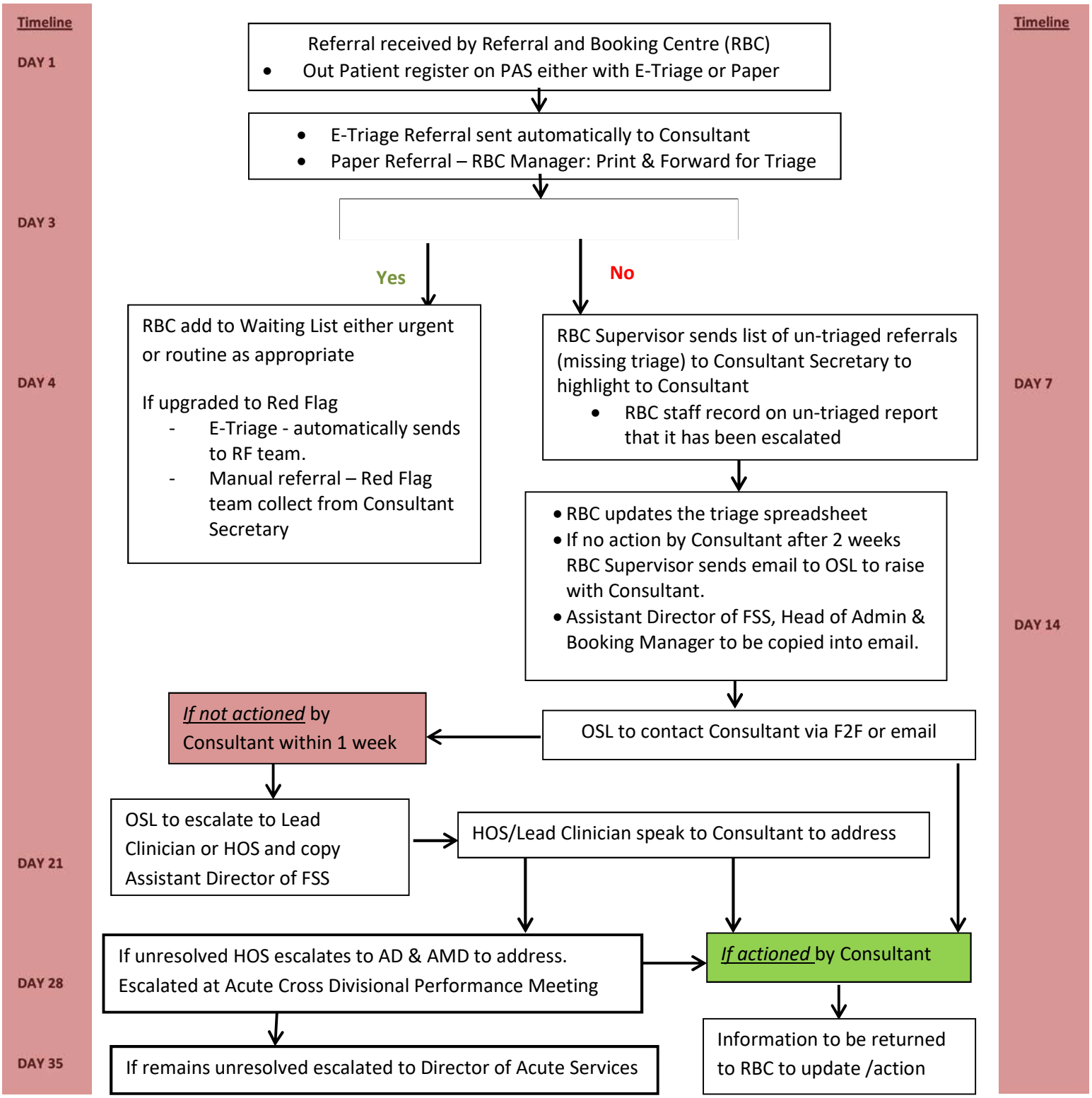
TRIAGE PROCESS

This process is developed by the Region under the IEAP (Integrated Elective Access Protocol) Referrals should be returned within 72 hrs but the Southern Trust have agreed 1 week to assist Clinicians as a more reasonable approach.

- **Red Flag referrals should be returned from Triage within 24hrs**
- **Urgent referrals should be returned from Triage within 72hrs**
- **Routine referrals should be returned from Triage within week.**

PURPOSE OF TRIAGE

- Consultant triage is to confirm that the speciality is appropriate and the clinical urgency is appropriate.
- It directs the referral to an appropriate service within the speciality (e.g. to vascular surgeons etc.)
- It allows the Consultant to request any investigations which the patient will require prior to outpatient attendance
- The Consultant can return referrals with advice and no outpatient attendance where appropriate.



Note: This process will incur a minimum of 5 weeks in total if referral is un-triaged within the target times which means that if the referral is upgraded to Red Flag it is in excess of 14 day Red Flag turnaround.
It is the responsibility of the Consultant to ensure Triage is done within the appropriate timescales detailed above.

Services not using e-triage	
ORTHOPAEDIC GERIATRICS	Planned e-triage commencement Jan/Feb 2021
HAEMATOLOGY	Planned implementation postpone due to service pressures
NEPHROLOGY	Currently taking a break from e-triage, will relook at recommencing early 2021
GENERAL MEDICINE	Minimal referrals to this service but working with service looking towards implementation early 2021
BREAST SURGERY	Consultants not currently keen on e-triage – reengaged with service
GERIATRIC MEDICINE	Currently engaging with service

Southern Health and Social Care Trust

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ADMINISTRATIVE & CLERICAL Standard Operating Procedure

Title	Consultant to Consultant Referrals	
S.O.P. Section	Referral and Booking Centre	
Version Number	v1.0	**Supersedes:** v0.1
Author	Katherine Robinson	
Page Count	3	
Date of Implementation	January 2011	
Date of Review	January 2012	**To be Reviewed by:** Admin and Clerical Manager's Group
Approved by	Admin and Clerical Manager's Group	

Standard Operating Procedure (S.O.P)
Referral and Booking Centre Procedures

Introduction

This SOP outlines the procedures followed by the Referral and Booking Centre to recognise a referral is in place from one consultant to another.

Implementation

This procedure is already effective and in operation in the Referral and Booking Centre.

Consultant to Consultant Referrals

The secretary for the consultant referring the patient should OP REG the patient on PAS with the OP REG date being the date the decision to refer was made (eg the clinic date)

This is done by using the Function:
DWA – ORE.

The name of the *referring consultant* should be entered into the comment field NOT the name of the consultant being referred to. Referrals should then be directed to the Referral and Booking Centre not to the secretary.

This will ensure that the patient now appears on a PTL and that the booking clerks will know who referred the patient and when.

When doing this the **Referral Source should be OC** (Other Consultant) **and NOT CON.**

Patients registered with a referral source as 'Con' do not appear on a PTL and can be missed.

Although all referrals are date stamped when they are received into the Referral and Booking centre **–** the original referral date will remain and will not be amended.

Southern Health and Social Care Trust

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A GUIDE TO PAYING PATIENTS

V.2 [11th February 2016]

DOCUMENT – VERSION CONTROL SHEET	
Title	Title: Guide to Paying Patients Version: 2
Supersedes	Supersedes: Guidelines for Management of Private Patients
Originator	Name of Author: Anne Brennan Title: Senior Manager Medical Directorate
Approval	Referred for approval by: Anne Brennan Date of Referral: 27th March 2014 to: • Trust Senior Management Team • Trust LNC
Circulation	Issue Date: 16th October 2014 Circulated By: Medical Directorate Issued To: As per circulation List: All Medical Staff
Review	Review Date: February 2017 Responsibility of (Name): Norma Thompson Title: Senior Manager Medical Directorate

CONTENTS

1. INTRODUCTION

1.1 The Trust came into existence on 1 April 2007 and is responsible for providing acute care across three sites namely:-

- Craigavon Area Hospital, Portadown
- Daisy Hill Hospital, Newry
- South Tyrone Hospital, Dungannon

1.2 The Trust welcomes additional income that can be generated from the following sources:-

- Private Patients
- Fee Paying Services
- Overseas Visitors

1.3 All income generated from these sources is deemed to make a valued contribution to the running costs of the Trust and will be reinvested to improve our facilities to benefit NHS and private patients alike.

1.4 All policies and procedures in relation to these areas will be carried out in accordance with Trust guidelines.

1.5 For further information please do not hesitate to contact the Paying Patient Office. [email: paying.patients@southerntrust.hscni.net or http://www.southerndocs.hscni.net/paying-patients/

2. OBJECTIVES

2.1 The purpose of this guideline is to:

- Standardise the manner in which all paying patient practice is conducted in the organisation.
- Raise awareness of the duties and responsibilities within the health service of medical staff engaging in private practice and fee paying services within the Trust.
- Raise awareness of the duties and responsibilities of all Trust staff, clinical and non-clinical in relation to the treatment of paying patients and fee paying services within the Trust.
- Ensure fairness to both NHS patients and fee paying patients at all times.
- Clarify for relevant staff the arrangements pertaining to paying patients and to give guidance relating to
  - record keeping
  - charging

- procedures and
- responsibilities for paying patient attendances, admissions and fee paying services.

- Clarify charging arrangements when consultants undertake fee paying services within the Trust.

3. CATEGORIES OF WORK COVERED BY THIS GUIDE

3.1 Fee Paying Services

3.1.1 Any paid professional services, other than those falling within the definition of Private Professional Services, which a consultant carries out for a third party or for the employing organisation and which are not part of, nor reasonably incidental to, Contractual and Consequential Services. A third party for these purposes may be an organisation, corporation or individual, provided that they are acting in a health related professional capacity, or a provider or commissioner of public services. Examples of work that fall within this category can be found in Schedule 10 of the Terms and Conditions (Appendix 1).

3.2 Private Professional Services *(also referred to as 'private practice')*

3.2.1 The diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under Article 31 of the Health and Personal Social Services (Northern Ireland) Order 1972), excluding fee paying services as described in Schedule 10 of the terms and conditions.

3.2.2 Work in the general medical, dental or ophthalmic services under Part IV of the Health and Personal Social Services (Northern Ireland) Order 1972 (except in respect of patients for whom a hospital medical officer is allowed a limited 'list', e.g. members of the hospital staff).

3.3 Overseas Visitors

3.3.1 The National Health Service provides healthcare free of charge to people who are a permanent resident in the UK/NI. A person does not become an ordinarily resident simply by having British Nationality; holding a British Passport; being registered with a GP, or having an NHS number. People who do not permanently live in NI/UK are not automatically entitled to use the NHS free of charge.

3.3.2 **RESIDENCY** is therefore the main qualifying criterion.

4. POLICY STATEMENT

4.1 Medical consultant staff have the right to undertake Private Practice and Fee paying services within the Terms and Conditions of the new Consultant Contract as agreed within their annual job plan review and with the approval of the Medical Director.

4.2 This Trust provides the same care to all patients, regardless of whether the cost of their treatment is paid for by HSC Organisations, Private Medical Insurance companies or by the patient.

4.3 Private Practice and Fee Paying services at the Trust will be carried out in accordance with:

- The Code of Conduct for private practice, the recommended standard of practice for NHS consultants as agreed between the BMA and the DHSSPS (Appendix 2).
- Schedule 9 of the Terms and Conditions of the Consultant contract which sets out the provisions governing the relationship between HPSS work and private practice (Appendix 8).
- The receipt of additional fees for Fee Paying services as defined in Schedule 10 of the Terms and Conditions of the Consultant Contract (Appendix 1).
- The principles set out in Schedule 11 of the above contract (Appendix 5).

4.4 All patients treated within the Trust, whether private or NHS should, where possible:

- be allocated a unique hospital identifier
- be recorded on the Patient Administration System and
- have a Southern Health & Social Care Trust chart.

4.5 The Trust shall determine the prices to be charged in respect of all income to which it is entitled as a result of private practice or other fee paying services which take place within the Trust.

5. CONSULTANT MEDICAL STAFF RESPONSIBILITIES

5.1 Private Practice

5.1.1 While Medical consultant staff have the right to undertake Private Practice within the Terms and Conditions of the new Consultant Contract as agreed within their annual job plan review, it is the responsibility of consultants, prior to the provision of any diagnostic tests or treatment to:

- ensure that their private patients (whether In, Day or Out) are identified and notified to the Paying Patients Officer.

- ensure full compliance with the Code of Conduct for Private Practice (see Appendix 2) in relation to referral to NHS Waiting Lists.
- ensure that patients are aware of and understand the range of costs associated with private treatment including hospital costs and the range of professional fees which the patient is likely to incur, to include Surgeon/Physician, Anaesthetist, Radiologist, Pathologist, hospital charges. Leaflets can be obtained from the Paying Patients Officer or the Paying Patients section of Southern Docs website – click here.
- obtain prior to admission and at each outpatient attendance a signed, witnessed Undertaking to Pay form (Appendix 3) which must then be sent to the Paying Patient Officer for the relevant hospital at least three weeks before the admission date. This document must contain details of all diagnostic tests and treatments prescribed.
- Establish the method of payment at the consultation stage and obtain details of insured patients' private medical insurance policy information. The Trust requires this information to be forwarded to the Paying Patient Officer **prior to admission** so that patients' entitlement to insurance cover can be established. This should be recorded on the Undertaking to Pay form [Appendix 3].
- Ensure that all patients, where appropriate, are referred by the appropriate channels, i.e. GP/other consultant.
- Ensure that private patient services that involve the use of NHS staff or facilities are not undertaken except in emergencies, unless an undertaking to pay for treatment has been obtained from (or on behalf of) the patient, in accordance with the Trust's procedures.
- Ensure that information pertaining to their private patient work is included in their annual whole practice appraisal.

5.2 Fee Paying Services - *see Appendix 1 for examples*

5.2.1 The Consultant job plan review will cover the provision of fee paying services within the Trust. Consultants are required to declare their intention to undertake Fee Paying Services work by forwarding the Paying Patient Declaration form to the Medical Director's office.

5.2.2 A price list for fee paying services is available from the Paying Patients Office or the Paying Patients section of Southern Docs website – click here. It is the responsibility of the Consultant to ensure that the Trust is reimbursed for all costs incurred while facilitating fee paying services work undertaken. These costs could include:

- use of Trust accommodation;
- tests or other diagnostic procedures performed;
- radiological scans.

5.2.3 Consultants who engage in fee paying activities within the Trust are required to remit to the Trust on a quarterly basis the income due.

1.2.4 Consultants should retain details of all patients seen for medical legal purposes. These should be submitted by the consultant on a quarterly basis along with the corresponding payment. See Section 11 for further details.

5.3 Additional Programmed Activities

5.3.1 Consultants should agree to accept an extra paid programmed activity in the Trust, if offered, before doing private work. The following points should be borne in mind:

- If Consultants are already working 11 Programmed Activities (PAs) (or equivalent) there is no requirement to undertake any more work.
- A Consultant could decline an offer of an extra PA and still work privately, but with risk to their pay progression for the year in question.
- Any additional PAs offered must be offered equitably between all Consultants in that specialty; if a colleague takes up those sessions there would be no detriment to pay progression for the other Consultants.

5.3.2 Consultant Medical Staff are governed by The Code of Conduct for Private Practice 2003 (at Appendix 2).

6. RESTRICTIONS ON PRIVATE PRACTICE FOR CONSULTANT MEDICAL STAFF

6.1 New Consultants

6.1.1 Newly appointed consultants (including those who have held consultant posts elsewhere in the NHS, or equivalent posts outside the NHS) may not undertake private practice within the Trust or use the Trusts facilities or equipment for private work, until the arrangements for this have been agreed in writing with the Trust Medical Director. A job plan must also have been agreed. An application to undertake private practice should be made in writing to the Medical Director through completion of the Paying Patient Declaration. New consultants permitted to undertake private work must make themselves known to the Paying Patients Officer.

6.2 Locum Consultants

6.2.1 Locum consultants may not engage in Private Practice within the first three months of appointment and then not until the detailed Job Plan has been agreed with the relevant Clinical Manager and approval has been granted by the Medical Director. This is subject to the agreement of the patient/insurer.

6.3 Non Consultant Grade Medical Staff

6.3.1 Non-consultant medical staff practitioners such as Associate Specialists may undertake Category 2 or private outpatient work, with the approval of the

Medical Director following confirmation that the practitioner undertakes such work outside his/her programmed activities as per their agreed job plan.

6.3.2 Other than in the circumstances described above, staff are required to assist the consultant to whom they are responsible with the treatment of their private patients in the same way as their NHS patients. The charge paid by private patients to the hospital covers the whole cost of the hospital treatment including that of all associated staff.

7. CHANGE OF STATUS BETWEEN PRIVATE AND NHS

7.1 Treatment Episode

7.1.1 A patient who sees a consultant privately shall continue to have private status throughout the entire treatment episode.

7.2 Single Status

7.2.1 An outpatient cannot be both a Private and an NHS patient for the treatment of the one condition during a single visit to an NHS hospital.

7.3 Outpatient Transfer

7.3.1 However a private outpatient at an NHS hospital is legally entitled to change his/her status for any a subsequent visit and seek treatment under the NHS, subject to the terms of any undertaking he/she has made to pay charges.

7.4 Waiting List

7.4.1 A patient seen privately in consulting rooms who then becomes an NHS patient joins the waiting list at the same point as if his/her consultation had taken place as an NHS patient.

7.5 Inpatient Transfer

7.5.1 A private inpatient has a similar legal entitlement to change his/her status. This entitlement can only be exercised when a significant and unforeseen change in circumstances arises e.g. when they enter hospital for a minor operation and they are found to be suffering from a different more serious complaint. He/she remains liable to charges for the period during which he/she was a private patient.

7.6 During Procedure

7.6.1 A patient may request a change of status during a procedure where there has been an unpredictable or unforeseen complexity to the procedure. This can be tested by the range of consent required for the procedure.

7.7 Clinical Priority

7.7.1 A change of status from Private to NHS must be accompanied by an assessment of the patient's clinical priority for treatment as an NHS patient.

7.8 Change of Status Form

7.8.1 Where a change of status is required a 'Change of Status' Form (Appendix 4) must be completed and sent to the Paying Patients Officer. This includes the reason for the change of status which will be subject to audit and must be signed by both the consultant and Paying Patients Officer. The Paying Patients Officer will ensure that the Medical Director approves the 'Change of Status' request.

7.8.2 It is important to note that until the Change of Status form has been approved by the Medical Director the patient's status will remain private and they may well be liable for charges.

8. TRUST STAFF RESPONSIBILITIES RELATING TO PRIVATE PATIENTS AND FEE PAYING SERVICES

8.1 A private patient is one who formally undertakes to pay charges for healthcare services regardless of whether they self-pay or are covered by insurance and all private patients must sign a form to that effect (Undertaking to Pay form at Appendix 3) prior to the provision of any diagnostic tests or treatments. Trust staff are required to have an awareness of this obligation.

8.2 The charge which private patients pay to the Trust covers the total cost of the hospital treatment excluding consultant fees. Trust staff are required to perform their duties in relation to all patients to the same standard. No payment should be made to or accepted by any non-consultant member of Trust staff for carrying out normal duties in relation to any patients of the Trust.

9. OPERATIONAL ARRANGEMENTS

9.1 Each hospital within the Trust has a named officer [Paying Patients Officer] who should be notified in advance of all private patient admissions and day cases. The Paying Patient Officer is responsible for ensuring that the Trust recovers all income due to the Trust arising from the treatment of private patients.

9.2 The Paying Patients Officer, having received the signed and witnessed Undertaking to Pay **Form at least three weeks** before the planned procedure will identify the costs associated with the private patient stay, will confirm entitlement to insurance cover where relevant and will raise invoices on a timely basis. [See Flow Chart 1]

9.3 The Medical Director will advise the Paying Patients Officer when a consultant has been granted approval to undertaken private practice. The Paying Patients Officer will advise the consultant of the procedures involved in undertaking private practice in the Trust.

9.4 Clinical governance is defined as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

9.5 This framework applies to all patients seen within this Trust. It is therefore a fundamental requirement of Clinical Governance that all patients treated within the Trust must be examined or treated in an appropriate clinical setting.

9.6 Any fee or emolument etc. which may be received by an employee in the course of his or her clinical duties shall, unless the Trust otherwise directs, be surrendered to the Trust. For further information please see Southern Trust Gifts and Hospitality Standards of Conduct policy.

9.7 Record Keeping Systems and Private Patients

9.7.1 All patients regardless of their status should, where possible, be recorded on Hospital Systems and their status classified appropriately. These systems include for example:

- Patient Administration System (PAS)
- Northern Ireland Maternity System (NIMATS)
- Laboratory System
- Radiology System(e.g. Sectra, PACS, NIRADS, RIS etc)

9.8 Health Records of Private Patients

9.8.1 All hospital health records shall remain the property of the Trust and should only be taken outside the Trust to assist treatment elsewhere:

- when this is essential for the safe treatment of the patient
- when an electronic record of the destination of the notes is made using the case note tracking system
- when arrangements can be guaranteed that such notes will be kept securely
- provided that nothing is removed from the notes

9.8.2 Consultants who may have access to notes for private treatment of patients must agree to return the notes without delay. Either originals or copies of the patient's private notes should be held with their NHS notes. Patients' notes should not be removed from Trust premises. Requests for notes for medico-legal purposes should be requested by plaintiff's solicitor through the normal channels.

9.8.3 Since the Trust does not have a right of access to patient notes held in non NHS facilities, when patients are seen privately outside the Trust their first appointment within the Trust, unless with the same consultant, will be treated as a 'new appointment' rather than a 'review appointment'.

9.8.4 In the event of a 'Serious Adverse Incident' or legal proceedings the Trust may require access to private patient medical records which should be held in accordance with GMC Good Record Keeping Guidance.

9.9 Booking Arrangements for Admissions and Appointments

9.9.1 A record of attendance should be maintained, where possible, for all patients seen in the Trust. All private in, day and out patients should as far as possible be pre-booked on to the hospital information systems. Directorates are responsible for ensuring that all relevant information is captured and 'booking in' procedures are followed. Each department should ensure that all such patients are recorded on PAS etc. within an agreed timescale which should not extend beyond month end.

9.10 Walk Ins

9.10.1 A private patient who appears at a clinic and has no record on PAS should be treated for record keeping purposes in exactly the same manner as an NHS patient (walk in) i.e. relevant details should be taken, registry contacted for a number and processed in the usual fashion. A record should be kept of this patient and the Paying Patient Officer informed.

9.11 Radiology

9.11.1 All patients seen in Radiology should be given a Southern Health and Social Care hospital number.

9.12 Private Patient Records

9.12.1 All records associated with the treatment of private patients should be maintained in the same way as for NHS patients. This includes all files, charts, and correspondence with General Practitioners.

9.12.2 Accurate record keeping assists in the collection of income from paying patients.

9.12.3 It should be noted that

- any work associated with private patients who are not treated within this Trust or consultants private diary work and correspondence associated with patients seen elsewhere should not be carried out within staff time which is paid for by the Trust.

9.13 Tests Investigations or Prescriptions for Private Patients

9.13.1 The consultant must ensure that the requests for all laboratory work, ie. radiology, prescriptions, dietetics, physiotherapy etc. are clearly marked as Private.

9.13.2 Consultants should not arrange services, tests investigations or prescriptions until the person has signed an Undertaking to Pay form which will cover the episode of care [Appendix 3]. This must be submitted three weeks before any planned procedure.

9.14 Medical Reports

9.14.1 In certain circumstances Insurance Companies will request a medical report from the consultant. It is the consultant's responsibility to ensure that this report is completed in the timeframe required by the insurance company otherwise the Trust's invoice may remain unpaid in whole or in part until the report has been received and assessed.

10. FINANCIAL ARRANGEMENTS - PRIVATE PATIENTS

10.1 Charges to Patients

10.1.1 Where patients, who are private to a consultant, are admitted to the hospital, or are seen as outpatients, charges for investigations/diagnostics will be levied by the hospital. A full list of charges is available from the Paying Patient Office on request. Patients should be provided with an estimate of the total fee that they will incur **before** the start of their treatment.

10.1.2 Prices are reviewed regularly to ensure that all costs are covered. A calendar of pricing updates will be agreed.

10.2 Charges for Use of Trust Facilities for Outpatients

10.2.1 It is the responsibility of the Doctor to recover the cost from the patient and reimburse the Trust, on a quarterly basis, for any outpatients which have been seen in Trust facilities. [See Flow Chart 2]

10.2.2 A per patient cost for the use of Trust facilities for outpatients is available. This will be reviewed annually.

10.2.3 It is responsibility of the doctor to maintain accurate records of outpatient attendances. It is an audit requirement that the Trust verifies that all income associated with use of Trust facilities for outpatients has been identified and collected. Accordingly, Doctors are required to submit a quarterly return to the Paying Patient office with the names of the patients seen together with details of any treatment or tests undertaken. This information should accompany the payment for the relevant fees as outlined above.

10.2.4 A Undertaking to Pay form will only be required if investigations/diagnostics are required.

10.3 Basis of Pricing

10.3.1 Charges are based on an accommodation charge, cost of procedure, including any prosthesis, and on a cost per item basis for all diagnostic tests and treatments e.g. physiotherapy, laboratory and radiology tests, ECGs etc. They do not include consultants' professional fees. Some package prices may be agreed.

10.4 Uninsured Patients – Payment Upfront

10.4.1 Full payment prior to admission is required from uninsured patients. Consultants should advise patients that this is the case. The patient should be advised to contact the Paying Patients Officer regarding estimated cost of treatment. [See Flow Chart 4]

10.5 Insured Patients

10.5.1 The Undertaking to Pay Form also requires details of the patient's insurance policy. The Paying Patients Officer will raise invoices direct to the insurance company where relevant, in accordance with the agreements with individual insurance companies.

10.5.2 Consultants, as the first port of contact and the person in control of the treatment provided, should advise the patient to obtain their insurance company's permission for the specified treatment to take place within the specified timescale. [See Flow Chart 4]

10.6 Billing and Payment

10.6.1 The Paying Patients Officer co-ordinates the collation of financial information relating to patients' treatment, ensures that uninsured patients pay deposits and that invoices are raised accordingly. The financial accounts department will ensure all invoices raised are paid and will advise the Private Patient Officer in the event of a bad debt.

10.7 Audit

10.7.1 The Trust's financial accounts are subject to annual audit and an annual report is issued to the Trust Board, which highlights any area of weakness in control. Adherence to the Paying Patient Policy will form part of the Trust's Audit Plan. Consultants are reminded that they are responsible for the identification and recording of paying patient information. Failure to follow the procedures will result in investigation by Audit and if necessary, disciplinary action under Trust and General Medical Council regulations.

11. FINANCIAL ARRANGEMENTS FOR FEE PAYING SERVICES

11.1 Consultants may see patients privately or for fee paying services within the Trust only with the explicit agreement of the Medical Director, in accordance with their Job Plan. Management will decide to what extent, if any, Trust facilities, staff and equipment may be used for private patient or fee paying services and will ensure that any such services do not interfere with the organisation's obligations to NHS patients. This applies whether private services are undertaken in the consultant's own time, in annual or unpaid leave. [See Flow Chart 3]

11.2 In line with the Code of Conduct standards, private patient services should take place at times that do not impact on normal services for NHS patients. Private patients should normally be seen separately from scheduled NHS patients.

11.3 Fee Paying Services Policy (Category 2)

11.3.1 Fee Paying Services (Category 2) work is distinct from private practice, however it is still non NHS work as outlined in the 'Terms and Conditions for Hospital Medical and Dental Staff'. Refer to schedules 10 and 11 (Appendices 1 & 5 respectively) for further details.

11.3.2 There are a number of occasions when a Category 2 report will be requested, and they will usually be commissioned by, employers, courts, solicitors, Department of Work and Pensions etc. the report may include radiological opinion, blood tests or other diagnostic procedures

11.3.3 It is the responsibility of the Doctor to ensure that the Trust is reimbursed for all costs incurred in undertaking Category 2 work, this not only includes the use of the room but also the cost of any tests undertaken.

11.3.4 In order to comply with the Trusts financial governance controls it is essential that all Fee Paying services are identified and the costs recovered. It is not the responsibility of the Trust to invoice third parties for Category 2 work.

11.3.5 It is the responsibility of the Doctor to recover the cost from the third party and reimburse the Trust, on a quarterly basis, for any Category 2 services they have undertaken, including the cost of any treatments/tests provided.

11.3.6 The Category 2 (room only) charge per session will be reviewed annually.

11.3.7 A per patient rate may be available subject to agreement with the Paying Patient Manager

11.3.8 It is responsibility of the doctor to maintain accurate records of Category 2 attendances. It is an audit requirement that the Trust verifies that all income associated with Category 2 has been identified and collected.

11.3.9 Doctors are required to submit a quarterly return to the Paying Patient office with the names of the patients seen together with details of any treatment or tests undertaken. This information should accompany the payment for the relevant fees of Category 2 work as outlined above and should be submitted no later than ten days after the quarter end.

11.3.10 In order to comply with Data Protection requirements, Doctors must therefore inform their Category 2 clients that this information is required by the Trust and obtain their consent. Consultants should make a note of this consent.

11.3.11 Compliance to this policy will be monitored by the Paying Patient Manager and the Medical Director's Office.

11.3.12 The Consultant is responsible to HM Revenue and Customs to declare for tax purposes all Category 2 income earned. The Trust has no obligation in this respect.

11.3.13 Any Category 2 work undertaken for consultants by medical secretaries must be completed outside of their normal NHS hours. Consultants should be aware of their duty to inform their secretaries that receipt of such income is subject to taxation and must be declared to HM Revenue and Customs. It is recommended that Consultants keep accurate records of income and payment.

12. RENUNCIATION OF PRIVATE FEES

12.1 In some departments, consultants may choose to forego their private fees for private practice or for fee paying services in favour of a Charitable Fund managed by the Trust that could be drawn upon at a later stage for, by way of example, Continuous Professional Development / Study Leave.

12.2 For income tax purposes all income earned must be treated as taxable earnings. The only way in which this income can be treated as non taxable earnings of the consultant concerned is if the consultant signs a 'Voluntary Advance Renunciation of Earnings form' (Appendix 7) and declares that the earnings from a particular activity will belong to a named charitable fund and that the earnings will not be received by the consultant. In addition a consultant should never accept a cheque made out to him or her personally. To do so attracts taxation on that income and it cannot be subsequently renounced. Therefore all such income renounced in advance should be paid directly into the relevant fund. Income can only be renounced if it has not been paid to the individual and a Register of these will be maintained by the Charitable Funds Officer.

12.3 The Trust will be required to demonstrate that income renounced in favour of a Charitable Fund is not retained for the use of the individual who renounces it. Thus, in the event of any such consultant subsequently drawing on that fund, any such expenditure approval must be countersigned by another signatory on the fund.

13. OVERSEAS VISITORS - NON UK PATIENTS

(Republic of Ireland, EEA, Foreign Nationals)

PLEASE NOTE THIS IS ONLY A BRIEF GUIDE FOR FURTHER INFORMATION PLEASE CONTACT THE PAYING PATIENT OFFICE

13.1 The NHS provides healthcare free of charge to people who are 'ordinarily resident' in the UK. People who do not permanently live in the UK lawfully are not automatically entitled to use the NHS free of charge.

13.2 **RESIDENCY** is the therefore the main qualifying criterion, applicable regardless of nationality, being registered with a GP or having been issued a HC/NHS number, or whether the person holds a British Passport, or lived and paid taxes or national insurance contributions in the UK in the past.

13.3 Any patient attending the Trust who cannot establish that they are an ordinary resident and have lawfully lived in the UK permanently for the last 12 months preceding treatment are not entitled to free non ED hospital treatment whether they are registered with a GP or not. A GP referral letter cannot be accepted solely as proof of a patient's permanent residency and therefore entitlement to treatment.

13.4 For all new patients attending the Trust, residency must be established. All patients will be asked to complete a declaration to confirm residency, (regardless of race/ethnic origin). If not the Trust could be accused of discrimination.

13.5 Where there is an element of doubt as to whether the patient is an 'ordinary resident' eg no GP/ H&C number or non UK contact details, the Paying Patients Officer must be alerted immediately.

13.6 Emergency Department

13.6.1 Treatment given in an Emergency Department, Walk in Clinic or Minor Inuries Unit is free of charge if it is deemed to be immediate and necessary.

13.6.2 The Trust should always provide immediate and necessary treatment whether or not the patient has been informed of or agreed to pay charges .There is no exemption from charges for 'emergency' treatment other than that given in the accident and emergency department. Once an overseas patient is transferred out of Emergency Department their treatment becomes chargeable.

13.6.3 All patients admitted from Emergency Department must be asked to complete declaration of residency status.

13.6.4 This question is essential in trying to establish whether the patient is an overseas patient or not and hence liable to pay for any subsequent care provided.

13.6.5 If the patient is not an ordinary resident or there is an element of doubt eg no GP/ no H&C Number, the patient should be referred to Paying Patients Office to determine their eligibility.

13.6.6 If the person has indicated that they are a visitor to Northern Ireland, the overseas address must be entered as the permanent address on the correct Patient Administrative System and the Paying Patients Office should be notified immediately.

13.7 Outpatient Appointments

13.7.1 In all cases where the patient has not lived in Northern Ireland for 12 months or relevant patient data is missing such as H&C number, GP Details etc the patient must be referred to the Paying Patients Office to establish the patient's entitlement to free NHS treatment. This must be established before an appointment is given.

13.8 Review Appointments

13.8.1 Where possible follow up treatment should be carried out at the patient's local hospital, however if they are reviewed at the Trust they must be informed that they will be liable for charges.

13.8.2 If a consultant considers it appropriate to review a patient then they must sign a statement to this effect waiving the charges that would have been due to the Trust.

13.9 Elective Admission

13.9.1 A patient should not be placed onto a waiting list until their entitlement to free NHS Treatment has been established. Where the Patient is chargeable, the Trust should not initiate a treatment process until a deposit equivalent to the estimated full cost of treatment has been obtained.

13.10 Referral from other NHS Trusts

13.10.1 When a Consultant accepts a referral from another Trust the patients' status should, where possible, be established prior to admission. However, absence of this information should not delay urgent treatment.

13.10.2 The Trust will operate a policy of 'Stabilise and Transfer'.

14. AMENITY BED PATIENTS

14.1 Within the Trust's Maternity Service, a number of beds are assigned Amenity Beds. It is permissible for NHS patients who require surgical delivery and an overnight stay to pay for any bed assigned as an Amenity Bed. This payment has no effect on the NHS status of the patient. All patients identified as amenity will be recorded on PAS as APG and an Undertaking to Pay for an Amenity Bed form (Appendix 6) should be completed ideally before obtaining the amenity facilities.

15. GLOSSARY

Undertaking to Pay Form

Private Patients may fund their treatment, or they may have private medical insurance. In all cases Private Patients must sign an 'Undertaking to Pay' form (Appendix 3). This is a legally binding document which, when signed prior to treatment, confirms the patient as personally liable for costs incurred while at hospital and confirms the Patient's Private status. ALL private patients, whether insured or not are obliged to complete and sign an 'Undertaking to Pay' form, prior to commencement of treatment. Consultants therefore, as the first point of contact should ensure that the Paying Patients Officer is advised to ensure completion of the 'Undertaking to Pay' form.

Fee Paying Services
Any paid professional services, other than those falling within the definition of Private Professional Services, which a consultant carries out for a third party or for the employing organisation and which are not part of, nor reasonably incidental to, Contractual and Consequential Services. A third party for these purposes may be an organisation, corporation or individual, provided that they are acting in a health related professional capacity, or a provider or commissioner of public services. Examples of work that fall within this category can be found in Schedule 10 of the Terms and Conditions (Appendix 1).

Private Professional Services *(Also referred to as 'private practice')*

- the diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under Article 31 of the Health and Personal Social Services (Northern Ireland) Order 1972), excluding fee paying services as described in Schedule 10 of the terms and conditions (Appendix 1).

- work in the general medical, dental or ophthalmic services under Part IV of the Health and Personal Social Services (Northern Ireland) Order 1972 (except in respect of patients for whom a hospital medical officer is allowed a limited 'list', e.g. members of the hospital staff).

Non UK patients
A person who does not meet the 'ordinarily resident' test.

Job Plan
A work programme which shows the time and place of the consultant's weekly fixed commitments.

16. APPENDIX 1: SPECIFIC EXAMPLES OF FEE PAYING SERVICES - SCHEDULE 10

1. Fee Paying Services are services that are not part of Contractual or Consequential Services and not reasonably incidental to them. Fee Paying Services include:

   a. work on a person referred by a Medical Adviser of the Department of Social Development, or by an Adjudicating Medical Authority or a Medical Appeal Tribunal, in connection with any benefits administered by an Agency of the Department of Social Development;

   b. work for the Criminal Injuries Compensation Board, when a special examination is required or an appreciable amount of work is involved in making extracts from case notes;

   c. work required by a patient or interested third party to serve the interests of the person, his or her employer or other third party, in such nonclinical contexts as insurance, pension arrangements, foreign travel, emigration, or sport and recreation. (This includes the issue of certificates confirming that inoculations necessary for foreign travel have been carried out, but excludes the inoculations themselves. It also excludes examinations in respect of the diagnosis and treatment of injuries or accidents);

   d. work required for life insurance purposes;

   e. work on prospective emigrants including X-ray examinations and blood tests;

   f. work on persons in connection with legal actions other than reports which are incidental to the consultant's Contractual and Consequential Duties, or where the consultant is giving evidence on the consultant's own behalf or on the employing organisation's behalf in connection with a case in which the consultant is professionally concerned;

   g. work for coroners, as well as attendance at coroners' courts as medical witnesses;

   h. work requested by the courts on the medical condition of an offender or defendant and attendance at court hearings as medical witnesses, otherwise than in the circumstances referred to above;

   i. work on a person referred by a medical examiner of HM Armed Forces Recruiting Organisation;

   j. work in connection with the routine screening of workers to protect them or the public from specific health risks, whether such screening is a statutory obligation laid on the employing organisation by specific regulation or a voluntary undertaking by the employing organisation in pursuance of its general liability to protect the health of its workforce;

   k. occupational health services provided under contract to other HPSS, independent or public sector employers;

   l. work on a person referred by a medical referee appointed under the Workmen's Compensation (Supplementation) Act (Northern Ireland) 1966; work on prospective students of universities or other institutions of further education, provided that they are not covered by Contractual and Consequential Services. Such examinations may include chest radiographs;

m. Appropriate examinations and recommendations under Parts II and IV of the Mental Health (Northern Ireland) Order 1986 and fees payable to medical members of Mental Health Review Tribunals;

n. services performed by members of hospital medical staffs for government departments as members of medical boards;

o. work undertaken on behalf of the Employment Medical Advisory Service in connection with research/survey work, i.e. the medical examination of employees intended primarily to increase the understanding of the cause, other than to protect the health of people immediately at risk (except where such work falls within Contractual and Consequential Services);

p. completion of Form B (Certificate of Medical Attendant) and Form C (Confirmatory Medical Certificate) of the cremation certificates;

q. examinations and reports including visits to prison required by the Prison Service which do not fall within the consultant's Contractual and Consequential Services and which are not covered by separate contractual arrangements with the Prison Service;

r. examination of blind or partially-sighted persons for the completion of form A655, except where the information is required for social security purposes, or by an Agency of the Department of Social Development, or the Employment Service, or the patient's employer, unless a special examination is required, or the information is not readily available from knowledge of the case, or an appreciable amount of work is required to extract medically correct information from case notes;

s. work as a medical referee (or deputy) to a cremation authority and signing confirmatory cremation certificates;

t. medical examination in relation to staff health schemes of local authorities and fire and police authorities;

u. delivering lectures;

v. medical advice in a specialised field of communicable disease control;

w. attendance as a witness in court;

x. medical examinations and reports for commercial purposes, e.g. certificates of hygiene on goods to be exported or reports for insurance companies;

y. advice to organisations on matters on which the consultant is acknowledged to be an expert.

17. APPENDIX 2 - A CODE OF CONDUCT FOR PRIVATE PRACTICE

November 2003

Recommended Standards of Practice for NHS Consultants

An agreement between the BMA's Northern Ireland Consultants and Specialists Committee and the Department of Health, Social Services and Public Safety for consultants in Northern Ireland.

A CODE OF CONDUCT FOR PRIVATE PRACTICE: RECOMMENDED STANDARDS FOR NHS CONSULTANTS, 2003

Contents

Part I: Introduction

Scope of Code

1.1 This document sets out recommended standards of best practice for NHS consultants in England about their conduct in relation to private practice . The standards are designed to apply equally to honorary contract holders in respect of their work for the NHS. The Code covers all private work, whether undertaken in non-NHS or NHS facilities.

1.2 Adherence to the standards in the Code will form part of the eligibility criteria for clinical excellence awards.

1.3 This Code should be used at the annual job plan review as the basis for reviewing the relationship between NHS duties and any private practice.

Key Principles

1.4 The Code is based on the following key principles:

- NHS consultants and NHS employing organisations should work on a partnership basis to prevent any conflict of interest between private practice and NHS work. It is also important that NHS consultants and NHS organisations minimise the risk of any perceived conflicts of interest; although no consultant should suffer any penalty (under the code) simply
- because of a perception;
- The provision of services for private patients should not prejudice the interest of NHS patients or disrupt NHS services;
- With the exception of the need to provide emergency care, agreed NHS commitments should take precedence over private work; and
- NHS facilities, staff and services may only be used for private practice with the prior agreement of the NHS employer.

Part II: Standards of Best Practice

Disclosure of Information about Private Practice

1.2 Consultants should declare any private practice, which may give rise to any actual or perceived conflict of interest, or which is otherwise relevant to the practitioner's proper performance of his/her contractual duties. As part of the annual job planning process, consultants should disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of NHS work and out of hours cover.

2.2 Under the appraisal guidelines agreed in 2001, NHS consultants should be appraised on all aspects of their medical practice, including private practice. In line with the requirements of revalidation, consultants should submit evidence of private practice to their appraiser.

Scheduling of Work and On-Call Duties

2.3 In circumstances where there is or could be a conflict of interest, programmed NHS commitments should take precedence over private work. Consultants should ensure that, except in emergencies, private commitments do not conflict with NHS activities included in their NHS job plan.

2.4 Consultants should ensure in particular that:

- private commitments, including on-call duties, are not scheduled during times at which they are scheduled to be working for the NHS (subject to paragraph 2.8 below);
- there are clear arrangements to prevent any significant risk of private commitments disrupting NHS commitments, e.g. by causing NHS activities to begin late or to be cancelled;

- private commitments are rearranged where there is regular disruption of this kind to NHS work; and private commitments do not prevent them from being able to attend a NHS emergency while they are on call for the NHS, including any emergency cover that they agree to provide for NHS colleagues. In particular, private commitments that prevent an immediate response should not be undertaken at these times.

2.5 Effective job planning should minimise the potential for conflicts of interests between different commitments. Regular private commitments should be noted in a consultant's job plan, to ensure that planning is as effective as possible.

2.6 There will be circumstances in which consultants may reasonably provide emergency treatment for private patients during time when they are scheduled to be working or are on call for the NHS. Consultants should make alternative arrangements to provide cover where emergency work of this kind regularly impacts on NHS commitments.

2.7 Where there is a proposed change to the scheduling of NHS work, the employer should allow a reasonable period for consultants to rearrange any private sessions, taking into account any binding commitments entered into (e.g. leases).

Provision of Private Services alongside NHS Duties

2.8 In some circumstances NHS employers may at their discretion allow some private practice to be undertaken alongside a consultant's scheduled NHS duties, provided that they are satisfied that there will be no disruption to NHS services. In these circumstances, the consultants should ensure that any private services are provided with the explicit knowledge and agreement of the employer and that there is no detriment to the quality or timeliness of services for NHS patients.

Information for NHS Patients about Private Treatment

2.9 In the course of their NHS duties and responsibilities consultants should not initiate discussions about providing private services for NHS patients, nor should they ask other NHS staff to initiate such discussions on their behalf.

2.10 Where a NHS patient seeks information about the availability of, or waiting times for, NHS and/or private services, consultants should ensure that any information provided by them, is accurate and up-to-date and conforms with any local guidelines.

2.11 Except where immediate care is justified on clinical grounds, consultants should not, in the course of their NHS duties and responsibilities, make arrangements to provide private services, nor should they ask any other NHS staff to make such arrangements on their behalf unless the patient is to be treated as a private patient of the NHS facility concerned.

Referral of Private Patients to NHS Lists

2.12 Patients who choose to be treated privately are entitled to NHS services on exactly the same basis of clinical need as any other patient.

2.13 Where a patient wishes to change from private to NHS status, consultants should help ensure that the following principles apply:

- a patient cannot be both a private and a NHS patient for the treatment of one condition during a single visit to a NHS organisation;
- any patient seen privately is entitled to subsequently change his or her status and seek treatment as a NHS patient;
- any patient changing their status after having been provided with private services should not be treated on a different basis to other NHS patients as a result of having previously held private status;
- patients referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients; and
- should a patient be admitted to an NHS hospital as a private inpatient, but subsequently decide to change to NHS status before having received treatment, there should be an assessment to determine the patient's priority for NHS care.

Promoting Improved Patient Access to NHS Care and Increasing NHS Capacity

2.14 Subject to clinical considerations, consultants should be expected to contribute as fully as possible to maintaining a high quality service to patients, including reducing waiting times and improving access and choice for NHS patients. This should include co-operating to make sure that patients are given the opportunity to be treated by other NHS colleagues or by other providers where this will maintain or improve their quality of care, such as by reducing their waiting time.

2.15 Consultants should make all reasonable efforts to support initiatives to increase NHS capacity, including appointment of additional medical staff.

Part III – Managing Private Patients in NHS Facilities

3.1 Consultants may only see patients privately within NHS facilities with the explicit agreement of the responsible NHS organisation. It is for NHS organisations to decide to what extent, if any, their facilities, staff and equipment may be used for private patient services and to ensure that any such services do not interfere with the organisation's obligations to NHS patients.

3.2 Consultants who practise privately within NHS facilities must comply with the responsible NHS organisation's policies and procedures for private practice. The NHS organisation should consult with all consultants or their representatives, when adopting or reviewing such policies.

Use of NHS Facilities

3.3 NHS consultants may not use NHS facilities for the provision of private services without the agreement of their NHS employer. This applies whether private services are carried out in their own time, in annual or unpaid leave, or – subject to the criteria in paragraph 2.8 - alongside NHS duties.

3.4 Where the employer has agreed that a consultant may use NHS facilities for the provision of private services:

- the employer will determine and make such charges for the use of its services, accommodation or facilities as it considers reasonable;

- any charge will be collected by the employer, either from the patient or a relevant third party; and

- a charge will take full account of any diagnostic procedures used, the cost of any laboratory staff that have been involved and the cost of any NHS equipment that might have been used.

3.5 Except in emergencies, consultants should not initiate private patient services that involve the use of NHS staff or facilities unless an undertaking to pay for those facilities has been obtained from (or on behalf of) the patient, in accordance with the NHS body's procedures.

3.6 In line with the standards in Part II, private patient services should take place at times that do not impact on normal services for NHS patients. Private patients should normally be seen separately from scheduled NHS patients. Only in unforeseen and clinically justified circumstances should an NHS patient's treatment be cancelled as a consequence of, or to enable, the treatment of a private patient.

Use of NHS Staff

3.7 NHS consultants may not use NHS staff for the provision of private services without the agreement of their NHS employer.

3.8 The consultant responsible for admitting a private patient to NHS facilities must ensure, in accordance with local procedures, that the responsible manager and any other staff assisting in providing services are aware of the patient's private status.

18. APPENDIX 3 - PRIVATE / NOT ORDINARILY RESIDENT IN UK NOTIFICATION AND UNDERTAKING TO PAY FORM

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

PRIVATE / NOT ORDINARILY RESIDENT IN UK NOTIFICATION AND UNDERTAKING TO PAY FORM

Private Patient: Yes ☐ No ☐ **Non-Ordinarily Resident in UK:** Yes ☐ No ☐

Name of Patient:			
Address:			
Postcode:	Telephone No:		
Date of Birth:			
H&C Number:			
Name of Insurer:		**Self Funding**	☐
Insurer Policy No:			

I have been seeing this person as a private patient. They are to be admitted / referred to Hospital on _____ as an _____

Inpatient Referral	☐	**Obstetrics** ☐ Estimated Duration of Stay	**Medical** ☐ Estimated Duration of Stay	**Surgical** ☐ Estimated Duration of Stay	**T & O** ☐ Estimated Duration of Stay
Day Case Referral	☐				
Diagnostics (Inpatient or Outpatient)	☐	**Laboratory** ☐ [please detail]	**Radiology** [pleas ☐ detail]	**Other** [e.g. ☐ Pharmacy]	

Undertaking to Pay Confirmation To be completed by Consultant			
I have advised the patient named above of the estimated hospital charges and of my fees			
Signed Consultant		**Date**	
Undertaking to Pay To be completed by the person who will pay the account			
I understand and agreed to pay Southern Health and Social Care Trust all charges[1] associated with this episode of care[2] .Where the Consultant may deem further procedures/investigations necessary which will incur additional charges, I understand that this may result in a different cost from that quoted to me and I undertake to pay the full costs incurred.			
Signed Patient		**Date**	

RETURN TO PAYING PATIENTS OFFICE CRAIGAVON AREA HOSPIAL/DAISY HILL HOSPITAL [email:payingpatients@southerntrust.hscni.net]

[1] A list of Tariffs is available from the Private Patients office

[2] Episode of Care – The total treatment of either an inpatient or day case patient from diagnosis through to discharge

Southern Health and Social Care Trust - A Guide to Paying Patients

19. APPENDIX 4 APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

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

APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

Name of Patient:	
Address:	
Postcode:	
Date of Birth:	
H&C Number:	
Name of Consultant	
Date of Last Private Consultation	

I have been seeing this person as a private patient. He/she has now been referred to Hospital as an NHS patient.

		Clinical Priority
Inpatient Referral	☐	
Outpatient Referral	☐	
Day Case Referral	☐	

Signed Consultant	
Effective Date	

Consultants are reminded that in good practice a patient who changes from private to NHS status should receive all subsequent treatment during that episode of care under the NHS as outlined in A Code of Conduct for Private Practice.

PLEASE FORWARD TO PAYING PATIENTS OFFICE [paying.patients@southerntrust.hscni.net]

20. APPENDIX 5 PRINCIPLES GOVERNING RECEIPT OF ADDITIONAL FEES – SCHEDULE 11

Principles Governing Receipt of Additional Fees - Schedule 11

1. In the case of the following services, the consultant will not be paid an additional fee, or - if paid a fee - the consultant must remit the fee to the employing organisation:

- any work in relation to the consultant's Contractual and Consequential Services;
- duties which are included in the consultant's Job Plan, including any additional Programmed Activities which have been agreed with the employing organisation;
- fee paying work for other organisations carried out during the consultant's Programmed Activities, unless the work involves minimal disruption and the employing organisation agrees that the work can be done in HPSS time without the employer collecting the fee;
- domiciliary consultations carried out during the consultant's Programmed Activities;
- lectures and teaching delivered during the course of the consultant's clinical duties;
- delivering lectures and teaching that are not part of the consultant's clinical duties, but are undertaken during the consultant's Programmed Activities.
- Consultants may wish to take annual leave [having given the required 6 week notice period] to undertake fee paying work [e.g. court attendance] in this instance the consultant would not be required to remit fees to the Trust.

This list is not exhaustive and as a general principle, work undertaken during Programmed Activities will not attract additional fees.

2. Services for which the consultant can retain any fee that is paid:

- Fee Paying Services carried out in the consultant's own time, or during annual or unpaid leave;
- Fee Paying Services carried out during the consultant's Programmed Activities that involve minimal disruption to HPSS work and which the employing organisation agrees can be done in HPSS time without the employer collecting the fee;
- Domiciliary consultations undertaken in the consultant's own time, though it is expected that such consultations will normally be scheduled as part of Programmed Activities1;
- Private Professional Services undertaken in the employing organisation's facilities and with the employing organisation's agreement during the consultant's own time or during annual or unpaid leave;
- Private Professional Services undertaken in other facilities during the consultant's own time, or during annual or unpaid leave;
- Lectures and teaching that are not part of the consultant's clinical duties and are undertaken in the consultant's own time or during annual or unpaid leave;

- Preparation of lectures or teaching undertaken during the consultant's own time irrespective of when the lecture or teaching is delivered.

This list is not exhaustive but as a general principle the consultant is entitled to the fees for work done in his or her own time, or during annual or unpaid leave.

And only for a visit to the patient's home at the request of a general practitioner and normally in his or her company to advise on the diagnosis or treatment of a patient who on medical grounds cannot attend hospital.

21. APPENDIX 6 - UNDERTAKING TO PAY CHARGES FOR AN AMENITY BED

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

UNDERTAKING TO PAY CHARGES FOR AN AMENITY BED

Name of Patient:	
Address:	
Postcode:	
Date of Birth:	
Hospital Number:	

Site: Craigavon ☐ Daisy Hill ☐

I was allocated an amenity bed on (date): _____ (time)

Ward: _____ Consultant: _____

I undertake to pay the Southern Health Social Care Trust £39 per night for an amenity bed, which has been provided for me at my request.

Number of days Amenity Bed required: _____

I understand that if I am required to stay in hospital more days than anticipated, the midwifery staff will ask me if I wish to continue and pay for the amenity bed, or if I wish to be transferred to the open ward.

Patient's Signature: _____ Date: _____

Midwife's Signature: _____ Date: _____

To be completed by WARD CLERK OR MIDWIFE when patient is being transferred /discharged from an amenity bed.

Date transferred / discharged from amenity bed _____

Signed by midwife / ward clerk when transferred / discharged _____

22. APPENDIX 7 – AGREEMENT FOR THE VOLUNTARY ADVANCE RENUNCIATION OF EARNINGS FROM FEE PAYING ACTIVITIES

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

AGREEMENT FOR THE VOLUNTARY ADVANCE RENUNCIATION OF EARNINGS FROM FEE PAYING ACTIVITIES

I *(name)* _____

Request that any monies due to me from patients in relation to fees from
(description of activity)

_____

_____

_____

_____

_____

_____

_____

Shall be transferred to *(Charity title and reference)* _____

For its sole use in the advancement of its aims in accordance with the Trust Deed until directed otherwise by me in writing.

This request is to take effect from (date*):* _____

Signed, sealed and delivered by: _____
(Full name in BLOCK CAPITALS)

Date: _____

In the presence of: _____

Date: _____

Address:: _____

_____

_____

_____ **Postcode:** _____

_____

23. APPENDIX 8 - PROVISIONS GOVERNING THE RELATIONSHIP BETWEEN HPSS WORK AND PRIVATE PRACTICE - SCHEDULE 9

1. This Schedule should be read in conjunction with the 'Code of Conduct for Private Practice', which sets out standards of best practice governing the relationship between HPSS work and private practice.

2. The consultant is responsible for ensuring that their provision of Private Professional Services for other organisations does not:

   - result in detriment to HPSS patients;
   - diminish the public resources that are available for the HPSS.

Disclosure of information about Private Commitments

3. The consultant will inform his or her clinical manager of any regular commitments in respect of Private Professional Services or Fee Paying Services. This information will include the planned location, timing and broad type of work involved.

4. The consultant will disclose this information at least annually as part of the Job Plan Review. The consultant will provide information in advance about any significant changes to this information.

Scheduling of Work and Job Planning

5. Where a conflict of interest arises or is liable to arise, HPSS commitments must take precedence over private work. Subject to paragraphs 10 and 11below, the consultant is responsible for ensuring that private commitments do not conflict with Programmed Activities.

6. Regular private commitments must be noted in the Job Plan.

7. Circumstances may also arise in which a consultant needs to provide emergency treatment for private patients during time when he or she is scheduled to be undertaking Programmed Activities. The consultant will make alternative arrangements to provide cover if emergency work of this kind regularly impacts on the delivery of Programmed Activities.

8. The consultant should ensure that there are arrangements in place, such that there can be no significant risk of private commitments disrupting HPSS commitments, e.g. by causing HPSS activities to begin late or to be cancelled. In particular where a consultant is providing private services that are likely to result in the occurrence of emergency work, he or she should ensure that there is sufficient time before the scheduled start of Programmed Activities for such emergency work to be carried out.

9. Where the employing authority has proposed a change to the scheduling of a consultant's HPSS work, it will allow the consultant a reasonable period in line with Schedule 6, paragraph 2 to rearrange any private commitments. The employing organisation will take into account any binding commitments that the consultant may have entered into (e.g. leases). Should a consultant wish to reschedule private commitments to a time that would conflict with Programmed Activities, he or she should raise the matter with the clinical manager at the earliest opportunity.

Scheduling Private Commitments Whilst On-Call

10. The consultant will comply with the provisions in Schedule 8, paragraph 5 of these Terms and Conditions. In addition, where a consultant is asked to provide emergency cover for a colleague at short notice and the consultant has previously arranged private commitments at the same time, the consultant should only agree to provide such emergency cover if those private commitments would not prevent him Or her returning to the relevant HPSS site at short notice to attend an emergency. If the consultant is unable to provide cover at short notice it will be the employing organisation's responsibility to make alternative arrangements and the consultant will suffer no detriment in terms of pay progression as a result.

Use of HPSS Facilities and Staff

11. Where a consultant wishes to provide Private Professional Services at an HPSS facility he or she must obtain the employing organisation's prior agreement, before using either HPSS facilities or staff.

12. The employing organisation has discretion to allow the use of its facilities and will make it clear which facilities a consultant is permitted to use for private purposes and to what extent.

13. Should a consultant, with the employing organisation's permission, undertake Private Professional Services in any of the employing organisation's facilities, the consultant should observe the relevant provisions in the 'Code of Conduct for Private Practice'.

14. Where a patient pays privately for a procedure that takes place in the employing organisation's facilities, such procedures should occur only where the patient has given a signed undertaking to pay any charges (or an undertaking has been given on the patient's behalf) in accordance with the employing organisation's procedures.

15. Private patients should normally be seen separately from scheduled HPSS patients. Only in unforeseen and clinically justified circumstances should a consultant cancel or delay an HPSS patient's treatment to make way for his or her private patient.

16. Where the employing organisation agrees that HPSS staff may assist a consultant in providing Private Professional Services, or provide private services on the consultant's behalf, it is the consultant's responsibility to ensure that these staff are aware that the patient has private status.

17. The consultant has an obligation to ensure, in accordance with the employing organisation's procedures, that any patient whom the consultant admits to the employing organisation's facilities is identified as private and that the responsible manager is aware of that patient's status.

18. The consultant will comply with the employing organisation's policies and procedures for private practice

Patient Enquiries about Private Treatment

19. Where, in the course of his or her duties, a consultant is approached by a patient and asked about the provision of Private Professional Services, the consultant may provide only such standard advice as has been agreed between the employing organisation and appropriate local consultant representatives for such circumstances.

20. The consultant will not during the course of his or her Programmed Activities make arrangements to provide Private Professional Services, nor ask any other member of staff to make such arrangements on his or her behalf, unless the patient is to be treated as a private patient of the employing organisation.

21. In the course of his/her Programmed Activities, a consultant should not initiate discussions about providing Private Professional Services for HPSS patients, nor should the consultant ask other staff to initiate such discussions on his or her behalf.

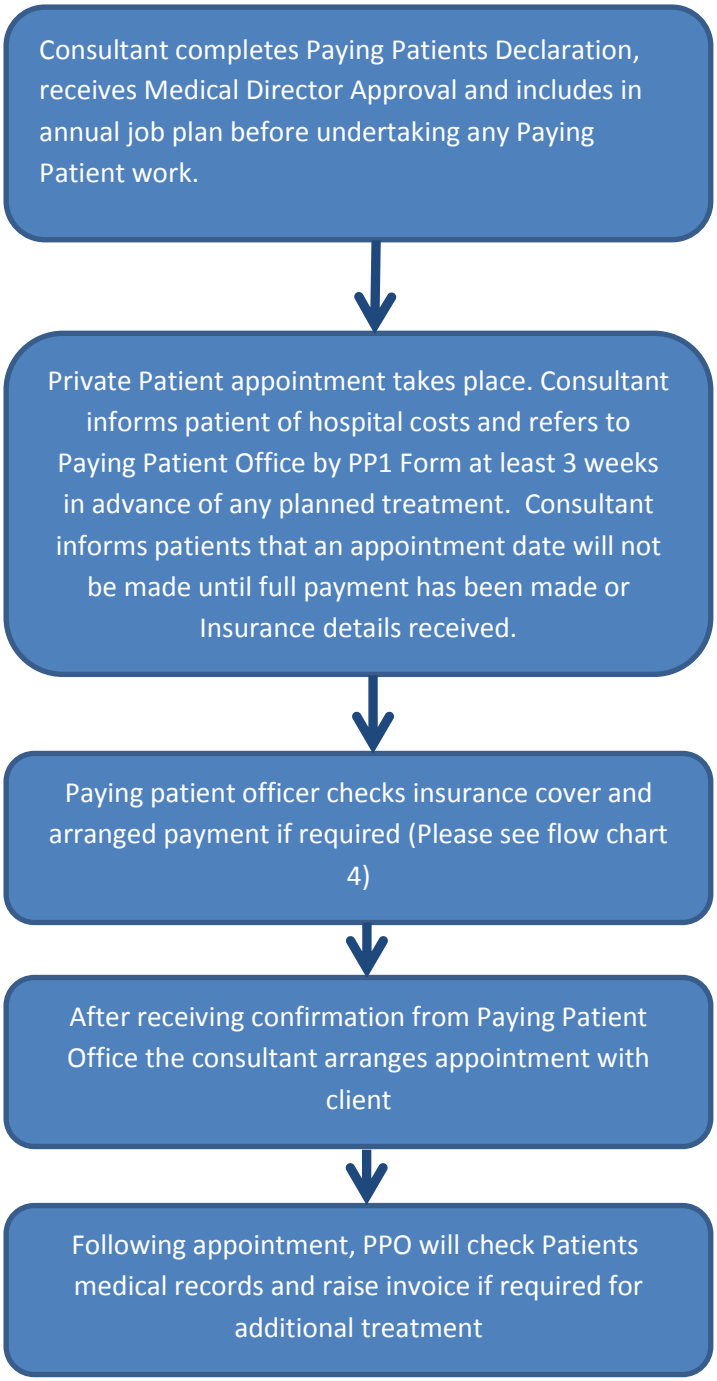
22. Where an HPSS patient seeks information about the availability of, or waiting times for, HPSS services and/or Private Professional Services, the consultant is responsible for ensuring that any information he or she provides, or arranges for other staff to provide on his or her behalf, is accurate and up-to-date.

Promoting Improved Patient Access to HPSS Care

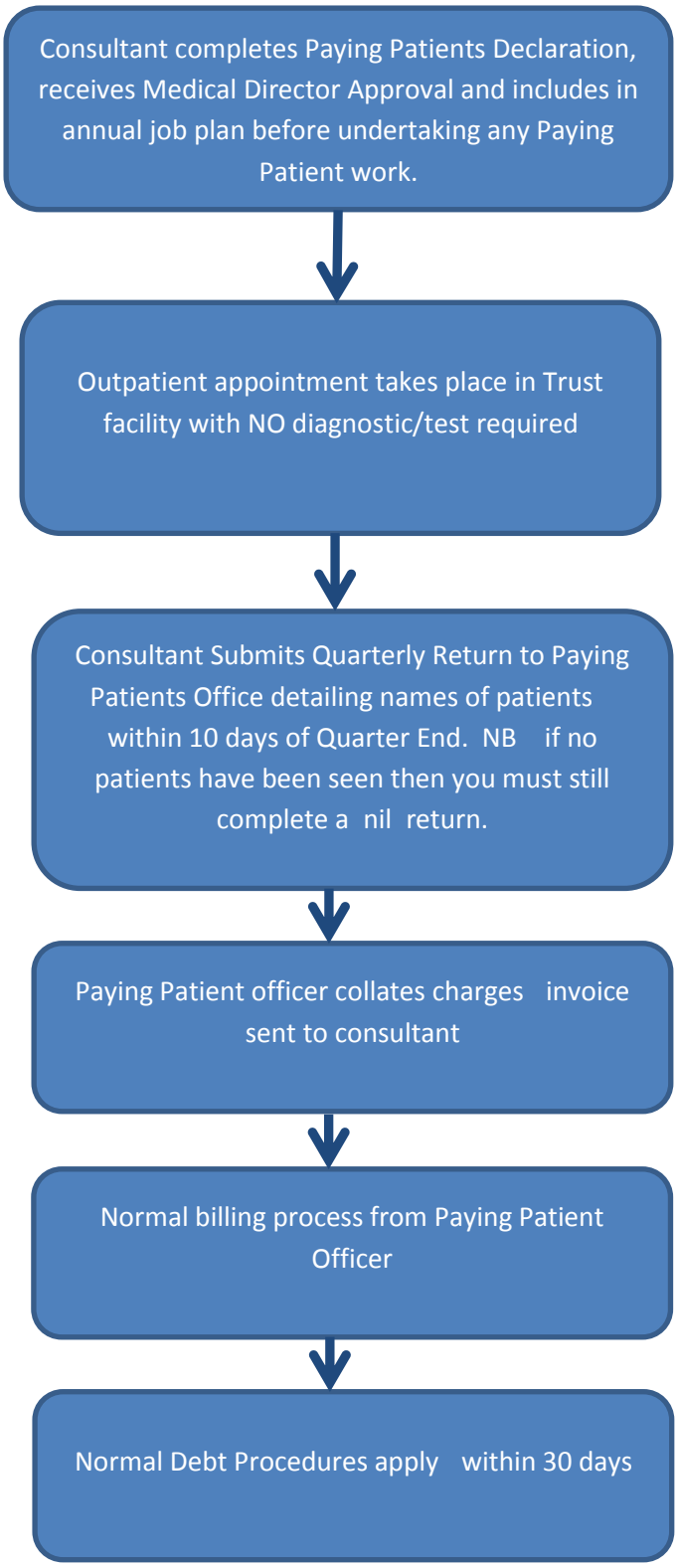
23. Subject to clinical considerations, the consultant is expected to contribute as fully as possible to reducing waiting times and improving access and choice for HPSS patients. This should include ensuring that, as far as is practicable, patients are given the opportunity to be treated by other HPSS colleagues or by other providers where this will reduce their waiting time and facilitate the transfer of such patients.

24. The consultant will make all reasonable efforts to support initiatives to increase HPSS capacity, including appointment of additional medical staff and changes to ways of working.

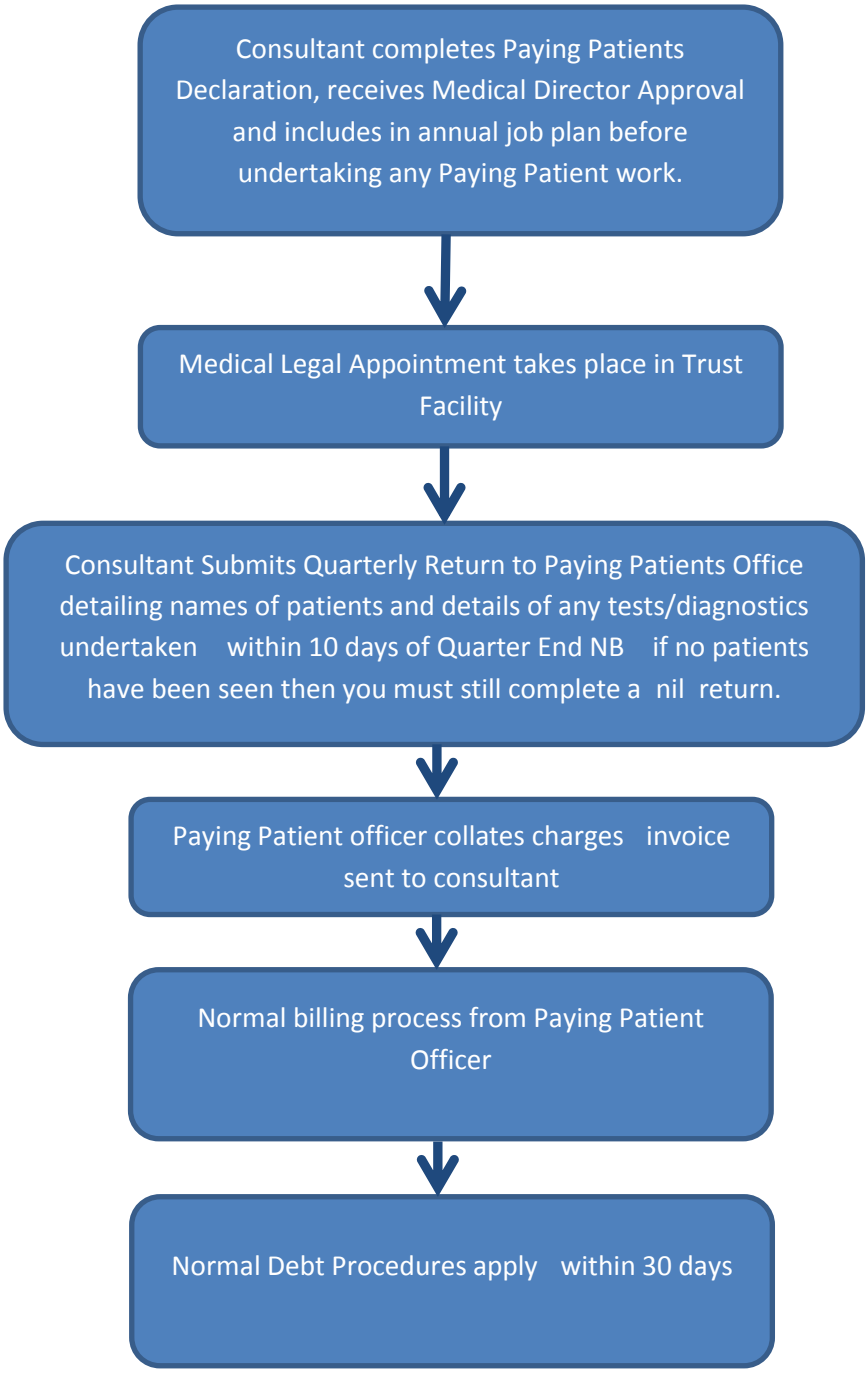
24. FLOW CHART 1 - PAYING PATIENTS [Inpatients]



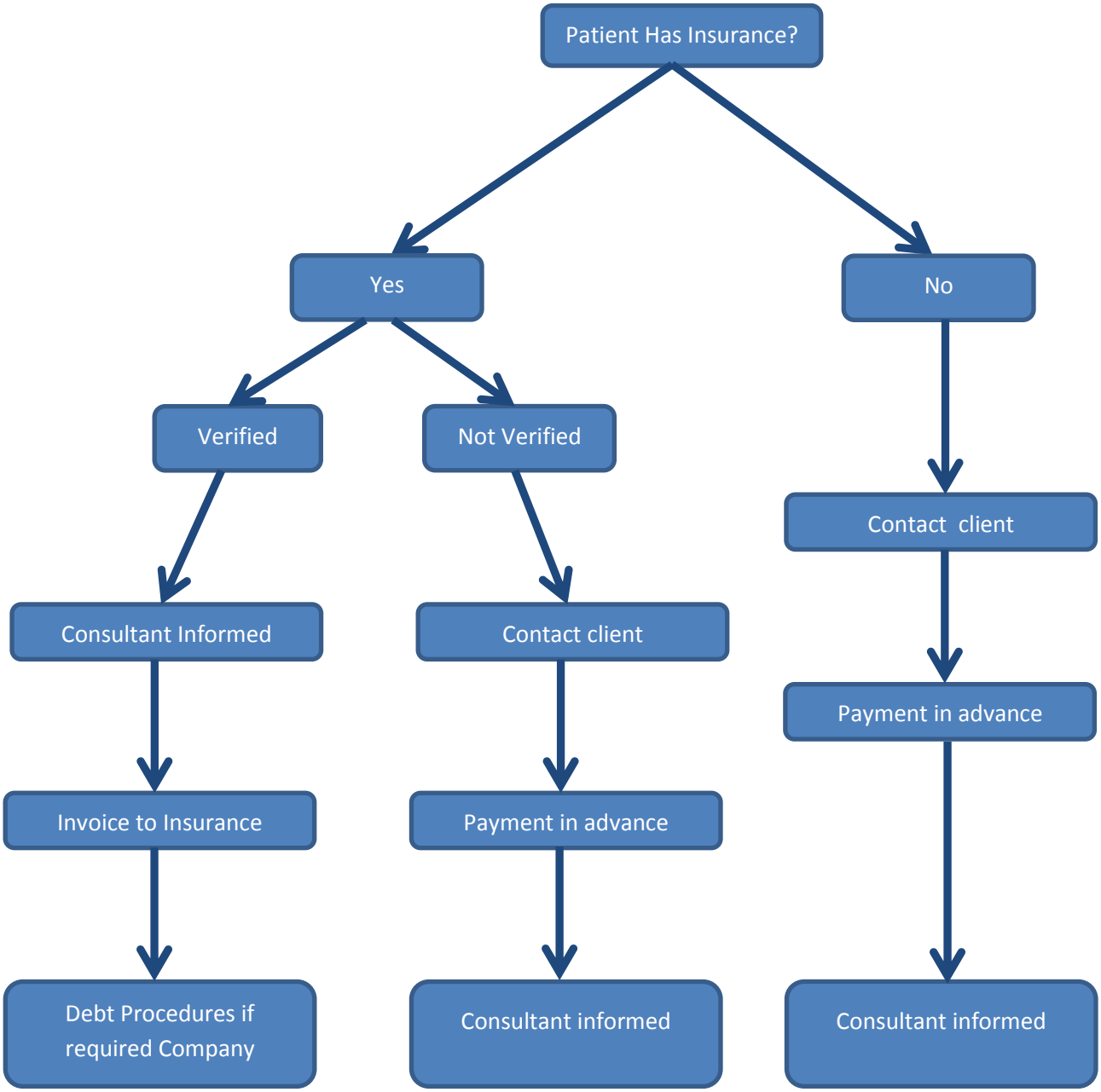
25. FLOW CHART 2 - PAYING PATIENTS [Outpatients]



26. FLOW CHART 3 - PAYING PATIENTS [Fee Paying Services]



27. FLOW CHART 4 – PATIENT INSURANCE



HSC Health and Social Care Board

0023/18

Query Request Form

Requires Immediate Response: Yes

Reason for Immediate Response: Required as an action following Internal Audit review of management of private patients

☐	**Data Definition**	☒	**Recording Issue**
☒	**Technical Guidance**	☐	**Other**

Name: Roberta Gibney **Date:** 8th August 2018

Organisation: BHSCT **Contact Number:** Personal Information redacted by the USI

Subject Heading: PAS OP Referral Source Code – Private to NHS

a) Issue: ***Please provide as much detail as possible in order for the query to be considered and resolved as quickly as possible. This query form will be published on SharePoint when resolved.***

Belfast Trust requests a Referral Source Code on PAS for outpatients who change status from Private to NHS. Currently there is no guidance for identifying such patients.

Patient who attends Trust as a private patient has category recorded as PPG. When treatment completed OP registration should be closed with Discharge Reason – Treatment Completed, however if during their treatment the patient decides to change status to NHS the OP registration should be closed with Discharge Reason – Transfer to NHS and a new OP registration opened:
PAS with referral source PTN (Private to NHS) (suggested code), mapped to Internal Value (2) and CMDS Value (11) on Referral Source Masterfile and category as NHS.

This will ensure that the original category of PPG is not overwritten to NHS and the information recorded as per the Draft Technical Guidance on Private and Overseas Patients is not lost.

Belfast Trust request that the above is adopted as regional PAS Technical Guidance.

b) Response:

When a patient transfers from Private to NHS during their treatment period the OP registration should be closed using:

Discharge Reason code: TNHS – Transfer from Private to NHS

A new OP registration should be opened using:

Referral Source code: PTN – Private to NHS

Approved by: Acute Hospital Information Group

Date: 11/09/2018 **Response Published:** Yes / ~~No~~

Email: *HSCDataStandards@hscni.net*
HSC Data Standards Helpdesk: (Personal Information redacted by the USI

These forms are available on the Information Standards & Data Quality SharePoint Site at *http://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Helpdesk.aspx*