cleanliness standards. Members of this team, namely, Mr Dean Sullivan, DHSSPS and Ms Mary Hinds, PHA, will visit the Trust on 29th January 2010.

Mrs Anita Carroll, Assistant Director, Acute Services, joined the meeting for a discussion on this item. She referred members to the Environmental Cleanliness Report which members receive on a monthly basis within the Performance Report. This report demonstrates the results of internal departmental and managerial audits, as well as the Infection Control Nurses Association (ICNA) audit results. She drew members' attention to the associated action plans developed for all areas following recommendations from departmental audits and to the Exception Report developed either from Internal Environmental Cleanliness or RQIA Unannounced Inspections. The Acting Chief Executive stated that these action plans to address cleanliness issues are owned by the Operational Directors. She referred to the fact that items in the Exception Report relate mainly to the fabric of the buildings and stated that she has written to the RQIA highlighting the difficulty for the Trust in completing minor capital works in the current financial climate.

The Acting Chief Executive went on to advise that the Senior Management Team had discussed the content of the Minister's letter and she was assured of the visibility of Directors on wards on a regular basis. The Chairman and herself also include ward visits in their programme of Trust visits. She assured members that effective monitoring arrangements, audit and assurance processes are in place and reported to the Senior Management Team on a weekly basis. She advised that Dr Rankin is the Director with overall responsibility for cleanliness issues within the organisation and Dr Loughran is the Director responsible for Infection Control.

iii) **Infection Control update**

Dr Loughran began by advising of the significant reduction in C difficile episodes and that the number of MRSA episodes have also reduced. He advised of the work in place to improve the management of the peripheral IV line. A standardised IV line pack is being piloted in two wards in both Craigavon and Daisy Hill Hospitals.

Dr Loughran updated the Board on the recent instances of Norovirus in a number of hospital wards. In an attempt to reduce episodes of this, there will be increased emphasis on stronger adherence to the Visiting Policy, in particular, bringing food into hospital.

The vaccination programme for Swine Flu continues.

7. **OPERATIONAL PERFORMANCE**

i) **Performance Report (ST 204/10)**

Mrs Clarke presented the report summarising the Trust's performance in December 2009 against Priority for Action (PfA) 2009/10 standards and targets and key performance indicators of corporate performance. The quarterly supplementary report on PfA targets for the quarter ending 31 December 2009 is also included.

Mrs Clarke stated that the Trust continues to perform well against the majority of the targets. She noted a continued improvement against the diagnostic reporting and timely hospital discharge targets and added that the Trust continues to achieve a high performance in terms of cancer referrals and an improved performance in mental health referrals. The risk areas remain as in previous months and are detailed in the report. Mrs Clarke highlighted that a number of risk areas relate to the need for investment as identified in item 5v) above.

The Acting Chief Executive referred to the fact that December and early January were particularly busy with high levels of admission and intensity of care experienced in both the acute hospitals and in community services. The Board of Directors paid tribute to the hard work and commitment by staff over this period and commended the good co-operation between the acute and community services.

Mrs Clarke circulated a report (Appendix III of the Performance Report) which provided an update on the Trust's performance against the Service and Budget Agreement 2009/10. She highlighted the associated risks with underperformance and opportunities to maximise income from over performance. In relation to speciality specific issues, key areas of continued discussion with the Commissioner include Obstetrics; T&O; Geriatric Bed-days; Acute General Psychiatry and service development areas. The Trust continues to highlight under performance in visiting speciality areas and to seek to secure additional areas of income.

The Board of Directors approved the Performance Report (ST204/10)

ii) **Finance Report (ST 205/10)**

Mr McNally presented the Financial Performance Report for the period ending 31 December 2009. He stated that it was disappointing to report an increase in the Trust's deficit of £806k, leaving a cumulative deficit of £3.48m for the nine month period ended 31 December 2009. He went on to advise of a deterioration between actual and planned outturn of £1.6m during December 2009. An initial analysis has identified items that have shown a significant deterioration and these are being reviewed to see if trends are emerging.

Turning to the financial forecast for 2010/11, Mr McNally referred to the fact that the Trust enters the third phase of

the CSR planning cycle with plans in place to deliver £22.3m of the £36m CSR efficiency target.

The Acting Chief Executive referred to the disappointing financial performance in December 2009. She advised that the Trust has been asked to produce a recovery plan. She also advised of a meeting with Mr Hugh Mullan that afternoon to seek additional Access Target funding and a meeting with the Minister on 15th February 2010. The Chairman confirmed that a Contingency Planning Workshop will be held on 4th February 2010.

iii) **Human Resources Report (ST 206/10)**

Mr Donaghy provided an update on current activities and issues as follows:-

- The cycle of recruitment for basic grade posts has been prepared and will be available on the Trust intranet by the end of January 2010. A number of block recruitment exercises have been conducted and have proven to be very effective as a means of developing suitable waiting lists. Work on the expansion of the bank unit is continuing to be progressed;
- Overall staff turnover rate is 4.1%'
- Sick leave rate at end November was 4.99%;

The Board of Directors approved the Human Resources Report (ST 206/10)

8. **BOARD REPORTS**

i) **Medical Staff Appraisal Scheme Annual 2008/09**

Dr Loughran presented the above-named report for information. He stated that it was pleasing to note that 84% of Consultants have been appraised across the

Trust and that figure continues to rise. He explained that the appraisal documentation looks at eight aspects of a doctor's work as set out by the GMC. Following the appraisal discussion, a Personal Development Plan (PDP) is developed prioritising the doctor's development needs for the following year. A key objective for the Trust is the refinement of its Appraisal Scheme to ensure that it is fit for purpose to ensure Revalidation. Dr Loughran referred members to the Trust's Quality Improvement Action Plan and associated Audits and to the Trust's Action Plan to implement the recommendations of the RQIA Review of Consultant Medical Appraisal in Northern Ireland.

The Chairman commended the commitment of the Trust to Medical Appraisal and the significant progress made to date.

ii) **Information Technology Annual Report**

Mrs Clarke presented the Information Technology Annual Report 2009 which sets out the progress made against the Information Technology Strategy. Members noted the amount of work that has been achieved over the year as regards IT Controls Assurance which is reflected in the improved self assessment score from 74.5% to 83%. Mrs Clarke outlined the developments planned for 2010. Mr Joynes commented that it was disappointing to note that migration of users from legacy infrastructures to a single Southern IT infrastructure was an outstanding action. Mrs Clarke responded by advising that every effort continues to be made to secure funding to progress this work.

9. **REGISTER OF INTERESTS 2009/10**

The Chairman advised that the Register and Declaration of Interests has been updated for the 2009/10 year and is available, upon request, from the Chair/Chief Executive's Office.

10. **BOARD COMMITTEES**

i) **Endowments and Gifts Committee – Minutes of meeting held on 12th October 2009**

In the absence of Dr Mullan, this item was deferred to the next meeting.

ii) **Audit Committee – Minutes of meeting held on 10th September 2009 (ST 207/10)**

Mrs Mahood presented the Minutes of the 10th September 2009 meeting for approval. At that meeting, Mrs Catherine McKeown, Head of Internal Audit BSO, presented the new standardised format for Internal Audit reports and members approved amendments to the Internal Audit Plan for 2009/10. Mrs Mahood advised that the Audit Committee agreed to produce a formal annual report to Trust Board for this financial year onwards.

The Board of Directors approved the Minutes of the Audit Committee meeting held on 10th September 2009 (ST 207/10)

iii) **Audit Committee – Revised Terms of Reference (ST 208/10)**

Mrs Mahood presented the revised Terms of Reference of the Audit Committee for approval. She stated that these had been updated to reflect the Committee's review of the Mid Year Assurance Statement and production of an annual report.

The Board of Directors approved the revised Terms of Reference of the Audit Committee (ST 208/10)

iv) **Governance Committee – Minutes of meeting held on 8th September 2009 (ST 209/10)**

The Chairman presented the Minutes of the 8th September 2009 meeting for approval.

The Board of Directors approved the Minutes of the Governance Committee meeting held on 8th September 2009 (ST 209/10)

11. **CHAIRMAN'S AND NON-EXECUTIVE DIRECTORS' BUSINESS**

A list of the Chairman's and Non Executive Directors' business was noted.

12. **ANY OTHER BUSINESS**

i) **Workshop on Contingency Plan/Finance**

The Chairman advised that a workshop on Contingency Planning would be held on 4th February 2010.

ii) **Membership of Committees as from 1 April 2010**

The Chairman advised that the current Committee Chairs will stand down as of 31st March 2010. As of 1 April 2010, the Chairs of the Committees will be:

- **Audit Committee** – Mr Alistair Joynes;
- **Governance Committee** – Mrs Deirdre Blakely;
- **Endowments & Gifts Committee** – Mrs Hetty Kelly;
- **Patient Client Experience Committee** – Mrs Roberta Brownlee

Mrs Deirdre Blakely will replace Mrs Roberta Brownlee on the Audit Committee.

iii) The Board of Directors congratulated Mrs Bronagh McKeown, Head of Physical and Sensory Disability Support Services on winning the Institute of Healthcare Management (IHM) Experienced Manager Award;

- The Board of Directors congratulated Mrs Una Turbitt, Named Nurse for Child Protection and Ms Stephanie Wilson, Primary Mental Health Worker, who facilitated a poster presentation on 'Promoting attachment in the first year of life' at the regional launch of the Association of Infant Mental Health. This project (involving a multi-disciplinary team) won a Queen's Nursing Institute Award in 2008 for practice development;

- Members were advised that on 19th January 2010, the "Leading Effective Supervision for AHPs in the Southern Health & Social Care Trust" was shortlisted as one of the finalists to the adjucation panel of the advancing Health Care Awards at the Department of Health, London. The winners of the award will not be announced until the final award ceremony on 12th March.

The next Board of Directors meeting will be held on Thursday, 25th February 2010 at 10.00 a.m. in the Boardroom, Daisy Hill Hospital, Newry

SIGNED: _____

DATED: _____

Southern Health and Social Care Trust

Minutes of a meeting of the Board of Directors held on Thursday, 24th September 2009 at 10.00 a.m. in Dungannon Council Offices

PRESENT:

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

IN ATTENDANCE:

Mrs P Clarke, Acting Director of Planning and Reform
Mr K Donaghy, Director of Human Resources and Organisational Development
Dr G Rankin, Director of Older People and Primary Care Services
Mrs J Youart, Director of Acute Services
Mrs S Cunningham, Southern Area Manager, Patient and Client Council
Mrs J Holmes, Board Secretary
Mr P Toal, Communications Manager
Mrs S Judt, Committee Secretary (Minutes)

1. CHAIRMAN'S WELCOME AND APOLOGIES

The Chairman welcomed everyone to the meeting. Apologies were recorded from Mrs D Blakely, Non Executive Director.

The Chairman welcomed Mrs M McAlinden, as Acting Chief Executive and Mrs P Clarke, Acting Director of Performance and Reform and Mr S McNally, Acting Director of Finance.

2. MINUTES OF BOARD MEETING HELD ON 25TH JUNE 2009

The minutes of the meeting held on 25th June 2009 were agreed as an accurate record and duly signed by the Chairman.

3. MATTERS ARISING

i) RQIA Review of Blood Safety

The Acting Chief Executive advised that the Trust has received the draft report from the RQIA for factual accuracy checking. Dr Loughran is taking the lead in providing the Trust's response.

ii) Update on 5-Year Strategic Plan

The Acting Chief Executive reported that the Minister had announced his approval of the Trust's plans on 9th July 2009. Implementation plans are underway and are being monitored by the Trust's Best Care Best Value Programme Board.

4. STRATEGIC ISSUES

i) Stepped Care Model for Adult Mental Health Services – Presentation (ST175/09)

Mr Rice presented an update on the 5 step model of service for mental health care. He referred to the ongoing review and modernisation programme for mental health services within the Trust which has been progressed by the 'Change in Mind' Project. Emerging from this project, the Trust is progressing towards a 5 step model of service provision, the main aim of which is to simplify patient pathways and provide more tailored care in accordance with self help/recovery approaches.

Mrs Brenda Byrne, 'Change in Mind' Project Manager, was welcomed to the meeting. She explained the project, the progress to date and the next steps. She advised that the Trust has implemented steps 1-3 and the focus is now on steps 4 and 5 – elective community mental health services. A single point of entry for adult mental health services has been established with

the centralised Mental Health Referral and Booking Centre becoming operational from 1st March 2009. In the first six months, this service received 2,125 referrals.

Mr Joynes asked about resources, in particular at the primary care interface. Mr Rice acknowledged that resources are an issue and have been identified to the Commissioner. He went on to say that in order to fully implement the model, there is a shortfall of approximately 44 Practitioners. Mr Joynes asked about resources to address work related and other related stress issues. Mr Rice responded by advising that this is an area which needs further consideration both in the workplace and within the community.

The Acting Chief Executive commended the significant work undertaken to date by the Mental Health and Disability Directorate and acknowledged the challenges ahead to bring the service model to fruition. She stated that an evaluation process is critical and asked that the evaluation framework is reported on at future Trust Board meetings.

The Chairman thanked Mrs Byrne for an excellent presentation.

The Board of Directors approved the Proposal for the development of a Stepped Care Model for Adult Mental Health Services (ST 175/09)

ii) **Centralisation of Acute Mental Health Inpatient Care – Outline Business Case (ST176/09)**

Mr Rice presented the Business Case for the Centralisation of Acute Mental Health Inpatient Care for approval. This sets out a proposed accommodation solution and location to enable the centralisation of 94 beds for the future provision of acute mental health inpatient care. 8 options were considered and the preferred option identified proposes the construction of a new 20 bed unit at Bluestone on the Craigavon Hospital site. The capital investment required is £5.471 million.

Mr Joynes referred to the risk that the centralisation of 94 mental health beds at Craigavon will not suffice in meeting the future needs of the Trust's population and asked for further detail on the controls in place to address this risk. Mr Rice agreed to update the paper to provide further clarification on the controls in place.

The Acting Chief Executive advised that the Trust has been assured that this level of capital funding is in Year 3 of the 10-year capital funding programme.

The Board of Directors approved the Outline Business Case for the Centralisation of Acute Mental Health Inpatient Care (ST 176/09)

iii) **New Service Model for Neonatology**

Mr B Dornan explained the background to the proposal for a new service model for Neonatology across the Craigavon Area Hospital and Daisy Hill Hospital sites. He introduced Mrs D Burns, Assistant Director, Performance and Improvement, who provided a brief update on the project. Mrs Burns explained that the model proposes an increase in the overall complement of level 3 cots and the introduction of transitional care cots across the two sites. The revenue funding required to implement the new service model for Neonatology is £183,083.

iv) **Neonatal Unit, Daisy Hill Hospital – Business Case for Capital Works (ST177/09)**

Mr Dornan presented the Business Case for Capital Works at the Neonatal Unit, Daisy Hill Hospital for approval. This sets out a proposal to address deficiencies in the standard of the accommodation and the range of facilities available within the Neonatal Unit. Mrs Burns advised that the preferred option proposes re-configuration of the existing floor plan of the unit and extension of the unit via re-location of adjacent accommodation within Daisy Hill Hospital. Capital funding requirements are £434k. Mr Dornan explained that money donated to the Neonatology Unit, Daisy Hill Hospital would be used to provide refurbishment of the parents room and facilities. Mr Graham queried the use of E&G funds for this purpose. In response, Mr Dornan advised that the decision to use this funding had been made after careful consideration and was appropriate. Dr Mullan stated that the purpose for which E&G funds may be applied will be discussed at the next E&G Committee meeting. In response to a question on patient flow, Mrs Burns stated that the Trust had undertaken a very extensive capacity and demand exercise and this demonstrated that the Trust could manage its patient flow. She added that the new model of working will reduce the requirement for out of Trust transfers.

The Chairman thanked Mrs Burns for a very informative presentation. The Acting Chief Executive commended the Children and Young People's Services Directorate on its work in relation to the 'Changing for Children' strategy.

The Board of Directors approved the Business Case for Capital Works, Neonatal Unit, Daisy Hill Hospital (ST 177/09)

5. **PATIENT/CLIENT SAFETY AND QUALITY OF CARE**

i) **Swine Flu Update**

Dr Loughran presented a short briefing paper outlining the current status of the Trust's preparedness in respect of Pandemic Influenza (Swine) planning. He advised that it is now 23 weeks since the initial alert in April 2009. Oversight and project management continues to be provided by the Senior Management Team with Directorate level planning and cross Trust operational leads planning group in place. A Trust Pandemic Influenza Plan is in place to ensure that the Trust can react and respond to an influenza pandemic in an efficient, robust, but flexible manner. The Trust has submitted its vaccination plan and it is anticipated that the vaccine against this strain of Swine Flu will be available mid October 2009. Vaccinators are currently being trained. In response to a question from Mr Joynes on the monitoring of staff absences relating to swine flu, Mr Donaghy advised that these continue to be recorded in the normal way. However, during periods of increased activity, including those associated with pandemic influenza, different reporting arrangements will be implemented.

ii) **Delegation of Statutory Personal Social Services Functions Report – Presentation (ST178/09)**

Mrs M McIntosh, Assistant Director of Social Work Services/Social Care Governance, was welcomed to the meeting. Mr Dornan introduced the combined Annual Report on the Discharge of Delegated Statutory Functions and Corporate Parenting Report for the period 1 April 2008 – 31 March 2009. He explained that work is ongoing to agree a regional template for this combined report.

Mrs McIntosh took members through the sections the Trust is required to report on and drew members' attention to the reports from each of the Directorates outlining their ability to discharge Delegated Statutory Function. Mrs McIntosh highlighted the following areas of concern which have been added to the Trust's Risk Register:-

- Approved Social Worker function under the Mental Health Order. Members were assured that following an audit of practice, an action plan is now being developed, a lead Approved Social Worker having been appointed to take forward the recommendations;

- Protection of Vulnerable Adults. An Adult Protection Forum has been established and there is a proposal to appoint a Co-ordinator and Senior Practitioners;

- Carers Assessments. Whilst there has been a gradual rise in the number of carers assessments being offered, the Trust is still short of the target of 51% and it is hoped that there will be some modification to this target in the current year. Mr Graham asked that activity in respect of respite provision for carers be included in the reporting template for next year and Mrs McIntosh agreed to take this forward;

- Unallocated child care cases. Due to action taken, there has been a significant decline in the number of unallocated cases, however, this remains a challenge. The Trust has submitted a bid to the Commissioner for additional resources to provide capacity to deal with referrals as soon as they are received.

In respect of Children and Young People, Mrs McIntosh advised of increased child protection and looked after children activity.

Members asked a number of questions to which Mrs McIntosh responded. The Chairman asked about benchmarking against other Trusts. Mrs McIntosh stated that with the regional reporting template being devised, this would allow for regional benchmarking. The Chairman thanked Mrs McIntosh for a very informative report.

The Board of Directors approved the Annual Report on the Discharge of Delegated Statutory Functions and Corporate Parenting Report 2008-09 (ST 178/09)

iii) **Update on Carers' issues**

Mr Graham, as the designated Board member with lead responsibility for issues relating to carers, gave a short presentation. He outlined some key issues, one of which is carers' assessments. Whilst significant progress has been made in some Directorates, the uptake target of 51% across all Directorates has not been achieved. Referring to Direct Payments, Mr Graham reported a 20% increase from last year. He explained that these figures are in relation to service users as figures are not available for carers who are in receipt of Direct Payments.

The Chairman asked about carers' assessments and if the reasons why carers decline to have an assessment could be explored further. Mr Graham stated that current data is not robust enough to accurately reflect the offer and uptake of carers assessments. The Acting Chief Executive stated that the Trust is aware of this and the other issues highlighted in Mr Graham's presentation. She advised that a progress report would be brought to Trust Board in six months' time to provide assurance on the action the Trust is taking in a co-ordinated way to address carers' issues.

iv) **RQIA Review of Hyponatraemia**

Dr Loughran explained that this was the second review of National Patient Safety Alert No. 22. Referring to the RQIA report 'Reducing the risk of hyponatraemia when administering intravenous fluids to children' Dr Loughran advised that the RQIA would be undertaking a review of the implementation of the recommendations on 9th November 2009. The Trust has undertaken a self-assessment and identified a number of areas requiring action to be taken. Actions are being progressed and Dr Loughran referred members to the detail of these in the Trust's Action Plan.

6. OPERATIONAL PERFORMANCE

i) Performance Report (ST 179/09)

Mrs Clarke presented the report summarising the Trust's performance in August 2009 against Priority for Action (PfA) 2009/10 standards and targets and key performance indicators of corporate performance. She stated that the Trust continues to perform strongly across a range of areas, namely Timely Hospital Discharge; Mental Health and Learning Disability Resettlement and Cancer. Members were advised of an improved performance in relation to complaints responded to within 20 working days, routine diagnostics and family group conferences.

Mrs Clarke drew members' attention to a number of risk areas, namely i) Inpatient/Daycase Access target; ii) Renal dialysis via fistula and iii) Unallocated child care cases. In relation to i), Mrs Youart advised that the Trust had undertaken a review of urology services and this had highlighted a capacity gap. This is a regional issue and a regional review of urology services is underway. Referring to renal dialysis via fistula, Mrs Youart stated that there should be an improved performance in the second half of the year as a result of medical staff being trained to undertake fistula creation. As regards unallocated childcare cases, members noted the management actions taken to mitigate the risk of unallocated child care cases.

Mrs Clarke took members through the changes in the Clinical and Social Care Quality section of the report. The Chairman asked about a peer group benchmark for Crash Call rates. She also asked if clinical outcome indicators could be incorporated into the Performance Report. Mrs Clarke advised that the Trust continues to work with CHKS on clinical indicators.

The Board of Directors approved the Performance Report (ST 179/09)

ii) Finance Report (ST 180/09)

Mr McNally presented the Financial Performance Report for the period ending 31 August 2009. He advised that the Trust is reporting a cumulative deficit of £3.1m for the five month period ended 31st August 2009 with an in month marginal surplus of

£115k, which represents an in month improvement of £848k compared to July 2009.

Mr McNally referred members to the report which sets out the Trust's performance against its Contingency Plan for the period ending 31 August 2009. He began by stating that the Trust's original Contingency Plan to achieve the £8m savings target was ambitious. However, it was felt that with some additional effort, the minimum target of £6.4m could be achieved. He stated that as at 31 August 2009, the Trust has achieved £1.5m savings against the 5 month target of £2.5m. This represents an underachievement of £1m and without corrective action, the Trust will underachieve its contingency plan by £3m. The two main areas of underachievement are as & when required payroll spend and goods and services expenditure.

Mr McNally advised that the Trust has been asked to review its year-end forecast. He reminded members of the previously advised deficit of around £2m and stated that the current position would indicate an estimated £3.7m deficit at year-end. In addition, the Trust is also incurring additional expenditure in relation to various factors and these require further exploration. Mr McNally advised that it has been agreed by the Senior Management Team that i) Managers and Budgetholders must contain expenditure within budgets; ii) the Trust contingency plan will be reassessed to deliver the full £6.4m target and strengthened as necessary to accommodate emerging pressures and iii) additional funding will continue to be pursued.

The Chairman advised that the Directors' Workshop on 29th October 2009 would focus on financial matters.

The Board of Directors approved the Finance Report (ST 180/09)

iii) **Human Resources Report (ST 181/09)**

Mr K Donaghy presented the Human Resources report and highlighted some of the key aspects as follows:-

- Recruitment and selection is, in the main, experiencing high levels of application, with the exception of the Payroll Manager post, Midwifery posts, Speciality Doctor posts in Geriatric Liaison and the Rapid Access Clinic and Speciality Trainee

posts in Accident and Emergency in Daisy Hill Hospital. Mr Donaghy outlined the various options the Trust is progressing to fill these posts.
- Substantial progress has been made in relation to agenda for change reviews;
- Staff turnover rate of 4%;
- Sick leave rate at end July 2009 was 5.58%;
- The population of RPA structures continues;
- No further VER/VR applications are being invited.

The Board of Directors approved the Human Resources Report (ST 181/09)

7. BOARD ASSURANCE FRAMEWORK

Mrs Holmes presented the Board Assurance Framework and drew members' attention to changes in the framework since May 2009. Referring to the changes to risks, Mrs Holmes explained that the risks remain broadly the same, however, controls have been strengthened in some cases and there are updates on some of the actions to address gaps in controls/assurances. Members discussed two new risks in relation to the provision of safe and effective care. In relation to service issues within Medicine and Unscheduled Care, Mrs Youart assured members that an action plan is in place to address the issues and locum arrangements are in place. Mr Rice referring to the potential risk of harm as a result of patients released from prison with no legal order in place, advised that the Trust has internal control mechanisms in place. However, due to the regional nature of the issues identified, the Trust has corresponded with the DHSSPS and the Northern Ireland Office, highlighting the need to formalise arrangements between appropriate agencies/bodies when patients are released from prison into the community. A response is awaited on how best to take this forward.

In concluding, Mrs Holmes asked the Board how they would like the Board Assurance Framework and the Corporate Risk Register presented in future. It was agreed that the Board Assurance Framework would be presented to the Trust Board and the Corporate Risk Register presented to the Governance Committee.

8. CORPORATE RISK REGISTER

This item was deferred.

9. **2008/09 ANNUAL REPORTING REQUIREMENTS**

i) **Annual Report and Statement of Accounts for 2008/09**

The Acting Chief Executive presented the Trust's Annual Report and Statement of Accounts for 2008/09. She stated that the report provides a flavour of the excellent work done by staff. Mr P Toal, Communications Manager explained that 95,000 copies have been printed and will be distributed with editions of local newspapers the following week.

The Chairman, on behalf of Board members, recorded appreciation to the Communications team and all those who had provided articles.

ii) **Trust Funds – Draft Annual Report and Accounts for the year ended 31 March 2009 (ST183/09)**

Mr McNally presented the draft Trust Funds Annual Report and Accounts for the year ending 31 March 2009 for approval. He explained that these had been presented in draft form to the Endowments and Gifts Committee on 8th June 2009 and to the Audit Committee on 10th September 2009. He stated that the External Auditors had presented their audit findings on these accounts to the Audit Committee and confirmed their recommendation to the Comptroller and Auditor General (C&AG) to issue a clean audit opinion.

The Board of Directors approved the Trust Funds Draft Annual Report and Accounts for the year ended 31 March 2009 (ST183/09)

iii) **Report to those charged with Governance – Trust Funds Accounts**

Mr McNally presented the Report to those charged with Governance on the Charitable Trust Funds Accounts for the year ended 31 March 2009. Members were advised that total incoming resources amounted to £831k, with expenditure totalling £514k in the year. Total Fund balances at the year end amounted to £2,717k.

iv) **Report to those charged with Governance – Trust Accounts 2008-09**

Mr McNally presented the Report to those charged with Governance on the Trust Accounts 2008-09, advising that the Comptroller and Auditor General (C&AG) had issued a clean audit opinion on the Trust's accounts (including the Account of monies held on behalf of Patients and Residents).

Mrs Mahood stated that key matters raised in the report had been discussed by the Audit Committee. She welcomed the clean audit opinion on the Trust's accounts, however, stated that it was disappointing to note External Audit's negative assurance in relation to 'progress on matters identified in previous audits'.

10. **BOARD REPORTS**

i) **Records Management Annual Report 2008/09 (ST 184/09)**

Mrs Clarke presented the Records Management Annual Report for approval. This sets out the Trust's position with regards to records management during 2008/09 and outlines the work planned for 2009/10. It provides assurance to Trust Board on how the Trust manages patient, client and corporate records. She drew members' attention to the considerable work undertaken to improve the safety, quality, systems and control of the Records Management function. Mrs Clarke advised that a Cetis E-Learning programme has been put in place to ensure that all staff are aware of and take responsibility for their compliance with Freedom of Information and Data Protection Legislation. Concluding, Mrs Clarke advised that the Trust's performance against the Records Management Controls Assurance Standard in 2008/09 was substantive and this was verified by Internal Audit.

The Board of Directors approved the Records Management Annual Report 2008/09 (ST 184/09)

iii) **Decontamination of Medical Devices Annual Report (ST 185/09)**

Mrs Youart presented the Decontamination of Medical Devices Annual Report 2008/09 for approval. She advised members that

the 2008/09 self assessment of the Trust's position against the Decontamination of Reusable Medical Devices Controls Assurance Standard was substantive. Mrs Youart summarised the key points in the report and drew members' attention to the considerable investment on interim improvements for endoscope decontamination within the Trust.

The Board of Directors approved the Decontamination of Medical Devices Annual Report 2008/09 (ST 185/09)

11. **SECTION 75 ANNUAL PROGRESS REPORT (ST 186/09)**

Mr Donaghy presented the above-named report for approval and took members through its content. This report provides evidence that there has been a sustained commitment across the Trust to fully meeting its statutory obligations under Section 75 and there has been significant progress in all areas of the Trust's Equality Scheme. Members noted the extensive range of methods the Trust uses to ensure the equality agenda remains high profile throughout the Trust. Mr Donaghy referred members to page 82 of the report on Interpreting Services and advised of over 17,000 requests for languages within the Southern Trust, the Southern area being notably the biggest user of interpreting services. He advised of a pilot underway in the Acute Directorate with The Big Word telephone interpreting company.

The Board of Directors approved the Section 75 Annual Progress Report (ST 186/09)

12. **BOARD COMMITTEES**

i) **Endowments and Gifts Committee – Minutes of meeting held on 19th January 2009 (ST 187/09)**

Dr Mullan presented the Minutes of the 19th January 2009 meeting of the Endowments and Gifts Committee for approval and highlighted the main discussion points. He advised that the key focus for the E&G Committee in 2009/10 will be the development of a strategic approach to the disbursement of Trust funds.

The Board of Directors approved the Minutes of the meeting of the Endowments and Gifts Committee held on 19th January 2009 (ST 187/09)

ii) **Audit Committee – Minutes of meeting held on 27th May 2009 (ST 188/09)**

Mrs Mahood presented the Minutes of the 27th May 2009 meeting of the Audit Committee for approval. Internal Audit reports had been presented and a satisfactory level of assurance had been received on 13 assessments and a limited level of assurance on 5 assessments. 5 reports remained outstanding at that point.

The Board of Directors approved the Minutes of the meeting of the Audit Committee held on 27th May 2009 (ST 188/09)

iii) Governance Committee – Minutes of meeting held on 12th May 2009 (ST 189/09)

The Board of Directors approved the Minutes of the meeting of the Governance Committee held on 12th May 2009 (ST 189/09)

13. **CHAIRMAN'S AND NON-EXECUTIVE DIRECTORS' BUSINESS**

A list of the Chairman's and Non Executive Directors' business was noted.

14. **ANY OTHER BUSINESS**

14.1 **SuperValu Awards**

The Board of Directors congratulated Roxborough House, Moy on winning the SuperValu Best Kept Health and Social Care Facility Award 2009.

The next Board of Directors meeting will be held on Thursday, 26th November 2009 at 10.00 a.m. in Daisy Hill Hospital, Newry

Wright, Elaine

From: McAlinden, Mairead [redacted]
Sent: 02 April 2014 20:26
Subject: 11am Urology Pre meeting

Wright, Elaine

From: McAlinden, Mairead [redacted]
Sent: 10 May 2014 17:34
To: Wright, Elaine
Subject: FOR DIARY: Urology Review Stocktake -

Elaine please note indiary but clashes with consultation section of Board W'shop (might finish early) Mairead

From: Corrigan, Martina
Sent: Friday, May 09, 2014 07:50 PM GMT Standard Time
To: McAlinden, Mairead
Cc: Burns, Deborah
Subject: FW: Urology Review Stocktake -

Mairead

Debbie had asked me to forward you to below date and time of the follow-up meeting with Mark Fordham, Beth and David.

Kind regards

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: Corrigan, Martina
Sent: 09 May 2014 08:47
To: 'Michael O'Hare'; Beth Malloy

Cc: Trouton, Heather; David McCormick; Stinson, Emma M; Burns, Deborah
Subject: RE: Urology Review Stocktake

Thanks Michael

I can now confirm that this meeting suits for 4pm on Thursday 29 May 2014 and this will be held in the Meeting Room, Admin Floor.

Martina

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

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

From: Michael O'Hare Personal Information redacted by USI
Sent: 08 May 2014 09:23
To: Corrigan, Martina; Beth Malloy
Cc: Trouton, Heather; David McCormick; Stinson, Emma M; Burns, Deborah
Subject: RE: Urology Review Stocktake - Further Information

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

Dear Martina,

I can confirm that this meeting time suits at the Board end, and will hold in the diaries at present.

Kind regards,
Michael

Michael O'Hare
Administrative Support Officer
Performance Management and Service Improvement Directorate Health and Social Care Board
12-22 Linenhall Street, Belfast, BT2 8BS
Tel: Personal Information redacted by USI

From: Corrigan, Martina
Personal Information redacted by USI
Sent: 08 May 2014 07:42
To: Beth Malloy
Cc: Trouton, Heather; Michael O'Hare; David McCormick; Stinson, Emma M; Burns, Deborah
Subject: RE: Urology Review Stocktake - Further Information

Beth

Just to advise that I am working at arranging this meeting for Thursday 29 May. I will confirm the time later today but hoping that this will be at around 4pm.

Can you advise if this date and time would suit before I change diaries?

Thanks

Martina

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

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

From: Beth Malloy Personal Information redacted by USI

Sent: 06 May 2014 13:11
To: Burns, Deborah
Cc: Trouton, Heather; Corrigan, Martina; Michael O'Hare; David McCormick
Subject: RE: Urology Review Stocktake - Further Information

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Debbie

It is expected the draft narrative from the Urology Review Stocktake will be available and circulated by 23 May 2014

Mark Fordham has requested we arrange Trust meetings discuss the Stocktake narrative.

We will have limited dates because we need to fit the meeting before the end of May, prior to Mark been unavailable for all of June. If we are not able to arrange we will push the meeting to July and this will more likely be into August, all which will delay the discussion. I appreciate this will not afford the required 6 weeks' notice and we will try to be as flexible as we can, but I hope you will be able to assist us in arranging this meeting; it is likely to be the week of 26 May.

Please do not hesitate to contact me if you need any clarification.

Thanks

Beth

Mrs Beth Malloy
Assistant Director Scheduled Services
Performance Management and Service Improvement Directorate Health and Social Care Board
Personal Information redacted by USI

From: Trouton, Heather
[redacted]
Sent: 02 April 2014 21:58
To: Beth Malloy
Cc: Corrigan, Martina
Subject: Re: Urology Review Stocktake - Further Information

Beth
It was sent by Martina Corrigan this afternoon

Heather

From: Beth Malloy [redacted]
Sent: Wednesday, April 02, 2014 06:50 PM GMT Standard Time
To: Burns, Deborah
Cc: Lappin, Lynn; Trouton, Heather; David McCormick [redacted]; Clarke, Paula; Michael Bloomfield [redacted]
Subject: RE: Urology Review Stocktake - Further Information

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Debbie

Who did they come from, I can't see them in my inbox?

Beth

Mrs Beth Malloy
Assistant Director Scheduled Services
Performance Management and Service Improvement Directorate Health and Social Care Board
07920187261
From: Burns, Deborah [redacted]
Sent: 02 April 2014 18:23
To: Beth Malloy

Cc: Lappin, Lynn; Trouton, Heather; David McCormick; Clarke, Paula; Michael Bloomfield
Subject: RE: Urology Review Stocktake - Further Information

Think job plans went today to you hopefully?
Thanks
D

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

From: Beth Malloy Personal Information redacted by USI
Sent: 02 April 2014 11:53
To: Burns, Deborah
Cc: Lappin, Lynn; Trouton, Heather; David McCormick; Clarke, Paula; Michael Bloomfield
Subject: RE: Urology Review Stocktake - Further Information
Importance: High

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

Dear Debbie

I refer to the request below, this information is outstanding.

Please can you advise when this information will be provided?

As you will appreciate the delay in the provision of this information may delay the completion of the Stocktake.

Thanks

Beth
Mrs Beth Malloy

Assistant Director Scheduled Services
Performance Management and Service Improvement Directorate Health and Social Care Board
Personal Information redacted by USI

From: Beth Malloy
Sent: 19 March 2014 21:51
To: Burns, Deborah
Cc: Lappin, Lynn; Heather Trouton
Personal Information redacted by USI; David McCormick
Subject: Urology Review Stocktake - Further Information

Dear Debbie

I appreciate we have not yet had the meeting with the Trust in relation to the Urology Review Stocktake. We are meeting next week, as discussed last week and prior to the meeting it would be helpful if the Trust provided the information below in relation to both the 5 posts and the additional 6th post. This should include vacant posts.

Please could you arrange for the following information to be sent to the Board?

Details of the Job Plan PAs for each of the following individuals within Urology of the SouthernTrust. Showing the details by day and total PAs for each of the Consultants and Other Support Staff in the Directorate Consultants (confirming their specialist area) Middle Tier Doctors (including grade) and Clinical Nurse Specialists (showing their grade)

It would be helpful if this information was submitted by COP on Tuesday of next week. So that we may consider with Mark prior to the meeting on the 3 April.

Regards

Beth

Mrs Beth Malloy
Assistant Director Scheduled Services
Performance Management and Service Improvement Directorate Health and Social Care Board Headquarters
12-22 Linenhall Street

Belfast
BT2 8BS
Northern Ireland

Mobile Personal Information redacted by USI
Landline Personal Information redacted by USI
Fax 028 9076 5262

_____

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Wright, Elaine

From: Wright, Elaine [redacted] >
Sent: 31 July 2014 11:22
To: Stinson, Emma M
Subject: Urology Modernisation Meetings
Attachments: image001.png; image002.png; image003.jpg

Emma – Confirming that 18 August is in the diary.
Unfortunately, Mairead is on leave on 1 September (and out of the country).
Thanks Elaine

From: Stinson, Emma M
Sent: 21 July 2014 16:34
To: McAlinden, Mairead; Clarke, Paula; Corrigan, Martina
Cc: Radcliffe, Sharon; Wright, Elaine
Subject: Urology Modernisation Meetings

Dear Mairead and Paula

Following correspondence from Mr Sullivan the following meetings have been arranged.

Internal Meeting Urologists	Monday 18th August 2014 at 5.00 pm with Meeting Room, Admin Floor, CAH
External Meeting Urologists and HSCB	Monday 1st September 2014 at 4.30 pm with Board Room, CAH

Martina – would you confirm with the Urologists please?

Many Thanks
Emma

Emma Stinson
PA to Mrs Deborah Burns
Interim Director of Acute Services
Southern Health and Social Care Trust

Admin Floor
Craigavon Area Hospital

Direct Line: Personal Information redacted by USI Direct Fax: Personal Information redacted by USI
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Wright, Elaine

From: Burns, Deborah [redacted]
Sent: 19 August 2014 11:51
To: McAlinden, Mairead
Subject: RE: Urology Sustainability Proposal

If you could would be good

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

-----Original Message-----
From: McAlinden, Mairead
Sent: 18 August 2014 22:34
To: Burns, Deborah
Subject: Urology Sustainability Proposal

Debbie, please pass on my appreciation to the Urology Team for the presentation this evening. I fully appreciate the amount of discussion, debate and analysis that went before what we heard tonight and the commitment to a different approach to the twinned problems of demand management and best use of clinical expertise. In speaking with Tony Stevens this evening on a related issue he is very keen to hear of the innovative approaches being developed by Team South after our discussions with Dean.

I am sure that the meeting will go well on 1 September and if it would be of any value would be happy to come in from leave to attend as I fully appreciate that all of the team have shown that level of commitment - just let me know. Well done to all involved.

Mairead

Health and Social Care Board

Performance Management and Service Improvement Directorate

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

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

Trust Directors of Acute Services

Our Ref: HM670
Date: 27 April 2010

Dear Colleagues

REGIONAL UROLOGY REVIEW

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

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

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

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

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

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

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

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

Yours sincerely

Personal Information redacted by USI

HUGH MULLEN
Director of Performance Management and Service Improvement

Enc

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

Appendix 1

1. UROLOGY REVIEW SUMMARY OF RECOMMENDATIONS

Section 2 – Introduction and Context

1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.

2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.

3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

Section 3 – Current Service Profile

4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.

5. Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.

6. Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.

7. Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.

8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.

9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.

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

Section 4 – Capacity, Demand and Activity

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

Section 5 – Performance Measures

12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

13. Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

16. Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.

17. Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

Section 7 – Urological Cancers

18. The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.

19. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.

20. Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

Section 8 – Clinical Workforce Requirements

21. To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.

22. Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.

23. At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.

Section 9 – Service Configuration Model

24. Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.

25. Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.

26. Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

Appendix 2

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

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

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

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

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

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

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

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

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

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

Appendix 3

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

Ref: Review Page 40-41
Outpatients: 1176 – 1680 per Consultant
Inpatient and Daycase FCE: 1000 - 1250 per Consultant

Existing 17 Consultants in post
Outpatients 19,992 to 28,560
IP/DC FCEs – 17,000 to 21,250

New 6 Consultant Appointments
Outpatients 7,056 to 10,080
IP/DC FCEs – 6,000 to 7,500

Regional Total
Outpatients 27,048 to 38,640
IP/DC FCEs – 23,000 to 28,750

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

Southern Health and Social Care Trust

Quality Care - for you, with you

Regional Review of Urology Services

Team South Implementation Plan

V0.3 revised 09 Nov 10

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Appendices

Appendix 1 Calculation of Sessions Required for Team South

1. Background

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

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

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

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

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

2. Current Service Model

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

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

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

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

The Urology Team

The integrated urology team comprises:

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

The ICATS Service

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

The following services are provided within ICATS:

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

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

Current Sessions

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

Table 1: Current Urology Sessions

	Craigavon	South Tyrone	Banbridge	Armagh	Total
Consultant Led OPs					
General	2.75 per week[1]	1 per month	2 per month	2 per month	4 per week
Stone Treatment	1 weekly				1 week

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

Main Theatres (CAH)	Weekly	
	6	3 all day lists

	Craigavon	South Tyrone
Day Surgery		
GA	1 weekly[2]	1 monthly
Flexible Cystoscopy	1.5 weekly[3]	
Lithotripsy	2 weekly	

1) 1 consultant led outpatient clinic at CAH is every week except the 3rd week in the month
2) Numbers treated on the weekly GA list at Craigavon are restricted by anaesthetic cover
3) 2 lists/1 list on alternate weeks

Current Activity

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

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

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

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

Table 3: Activity by Consultant for 2009/10

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

[1] INCLUDES flexible cystocopies (M45) and DCs/FCEs with no primary procedure recorded.
[2]Mr Akhtar undertakes an alternative weekly biopsy list at Thorndale. These patients are recorded under ICATS.

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

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

Pre-operative Assessment

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

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

Suspected Urological Cancers

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

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

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

3. Benchmarking of Current Service

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

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

Table 4: Regional Benchmarking

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

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

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

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

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

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

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

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

4. Demand for Team South Urology Service

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

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

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

Table 6: Projected Outpatient Activity for Team South

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

Notes:

1) Actual attendances at consultant led clinics, as shown in Table 6 of the Trust's Implementation Plan. In house additionality is included.

2) In 2009/10 240 Stone Treatment Clinic new attendances were recorded as review.

3) Actual attendances at ICATS clinics.

4) Fermanagh referral figure was taken from the Board's model (it is lower than the SHSCT original estimate).

5) The same DNA rate was used as in the Board's model. The actual DNA rate in 2009/10 was 5.5%.

6) The same growth rate was used as in the Board's model.

7) A General Surgeon based at Daisy Hill Hospital also sees urology patients. It is estimated that 610 new attendances at his clinics in 2009/10 were urology patients. **Capacity for the future needs to be built into the service model for these referrals although this work will continue to be undertaken by the General Surgeon.**

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

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

Table 7: Projected Activity for Team South

		2009/10 Actual Activity					
		Core Activity	**IHA**	**IS**	**Growth in WL**	**SHSCT Activity to be Provided**	**Team South Capacity Required [3]**
2009/10	Day Case	1502	3	383	47	1935	**2283**
	Elective FCE	1199	29	140	28	1396	**1647**
	Non Elective FCE	629	0	0		629	**742**

1) Source is Business Objects
2) 2009/10 breaches have been used to estimate growth in waiting list for day cases and FCEs
3) 18% added for Fermanagh, based on population size relative to SHSCT population

5. Proposed Service Model

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

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

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

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

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

Table 8: Weekly Sessions for New Service Model

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

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

Table 9: Proposed Consultant Led Sessions

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

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

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

		Core Activity
2009/10	Consultant Led New OP	850
	Consultant Led Review OP	2151
	Total Activity	3001

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

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

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

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

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

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

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

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

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

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

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

6. Timetable for Implementation

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

APPENDIX 1

Calculation of Sessions Required for Team South

Calculation of Sessions Required for Team South

Prostate Pathway (Revised)

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

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

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

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

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

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

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

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

LUTS

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

419 new patients @ 4 per session = 105 sessions

336 reviews @ 8 per session = 42 sessions

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

Registrar input is required.

Haematuria (Revised)

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

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

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

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

Andrology/General Urology ICATS

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

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

Urodynamics

These will be located alongside consultant clinics.

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

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

Consultant Clinics

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

Stone Treatment

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

Day Cases

Flexible Cystoscopy

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

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

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

It has therefore been assumed that 56% of 2283 cystoscopies will be required = 1279. 237 of these will be done in Thorndale (Haematuria service), leaving1042.

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

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

Lithotripsy

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

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

Other Day Cases

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

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

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

Of the 2735 day cases:

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

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

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

Inpatients

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

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

Integrated Elective Access Protocol (IEAP)

Awareness Sessions for Admin and Clerical Staff within Acute Services Division

Mrs Pauline Matier
Mrs Sharon Glenny
Mrs Phyllis Richardson
Ms Wendy Clayton

OCTOBER / NOVEMBER 2008

Awareness Session Content

- Overview of Out-patient Target and Pathway
- Overview of Diagnostics Target and Pathway
- Overview of ICATS Targets and Pathway
- Overview of Cancer Targets and Pathway
- Study of Elective Targets and Pathway

Out-Patients

Mrs Pauline Matier

Out-Patients

- Achieved maximum waiting time of 13 weeks from referral to first OP appointment in March 2008
- Working towards achievement of 9 week target by end March 2009
  - Internal milestones to achieve this

Underpinning Principles

- Patients are treated on the basis of clinical urgency
- Patients with the same clinical need are treated in turn – Primary Target Lists (PTLs)
- To ensure equity chronological management should exist at specialty/sub-specialty level
- Patients managed in 2 streams – urgent and routine
- Referrals to be registered within 1 working day of receipt and be able to track through system
  - Centralised registration process and dedicated booking function

ICATS

Mrs Pauline Matier

ICATS – Key Messages

- All referrals will be received, registered and processed in nominated Hospital Registration Offices (HROs)
- Referrals will be registered and scanned within 24 hours of receipt and triaged within 3 working days of receipt
- All new and review patients should be partially booked
- Underpinning principles for out-patients apply to ICATS

Diagnostics

Ms Wendy Clayton

Diagnostics - Targets

- All patients will have their diagnostic investigation within 9 weeks of receipt of referral by end March 2009
  - This applies to all imaging, audiology, neurophysiology, urodynamics, cardiology and sleep studies
    - Internal milestones will be set

Diagnostics - DRTT

- The standard for diagnostic reporting turnaround time
  - Urgent Referrals: 100% of results must be verified and dispatched to the referring clinician within 2 (calendar) days of the test being undertaken
  - Routine Referrals: 75% of results must be verified and dispatched to the referring clinical within 2 weeks (14 calendar days, including weekends and public holidays) of the test being undertaken.
    - All routine tests must be reported on within 4 weeks (28 calendar) days.

		13 Week PTL					
		Sep 08			Oct 08		
		Sept DTL	Booked DTL	% Booked	Oct DTL	Booked DTL	% Booked
IMAGING	MAGNETIC RESONANCE IMAGING	4	4	100%	8	8	100%
	COMPUTERISED TOMOGRAPHY	0	0	#DIV/0!	0	0	#DIV/0!
	NON-OBSTETRIC ULTRASOUND	0	0	#DIV/0!	19	12	63%
	BARIUM ENEMA	27	25	93%	67	43	64%
	DEXA SCAN	0	0	#DIV/0!	0	0	#DIV/0!
	RADIO-NUCLIDE IMAGING	0	0	#DIV/0!	32	12	38%
PHYSIOLOGICAL MEASUREMENT	AUDIOLOGY - PURE TONE AUDIOMETRY	0	0	#DIV/0!	7	7	100%
	CARDIOLOGY - ECHOCARDIOGRAPHY	58	55	95%	229	200	87%
	CARDIOLOGY - PERFUSION STUDIES	0	0	#DIV/0!	0	0	#DIV/0!
	NEUROPHYSIOLOGY - PERIPHERAL NEUROPHYSIOLOGY	24	18	75%	91	46	51%
	RESPIRATORY PHYSIOLOGY - SLEEP STUDIES	1	1	100%	8	4	50%
	URODYNAMICS - PRESSURES & FLOWS	9	6	67%	14	4	29%
TOTAL		123	109	89%	475	336	71%

Key Messages

- Clinic outcomes must be recorded on the day
- A standard for reporting of tests will be introduced in 2008 and Trusts will be expected to monitor and audit compliance
- A continuous process of data quality validation must be in place
- Where more than one test is required, the first test should be added to the waiting list, with additional tests noted

TRUST TOTAL	Urgent Activity with Verified Report Within 48 Hour Target (% of Total Urgent Activity)		Urgent Activity with Verified Report Outside of 48 Hour Target (% of Total Urgent Activity)		Urgent Activity Unreported		Total Urgent Activity
	No	%	No	%	No	%	No
MRI	83	47%	88	50%	5	3%	**176**
CT	263	27%	653	67%	62	6%	**978**
US	147	28%	335	64%	40	8%	**522**
DEXA	0	0%	0	0%	0	0%	**0**
Ba Enema	14	38%	11	30%	12	32%	**37**
Nuclear Medicine	1	2%	61	97%	1	2%	**63**
TOTAL	**508**	**28.60%**	**1148**	**64.64%**	**120**	**6.76%**	**1776**

Received from Mairead McAlinden on 20/06/2022. Annotated by the Urology Services Inquiry.

Diagnostics - Endoscopy

- Global Rating Scale (GRS)
  - Web based consensus recording quality improvements in endoscopic services in the NHS
  - Enables endoscopic services to assess how well they provide a patient centred service
  - Trust currently undergoing this process
  - Anticipate a number of changes in how this service is managed, eg, reporting of test results (DRTT)

Cancer

Ms Wendy Clayton

Cancer

- 31 Day target – achieved 95% in 07/08
  - To achieve 98% by 31st March 09
- 62 Day target – achieved 95% in 07/08
  - To achieve 95% by 31st March 09

Key Messages

- Communication with Cancer Trackers
- Cancer pathway crosses outpatients, diagnostics, daycases & inpatients
- All cancer patients on ‘Red Flag’ pathway are Urgent
- Management of ‘Red Flag’ patients should be in line with IEAP

Elective Admissions

Mrs Sharon Glenny

Mrs Phyllis Richardson

Elective Admissions - Targets

- 21 weeks maximum waiting time target achieved at 31st March 2008
- Working towards achieving maximum waiting time target of 13 weeks by 31st March 2009
  - Trust has set in place internal milestones to achieve this

Underpinning Principles

- The IEAP requires
  - High level of administrative management to include
    - Corporate, MD and AMDs, OSLs and clerical teams
  - More patient focus and greater transparency
    - Booked patient pathway
    - More patient choice
    - Pooling of lists
  - More discipline in terms of planning and notice
    - Consultant leave policy and scheduling of sessions

Key Messages

- Booking schedules will be developed to support patients having a choice of a date and time TCI – indicative dates should be discussed with patients
  - Fully booked elective pathway

- SDU Visit Recommendations in terms of Booking Processes – progress towards a booking strategy based on dedicated resources to manage the pathway, facilitating choice for patients
  - The Trust should consider development of a dedicated team to manage the booking process and the introduction of choice for theatre and endoscopy sessions, in line with IEAP guidelines
    - Centralised waiting list management – small pockets already in existence across different specialties

Key Messages

- All waiting lists must be maintained on hospital administration systems i.e. PAS
- Following a decision to admit, patients must be added to the relevant waiting list within 2 working days
  - Patients to be added to the Waiting List Form
- All OPCS codes must be entered onto PAS
- Patients should be added to either active or planned waiting lists according to policy definitions
  - Data definitions for Planned, Waiting List, Booked must be adhered to
- Clinical priorities must be identified – 2 streams "Urgent" and "Routine"

Key Messages

- Patients who have agreed the date and time of their admission, and who DNA, will normally be referred back to the referring clinician
- Under exceptional circumstances a clinician may decide that a 2nd admission date should be offered – the second admission date must be agreed with the patient
- Where a fixed appointment has been issued, patients will have 2 opportunities to attend
- If patients cancel their TCI date, they will be given a second opportunity (within 6 weeks)
- Where a hospital initiates a cancellation (for non-clinical reasons), an alternative reasonable TCI date will be offered within a maximum of 28 days

Received from Mairead McAlinden on 20/06/2022. Annotated by the Urology Services Inquiry.

Underpinning Principles

- Robust process developed to ensure compliance with consultant leave policy
  - Taken forward by Medical Directorate Office
- Where a decision to admit depends on the outcome of diagnostic tests, patients should not be added to the elective waiting list until diagnostic results known
- Patients will be given reasonable notice
  - Minimum of 3 weeks and a choice of 2 admission dates

Received from Mairead McAlinden on 20/06/2022. Annotated by the Urology Services Inquiry.

Development of Pre-Operative Services

- 100% of patients for elective procedure must have an appropriate form of pre-operative assessment by 31st March 2009
  - Interim target of 75% by 1st January 2009
- Pre-op assessment will be brought back to the out-patient stage of the journey, initiating with a health screening questionnaire on the day of DTA being made – 100% of patients
- Following review of questionnaire a percentage of patients will require a full face-to-face assessment – anticipated to happen within a week of initial assessment

Personal Treatment Plans (PTPs)

- Personal Treatment Plans must be put in place for patients who:
  - have been cancelled by the hospital
  - are suspended
  - are a potential breach
- The plan should be:
  - agreed with the patient
  - recorded in the patients notes
  - Monitored to ensure the PTP is delivered

Cancellations/DNAs

- Patient DNAs (after accepting reasonable offer) – remove
  - Creates – clinical risk/vulnerable adult
  - Communicate with GP re new date
- Patient cancels/refuses second reasonable TCI offer – can be removed (IS offer is regarded as reasonable)
- All waiting list removals should have a letter to GP and a letter to patient

Hospital Initiated Cancellations

- All hospital initiated cancellations should be escalated to appropriate line manager/operational support lead
- Patient must have another offer within month if maximum wait patient, or within 28 days
- Must have a personal treatment plan
  - New date before cancellation
  - Reason for cancellation recorded
- Letter to be issued with
  - New date
  - Reason for cancellation
  - Apology

Waiting List Suspensions

- Patients can be suspended for social or clinical reasons for a maximum period of 3 months
- If suspending a patient an action plan is needed prior to re-instatement on waiting list to check availablility/fitness for surgery
  - Waiting List Suspensions Policy and PTP
- Suspended patients will have a review date – all review dates will be set up for the 1st of the month (form)
- If unavailable for more than 3 months remove from waiting list
  - Letter to GP and patient
  - Re-refer back when fit and available
- Impact on students/pregnant patients
- Trusts are to ensure that suspension levels are no greater than 5%

Planned Patients

- Planned patients are defined as those patients who for clinical reasons require their treatment at a set point in time in the future
  - Endoscopy patients – repeat procedure in one year
  - Cataract patients – one eye added to waiting list, second procedure is planned
  - Injection patients – first injection waiting list, second and third is planned
- Patients should not be added to a planned waiting list where resource issues are the reasons for being planned, eg, lack of equipment
- Planned patients should be included in scheduling of theatre sessions bearing in mind patients expected admission date.
  - Guidance on the management of planned patients on PAS
- Currently a backlog of planned patients as the Trust focused on delivering access targets – a recovery plan has now been submitted to address the backlog

General Principles

- Don't add to waiting list if
  - Not clinically fit for surgery
  - Still awaiting for diagnostics which prevent surgery
  - Patient undecided or not available immediately
- Patients/GPs should know if patients are on a waiting list and should know if they are removed
- We have responsibility to offer reasonable notice
- Patients have a responsibility to:
  - confirm intention to attend, and
  - actually attend

General Principles

- Need to reduce hospital initiated cancellations and increase our planning cycle
- If it becomes known that a patient has not been added to a waiting list, or incorrectly added to a waiting list – this must be escalated immediately to the appropriate line manager/Operational Support Lead
  - Procedure for dealing with patients who have not been added, or incorrectly added to an elective waiting list
  - Affect on scheduling and Service Delivery Plans

The Way Forward

- Fully booked elective patient pathway
  - Patient attends OPD
  - Added to waiting list on day
  - Complete POA health screening questionnaire
  - If need TCI in less than 6/52 attend POA on same day and leave with date TCI
  - If need TCI after 6 weeks, receive partial booked appointment for POA or have telephone assessment
  - Leave POA appointment with date to come in if appropriate or action plan “to get ready”
- New process/thinking required to deliver this model
  - Links to new theatre management system with POA and direct theatre scheduling
  - Defined capacity planning
  - Administratively intensive initially

Service Delivery Unit Visit - Feedback

- Key recommendations/actions made both at a corporate and operational level
- All patients to be listed on PAS within 2 working days of a decision to list
  - Waiting List Additions Form
- All patients added to WLs should have their procedure coded
  - Achieved
- Patients will only be added to active waiting list if fit/available to come in
  - Trust should continue to monitor performance against standard
- Patients should be managed in 2 streams – urgent and routine
  - Achieved
    - Recognition of red flags

Service Delivery Unit Visit - Feedback

- Planned Patients should be monitored where the indicative month of treatment is in the past
  - A recovery plan to address the backlog to be developed
    - Submitted and funding secured to address backlog
  - Operational capacity planning must take into consideration clinical timeframes for planned patients
    - Service Delivery Plans
    - Scheduling of patients

Service Delivery Unit Visit – Feedback

- Suspended Patients
  - IEAP training programme must highlight the suspension standards and put in place processes to manage same
    - Awareness training today as well as supporting policy document
- Pooled Lists
  - Recognition of the good work in pooling of specialty specific waiting lists
  - Good practice should be shared across the organisation
    - Plans being developed initially for pressured specialties

Service Delivery Unit Visit - Feedback

- Agreed escalation process in place between admin staff (clerks/secretaries managing waiting lists) and operational/senior managers
  - Escalation process for cancellations, Omissions from waiting lists, etc included within this awareness session and supporting information pack
- Cancelled Operations
  - Levels and reasons for cancelling operations should be routinely monitored
    - Data collected via theatres
    - Theatre escalation policy

Received from Mairead McAlinden on 20/06/2022. Annotated by the Urology Services Inquiry.

Appendices

- Please take these away with you today and read them!
  - Flow chart for booking process – draft format
  - Patients to be added to the waiting list form
  - Procedure for Dealing with Patients Who Have Not Been Added, or Incorrectly Added to an Elective Waiting List
  - Personal Treatment Plan (PTP) to be used when backdating patients onto waiting list for elective treatment
  - Guidance for the management of planned patients on PAS
  - End User Letter Codes
  - Procedure for Managing Waiting List Suspensions

Questions

?

Southern Health and Social Care Trust

Quality Care - for you, with you

CORPORATE RISK REGISTER

to Governance Committee

10th September 2013

Reviewed by SMT on 28th August 2013

Summary of Corporate Risks as at August 2013

There are 18 Corporate Risks (8 high level and 10 moderate level) as agreed by the Senior Management Team on 28th August 2013

Note – Red font indicates the changes that have been made to the Register since June 2013

** Denotes areas highlighted for detailed review at next monthly SMT (September 2013)*

Risk No.	HIGH RISKS	* Corporate Objective	Risk Rating	Change to Status since January 2013
1.	Ongoing achievement of PfA access targets and review appointments	1	HIGH	Unchanged
2.	Achievement of statutory duties/functions - Level of Residential Home/Nursing Home/ Domiciliary Annual Reviews not completed - Care Management processes*	1	HIGH	Unchanged
5.	Insufficient capital to maintain and develop Trust estate (facilities, equipment etc) to support service delivery and improvement	1	HIGH	Unchanged
7.	High Voltage capacity limit on electrical supply to Craigavon Hospital	1	HIGH	Unchanged
9.	High Pressure Hot Water System	1	HIGH	New risk added on 27.03.13
14	Accreditation status of Laboratory, Craigavon Area Hospital	1	HIGH	New risk added on 26.06.13
16	Financial Balance – risk in 2013/14 that the Trust will not achieve financial balance in year	5	HIGH	⇧
18.	Implementation of Business Systems Transformation Programme*	5	HIGH	Unchanged

Risk No.	MODERATE RISKS	* Corporate Objective	Risk Rating	Change to Status Since January 2013
3.	Systems of assessment and assurance in relation to quality of Trust services	1	MODERATE	Unchanged
4.	Compliance with Standards and Guidelines	1	MODERATE	Unchanged
6.	Fire Safety	1	MODERATE	Unchanged
8.	Asbestos – legal compliance with legislation*	1	MODERATE	Unchanged
10.	HCAI	1	MODERATE	Unchanged
11.	Risk of harm to patients from water borne pathogens	1	MODERATE	Unchanged
12.	Protection of Vulnerable Adults – inconsistencies in practice and issues with interagency working*	1	MODERATE	Unchanged

Risk No.	MODERATE RISKS	* Corporate Objective	Risk Rating	Change to Status Since January 2013
13	Robust Business Continuity Planning*	**1**	**MODERATE**	Unchanged
15	Fully Embedded Appraisal system	**4**	**MODERATE**	Unchanged
18	Management and monitoring of procurement and contracts	**5**	**MODERATE**	Unchanged

Corporate Objectives

1: Provide safe, high quality care.

2: Maximise independence and choice for our patients and clients.

3: Support people and communities to live healthy lives and improve their health and wellbeing.

4: Be a great place to work, valuing our people.

5: Make the best use of resources.

6: Be a good social partner within our local communities.

Southern Health & Social Care Trust: Summary of Corporate Risks as at August 2013

No	Risk Area and Principal Risks	Key Controls	Action Planned/Progress update (August 2013)	Lead Director	Status
1	Achievement of Priority for Action access targets and review appointments to secure timely assessment and treatment • A number of inpatient/day case/outpatient waiting times beyond access standards/targets (Acute,OPPC and Mental Health areas) • Outreach specialties (oral surgery, ophthalmology, etc) not within control of Trust • Outpatient Reviews in a number of specialties significantly beyond clinical review timescales • Plain film X Ray reporting only maintained at current level of Ionizing Radiation Medical Exposure Regulations with unfunded additional capacity and no regional standard for areas appropriate for Ionizing Radiation Medical Exposure Regulations	• Bi-weekly reporting to Senior Management Team • Monthly reporting to Trust Board • Action plans in place for reductions in waiting times with associated business cases submitted for capacity gaps where defined/agreed. • Fortnightly Elective Performance meetings with Health and Social Care Board • Outpatients Review backlog action plan in place and being incrementally implemented. • Identification of capacity gaps to HSCB for non recurrent funding for additional capacity on a specialty basis	• On-going work with Health and Social Care Board to agree capacity gaps and associated recurrent funding requirements. A number of Investment Proposal Templates (IPTs) submitted and others to be developed after notification of Commissioner intent to proceed. Offers now made by Health and Social Care Board for General Surgery, Gynaecology and ENT investment. Ongoing discussion regarding level of funding proposed. • Engagement with Health and Social Care Board on Quarter 1 and Quarter 2 bids for non recurrent funding for all specialties with gaps with requirement to maintain access at March 2013 and improve in accordance with Commissioning Plan targets for 2013/14 position by September 2013. Capacity increased both in-house and in Independent Sector (IS). • Independent Sector contracts rolled over into 2013/14 for Ophthalmology, Orthopaedics, Gynaecology and new contracts being procured for Ophthalmology, Orthopaedics, General Surgery, Pain Management, Urodynamics, Mobile MRI and Mobile Catherisational Laboratory capacity • Business case for Team South Urology approved (July 2011). 3 Urologists are now in post. • Consultant recruitment for local Ophthalmology service successful with the lead post appointed. Recruitment for second Consultant	Performance and Reform/ Operational Directors	HIGH

			post not yet successful • In house additional capacity utilised where possible within funding allocated • Recovery plans developed for AHP services – awaiting Commissioner response Plain Film X Ray • Independent Sector and In-house additionality utilised (but unfunded) to maintain reading of non-Ionizing Radiation Medical Exposure Regulations plain film X Rays at 28 days • Phase 1 Action Plan in progress. Phase 2 report received and Action Plan developed. Action Plan sent by Chief Executive to Chief Medical Officer and Health and Social Care Board to seek clarification on timescales and process for regional actions. Response received and regional group now convened. • Proposal developed to extend range of x-rays read by Radiographers to be submitted to Commissioner with repeated request for recurring funding for Independent Sector additionality (see above). Current costs of £14K per month Outpatient Review Backlog • Whilst significant reduction in volume of review backlog achieved initially in the number of routine waits in Q3 and 4 of 2011/12, there has been an increasing trend in 2012/13 as the system continues to bring in significant volumes of in-house additional new patients to meet access targets.		

			• Trust anticipates a rolling backlog in reviews until recurrent demand/ capacity gaps have been addressed. • Of the total waits, 88% of those waiting have been waiting from 1 April 2012. • The largest volumes of waits are in Urology and ENT with the longest waits in Urology. • Work continues to cleanse lists and Specialist Nurses are working with relevant consultants to screen urgent reviews and longest waiters • Whilst some funding has been provided in 2012/13 to address review backlog, capacity to put in the place the additional capacity required is limited by availability in specialties that have capacity gaps and require to utilise capacity to maintain access times for new referrals also. • Health and Social Care Board has agreed funding to address review consequences of new in-house additional capacity being delivered in 2013/14.		
2	Achievement of statutory functions/duties: Care Management Processes. Risk includes: • Level of Older People and Primary Care Residential Home/Nursing Home/Domiciliary clients Annual Reviews not completed. • The Trust should have robust care management communication processes in place and	• Monthly monitoring of reviews undertaken by Head of Service/Assistant Directors • Group established to examine operational management of the annual review process • Delegated Statutory Functions Report • Monthly reporting to Trust Board (from August 2013) • Annual meeting with Heath & Social Care Board Director of Social Care/Children's Services	• Domiciliary Care Reviews – monthly reporting exercise underway to identify the number of reviews carried out and those outstanding. • Reviews completed by 31/7/2013: Domiciliary Care: 75.3% Nursing Homes – 80% Residential Homes – 84% Overall completion rate – 77% 24.7% have been waiting longer than a year to have their reviews carried out	Older People and Primary Care	**HIGH**

	an assurance through audit that staff are appropriately undertaking these functions, including a clear understanding of the relative roles and responsibilities of the Trust's professional staff, contracts and finance functions, and clarity about the roles and responsibilities of RQIA and the Office and Care and Protection within the Care Management process.		• Care Home Support Team (Permanent Placement Team) in process of establishment. This team will be established by end 2013. The service model will be developed to carry out reviews for all clients in Nursing/Residential Homes and contract reviews etc. • Adult Safeguarding Team to consider further targeted vulnerable adults training for those staff in care management and involved in annual reviews. • The review of care management processes has been completed. Draft operational guidance and recommendations from the review approved by the Senior Management Team on 26.6.2013. Implementation Plan drafted and agreed by the Senior Management Team.		

3	Systems of assessment and assurance in relation to quality of Trust services	• Clinical and Social Care Governance Review completed and new structures/processes embedded • Update on progress to Governance Committee on a quarterly basis • Governance Committee, Senior Management Team and Governance Working Body in place and operating to agreed remit • Directorate, Division and Professional Governance Fora in place and reporting to Senior Management Team/ Governance Committee • Caspe Healthcare Knowledge Systems (CHKS) comparative mortality benchmarking tool - contract in place and information extracted for governance information • Review of Specialty Mortality and Morbidity system completed. • Mortality Reports to Governance Committee • Chair/Chief Executive/Director/Non Executive Director programme of visits in place and feedback to Chief Executive • Executive Director of Nursing report to Trust Board showing performance against Nursing Quality Indicators (NFIs) • Serious Adverse Incident/Adverse Incident reporting system in place	• Web-based incident reporting (on Datix) rolled out across the Trust • Work has commenced on review of Risk Management Policy • Clinical and Quality indicator programme of work across Directorates • Internal Audit Review of Clinical and Social Care Governance achieved satisfactory assurance. Report presented to Governance Committee - September 2013. • Review of Mortality and Morbidity process underway to be completed by December 2013, ensuring that all aspects of care considered (via nursing input) and outcomes fed into Governance systems	Chief Executive Medical Director	MODERATE

	Learning from Adverse Incidents, complaints and user feedback - lack of formal, embedded system of learning	• For Serious Adverse Incidents and appropriate level of Adverse Incidents, investigation/Root Cause Analysis process embedded with reports to Director/Senior Management Team Governance to approve recommendations/actions and ensure shared learning • Governance Committee Senior Management Team, Governance Working Body, Divisional and Directorate Governance Fora, Professional Governance Fora, Patient and Client Experience Committee for shared learning	• 4 issues arising from Serious Adverse Incidents brought to Governance Working Body and being taken forward for organisational learning. Progress updates to Governance Committee on a rotational basis.		
4	Compliance with Standards and Guidelines (S&G) • From 1st April 2007, a total of 736 standards and guidelines have been externally endorsed to the SH&SCT by a range of external agencies and placed on the Trust register. Due to the volume/ complexity of new S&G being issued to the Trust by external agencies, it is a challenge for the Trust to monitor and review the compliance status of all of these S&G • From 1st April 2012 to 30th June 2013, a total of 279 new standards and guidelines have been	• Standards and Guidelines Risk Assessment and Prioritisation Group established in April 2011. All newly issued S&G have been reviewed and managed through the new corporate process prior to sending to the nominated Lead Director and Change Lead for action • New AMD for Standards and Guidelines (Acute Services) in post from 1 April 2013 • Establishment of six monthly performance/accountability reports for standards and guidelines. • Standard item for discussion at SMT (monthly) and Governance Committee with submission of relevant reports /	• Since 4/10/2012 a BSO graduate intern has undertaken a comprehensive look back exercise to identify all standards and guidelines that have been issued from 1/04/2007 to 31/03/2010. A total of 281 standards and guidelines have been identified and added to the Trust S&G register. The systemic review of these identified circulars is currently being finalised by the relevant Operational Directorates for prioritisation and action planning (where required) and provision of a statement of assurance to confirm that the required recommendations have been embedded within clinical practice. The outcomes from this look back exercise will be captured within the Trust S&G Accountability Report. • There is a need to establish a more effective information system for the	Chief Executive	**MODERATE**

	regionally endorsed from a range of different external agencies. There were 116 standards and guidelines received during 2011/12. This has been a 97% increase in service activity. • There is often a time lag between when the external agencies require the Trust to achieve full compliance and when this is actually achieved • From 1/9/2013, the Patient Safety and Quality Manager's post will be vacant for 1 year	assurance statements • Standard item for discussion at the Directorate Governance meetings with submission of relevant reports • For those that are 'pharmacy' related a compliance report is also presented by the Trust's Medicines Governance Pharmacist to the Operational Directors and members of the Drug and Therapeutics Committee on a quarterly basis. • Database established and system in place for logging and monitoring • SABS system in place for Safety Action Bulletins • Process map to ensure effective dissemination and management of Safety Action Bulletins	logging and project management of these standards and guidelines in order to ensure all actions are being progressed within the specified timescales by the nominated change lead. Given the volume of standards and guidelines within the system, this is now urgently required in order to effectively manage the risk and ensure that work is being progressed and monitored on an ongoing basis. • Additional Band 2 appointed for one year to support Standards & Guidelines.		
5	Insufficient capital to maintain and develop Trust estate to support service delivery and improvement	• Maintaining Existing Services prioritised investment plan agreed by Trust Board and shared with Department • Recent capital allocations have addressed highest priority risks. This process is on-going. Capital Resource Limit also utilised where possible to address highest risk • Strategic development plans in place for major projects and business cases submitted for highest risk areas	• On-going prioritisation and bidding process for capital in place • Fire Safety Action Plan in place and agreed to inform Maintaining Existing Services investment • Recommendations from RQIA hygiene inspection reports prioritised for Capital Resource Limit/Minor works where no other funding source available • £1.99m Maintaining Existing Services funding secured for 2013/14. • Craigavon Area Hospital Main Theatres Refurbishment Project is on	Performance and Reform	HIGH

		Specific examples: • Fire Safety Action Plan in place (see below) • High Voltage capacity limit on supply to Craigavon Area Hospital Identified (see below) • High pressure hot water system (HPHW) at Craigavon Area Hospital (see below) • £2.9m secured to complete structural works to tower block at South Tyrone Hospital	programme. The 4 theatres have been completed and are in use and work has commenced on the new recovery ward. The final phase is due for completion by May 2014. • Business cases in development to address significant Maintaining Existing Services infrastructure issues requiring investment > £500k Business cases for High Voltage/Electrical works and Mechanical Infrastructure have been approved by DHSSPS enabling works to progress during 2013/14. • Structural engineer reports commissioned for sites at higher risk to inform action plan		
6	Fire Safety and compliance with Fire Safety Regulations (NI) 2010	• Fire Safety Action Plan in place and to be monitored quarterly • Local Fire Safety Management Arrangements in place • Funding to resolve deficiencies – prioritised within Maintaining Existing Services • Approximately £1.1 million was invested in 2012/13 to improve fire safety by upgrading the fire alarm system in Daisy Hill Hospital, fire compartmentation works throughout the Trust and installation of the bed escape lifts at Craigavon Area Hospital	• Staff training on-going • New methods for delivering mandatory fire training agreed and to be implemented and tested 2013/14 • Programme of fire risk assessments and fire drill exercises in the hospitals are being carried out • Initial Firecode funding allocation from Maintaining Existing Services for 2013/14 c. £450k is for fire alarm systems which is to be directed to next highest priority risks and further funding continues to be sought • 2013/14 MES funding bid for bed escape lifts in Daisy Hill Hospital and new stair – funding not provided in initial allocation • Minor alterations to be carried out to escape stair in Daisy Hill Hospital to more easily accommodate ski sheet evacuations • Internal Audit undertaking audit July/August 2013	Performance and Reform	MODERATE

7	High Voltage capacity limit on electrical supply to Craigavon Area Hospital • Identified under Maintaining Existing Services scheme • Possible limit to expansion of service provision on the Craigavon Area Hospital site • Increased electrical demand on existing limited supply may exceed capability of supply	• All future development/ expansion of the estates is to be notified to Estate Services • Generator backup • Load shedding • Monitoring current demand • Business Continuity Plans for restabilising electrical service in the event of unplanned interruption	• Schemes to provide a new supply for the site are ongoing with Northern Ireland Electricity. A new 6MVA supply has been agreed. Site wide installation of High Voltage supply now ongoing. (our current position is this project is not sufficient to significantly impact the overall risk rating). • Independent experts appointed to provide Infrastructure condition report and inform plans for new High Voltage/Low Voltage infrastructure • Mechanical Infrastructure and Electrical Infrastructure Business Cases have been approved and these projects are being progressed in parallel as both Combined Heat and Power (within Mechanical) and new High Voltage intake (within electrical) Strategic Outline Case are required to manage the onsite risk. • Peak Lopping is installed and completed following agreement with Northern Ireland Electricity • Phase 1 business case for Low Voltage works to provide short-term mitigation for risks approved in June 2012 for £2.5m works now completed.	Performance and Reform	HIGH
8	Asbestos and compliance with Control of Asbestos (N.I.) 2007 • Risk of exposure to asbestos by being unable to identify existing asbestos across all Trust property and from lack of a unified/single asbestos management plan.	• Estates Services Asbestos Management Group • Asbestos Policy in place • Revised Asbestos Management Procedures in place • Refurbishment and Demolition Surveys performed when significant work is required on any facility older than 2000 • Asbestos Registers in two legacy systems plus one on-line system	• Re-survey of all applicable Trust facilities has been undertaken. • One year's management inspections integrated into the Trust's existing Asbestos Register.	Performance and Reform	**MODERATE**

9	Upgrade of High Pressure Hot water System (HPHW) at Craigavon Area Hospital required • Reliance on a single set of heating pipes for heating and hot water into all hospital areas in the main hospital block and for conditioned air for critical air handling plant into theatres etc. • Pipeline and expansion bellows beyond recommended lifespan and failure would have major impact on provision of hospital services/lead to temporary closure	• Independent expert inspection carried out at end of March 2013 • Full business case for replacement of the HPHW system/mechanical infrastructure (£8.1m) approved July 2013. • Mitigating measures (Priority Risk Mitigation and Enabling Works) have been designed to provide resilience to the system as an interim measure with the following now in place (as at 29.3.2013) - Replacement bellows ordered to facilitate urgent repairs if required - Hot air blowers on site • Emergency Plans/Business Continuity plan controls in place (see corporate risk 13)	• Service Contingency plans in place. However, due to delay in business case approval, contingency plans will be reviewed due to works programme extending into winter. Additional temporary plant will be required for CSSD plant room • Implementation of mitigating measures (Priority Risk Mitigation and Enabling Works) - Works to reconfigure the system to connect exiting steam supply to some heat exchangers and ventilation plan that will support maintenance of some hospital/theatre services - Provision of temporary Packaged/Mobile Boiler Houses to maintain acceptable but not optimum heating levels and hot water to most hospital areas	Performance and Reform	**HIGH**
10	HCAI • Risk to achievement of Priorities for Action target identified • Risk to patient safety • Financial impact of retaining Ramone Ward facility • Lack of automated HCAI surveillance system linked to Trust laboratory system	• Dedicated isolation ward on Craigavon Area Hospital site • Comprehensive isolation policy in place and strictly adhered to • On-going mandatory and tailored training • Manual surveillance systems in place • Comprehensive governance structure in place, including bi-monthly Strategic Forum and fortnightly Clinical Forum • Outbreak /incident management plan in place • Independent and self-audit programme in place • Extensive action plans in place	• On-going measurement of compliance against DHSSPS Communiqués • Ongoing self auditing using the RQIA Audit tools. Compliance statement completed August 2013 and action plan developed • Neonatal RQIA audit completed July 2013 • Measurement of compliance with RQIA Governance Audit Tool and presentation to HCAI Strategic Forum in May 2013 • Learning outcomes from RCAs being shared with senior and junior medical staff – May 2013. Further involvement with GPs on c.difficile cases planned. • Further development of Urinary	Medical Director	MODERATE

		to deal with trends/prevalent HAIs • Antibiotic stewardship including antibiotic ward rounds • Root Cause Analysis process in place • Compliance monitoring against key DHSSPS standards and guidelines relating to HCAI	Catheter project to target E-coli infections. Snap shot audit undertaken. Major staff awareness audit to commence in September 2013 • Engagement with PHA and HSCB on funding streams for Ramone facility (August 2013) • Engagement with PHA on Regional Surveillance system funding and procurement to recommence in September 2013		
11	Risk of harm to patients from water borne pathogens (i.e. legionella, pseudomonas)	• Water Safety Group in place • Water Safety Plan • Revised Legionella policy and procedures in place • Compliance with PHA and HEIG guidance: HSS(MD)6/12 - Water sources and potential for pseudomonas aeruginosa infection from taps and water systems • Legionella risk assessments, sampling and monitoring regime in place (as per L8, PHA & HEIG), results analysed, appropriate action taken as required • Pseudomonas sampling and monitoring regime in place in Neonatal Unit and Special Care Baby Unit; in progress in augmented care • IPC guidance on environmental cleaning developed and rolled out (sinks, equipment, etc.) • Infection prevention and control guidance and procedures are continuously reviewed, modified and issued to address	• A water dosing system for copper sliver ionisation of Ramone Building is currently under trial • Extension of legionella testing areas • Consideration of opportunities to increase automated water temperature and flow monitoring • Review of resources needed to manage water quality systems (Microbiology, IPC and Estate Services) completed and identified to Health and Social Care Board/Public Health Agency as part of an overall organisational assessment of the unfunded impact of meeting standards and guidelines (July 2013) • Independent review of water safety plans completed and draft report received – assurance and recommendations agreed at Water Safety Group (July 2013) • £450K MES funding secured for priority works identified through risk assessments	Director of Performance & Reform/ Medical Director	MODERATE

		emerging risks • Infection prevention and control audit programme and implementation of appropriate actions based on findings • On-going staff education programme highlighting risks of water borne pathogens • Design of water systems within care facility/environment; attention is given to designing system that will reduce the likelihood of propagation of water borne pathogens			
12	Protection of Vulnerable Adults – inconsistencies in practice and issues with interagency working	• Lead Director and lead professional for Adult Safeguarding in place and Safeguarding Partnership Board/Forum/structures in place • Specialist Safeguarding Team to provide advice and support • Procedural guidance completed • Training to all managers • Report to Trust Board as part of Statutory Functions Reporting • Action Plan to Governance Committee • Director of Social Work Report to Trust Board	• Corporate Mandatory Vulnerable Adults training on-going. Investigating Officer/Designated Officer training planned for September/October 2013. • Email issued to Assistant Directors on 11.7.2013 advising of updated position regarding Soscare Vulnerable Adults module. Compliance rate increased to approximately 54%. Assistant Directors requested to draw this to the attention of staff. Meeting with Community Information Department and ICT requested by Safeguarding Lead. • Protection of Vulnerable Adults Forms updated to take account of learning arising from local research paper. These were issued to all staff and to domiciliary care/residential/nursing home providers for immediate implementation. The new alert form to be issued to all community and voluntary providers. This information will form part of the roll forward letter.	Director of Children and Young People's Services/ Executive Director of Social Work	MODERATE

			• 'Sharing the Learning' conference planned for December 2013 with Margaret Flynn, author of Winterbourne View SCR report as keynote speaker. • Trust response to regional safeguarding training plan includes requirement for Joint Protocol/Achieving Best Evidence (JP/ABE) safeguarding staff to attend minimum of 2 support sessions and 2 refresher training support sessions per annum. • First phase of expression of interest process completed. 9 ASW staff taking up new role. 2nd phase underway. IPT1 proposal for 2013/14 monies approved by SMT and forwarded to HSCB.		
13	Development of robust Business Continuity Planning arrangements	• Performance management arrangements in place between Public Health Agency/ Health and Social Care Board and Trust • Further development of plans for severe weather • Engagement of Consultant • Business Continuity Management Policy • Corporate Emergency Management Plan • Trust wide Business Impact Analysis • Progress reports provided on a monthly basis by the Business Continuity Manager to the Medical Director • Updates provided to Senior Management Team via Medical Director's report and Governance Committee	• A standardised template developed to assist Heads of Service with the review and/or development of Departmental Business Continuity and Emergency Response Plans will be issued to Directors/Assistant Directors by early summer 2013. • To ensure robustness, Emergency response and Business continuity plans are best tested at the operational level (service and department) . At least 2 high level exercises will be carried out in 2013-14. This will test the overall Trust response at a high level. Arrangements will also be put in place to encourage managers to test their own individual plans annually. This will be monitored through the Medical Directors office.	Medical Director/ Operational Directors	**MODERATE**

14	Inability of Laboratory at Craigavon Area Hospital to maintain its Biochemistry Accreditation Status	• Action Plan in place to address non-conformances • External Quality Assurance and Internal Quality controls	• Action plan updated as progress is made. • Application for re-accreditation to be made in October 2013		**HIGH**
CORPORATE OBJECTIVE 4: BE A GREAT PLACE TO WORK, VALUING OUR PEOPLE					
15	Fully embedded appraisal system – lack of evidence of compliance	There are a variety of mechanisms in place to ensure appraisal takes place:- • Consultant Appraisal • Professional Supervision • Knowledge and Skills Framework (KSF) policy and monitoring system in place • KSF Staff Attitude Survey results provide staff view	KSF / PDPs are operational in the Trust. It is recognised that the majority of professional staff groups avail of the Supervision process, therefore the current focus is to ensure the unregulated workforce has the opportunity to have a Personal Development Review meeting with their Line Manager and develop a Personal Development Plan. Directorate aligned staff from the Vocational Workforce Assessment Centre meet with teams, managers or staff on a one to one demonstrating the documentation, giving support and encourage team leaders to complete Personal Development Plans (PDP's) with their staff. From January 2013 to May 2013, 70 KSF awareness sessions have been delivered in different locations throughout the Trust. These sessions are on-going. They have been very well attended by staff (725 in total) from various disciplines and various bands. There has been a significant increase in completed PDP forms being returned to HR. Vocational workforce Assessment Centre staff follow up staff that has have had KSF awareness training but	Director of Human Resources	**MODERATE**

			have not yet completed their PDP form and give them assistance where necessary.		
CORPORATE OBJECTIVE 5: MAKE THE BEST USE OF RESOURCES					
16	• Achievement of financial balance in 2013/14 2013/14 to include requirement for cash release • In year • Recurring	• Contingency Plan for 2013/14 in place • Best Care Best Value (BCBV) Project structure • Financial monitoring systems in place • Monthly report to SMT and Trust Board	2013/14 Budget approved by Trust Board on 30th May 2013 A revised TDP was submitted to HSCB in July 2013 and a number of meetings have taken place with the commissioner – this work is ongoing. HSCB requested all Trusts to submit a break-even plan which would include measures that had minimal impact on services. The Trust has submitted a plan totalling £3.2m and in doing so clearly identified any service impacts to patients\clients. The Trust awaits the consideration of HSCB. Trust has put in place directorate monitoring meetings to review progress against all TYC plans both in terms of deliverability in year and recurrently. Older People and Primary Care Directorate has a continued focus on community care expenditure which includes Domiciliary Care and Care Home bed expenditure with a view to reducing current over expenditure and identifying opportunities for cash releasing. In respect of the financial pressure arising through nursing paybill, the Acute Directorate has undertaken a workforce review using 4 different tools for comparative purposes and is	Finance and Procurement/ All	**HIGH**

			currently engaged with the Public Health Agency/ Health & Social Care Board re these tools which demonstrate a usage that is compatible with the tools, but in excess of funded staffing levels		
17	Management and monitoring of procurement and contracts – not compliant with best practice guidance	• Clarification required with respect to Centre of Procurement Excellence coverage and capacity. Issue raised with A McCormick July 2011 seeking regional way forward • Interim approach for social care procurement agreed by Senior Management Team in absence of Centre of Procurement Excellence support including awareness training for Community Contracts Team and 'light touch' support/advice to ongoing procurements by Centre of Procurement Excellence • Contracts management improvement group established and key actions formed • Bimonthly reporting to SMT • Project Team established and central database for all identified local Trust contracts in place. • New guidance on Single Tender Action (STA) processes issued and implemented. Follow up training provided in March 2013. • Training on Contract Management with focus on responsibilities of Contract Owners rolled-out in November with follow up sessions delivered in January 2013	• Action plans in place to address weaknesses identified in Internal Audit reports with updates to Senior Management Team and Audit Committee • Monitoring reporting in place providing a summary position on procurement status/risk at Directorate level and follow up actions with Directorates ongoing • Interface meeting established with BSO/PaLS and process agreed for prioritization of e procurement requirements within available capacity. • Additional capacity for procurement sourced via third party provider contracted by BSO/PaLS. Further small amount of in-house capacity has been established to support low risk procurements in Estates and support key social care procurements (Domiciliary Care and Meals) under influence of CoPE • Trust has responded to draft recommendations of J. Allen Review of Procurement. Final recommendations of Procurement Policy awaited • Proposals brought forward by Trusts on regional basis to address procurement deficit for Estates services not agreed regionally. Regional Social Care	Performance and Reform/ Finance/All	MODERATE

			Procurement Group developing strategy for social care procurements. No agreed regional way forward for procurement capacity gaps. Issues continue to be raised with DHSSPS and Regional Procurement Board		
18	Implementation of Business Systems Transformation Programme • Maintenance of existing services over the 12-18 month implementation period in light of the potential retention and morale impact on those staff to be displaced • Disruption to ongoing business resulting from the secondment of 26-30 staff to oversee the implementation • Disruption to transaction processing/quality of management information/financial forecasting and achievement of financial duties • Maintenance of staff preparedness in light of absence of clear confirmation that system stability and functionality issues have been resolved and an achievable 're-plan' put in place	• The Trust has established an implementation structure • Engagement in regional process • Chief Executive letter to Ms Julie Thompson, on behalf of Trust Board, requesting assurance that lessons have been learned from FPL and will be applied to HRPTS	• Human Resources strategy outlining the options for those staff potentially displaced • Secure backfill staff with the appropriate skills and experience on a timely basis • The Trust may need to reschedule corporate priorities as the workload associated with the implementation increases • The Human Resources Payroll, Travel and Subsistence (HRPTS) side continues to face delays and contractual difficulties. It is expected that this side of the implementation will be delayed until September/October 2013. There will be a knock-on effect on shared service implementation.	Human Resources/ Finance	HIGH

	• Transfer to Shared Services and maintenance of service delivery		• The Trust has agreed with BSO the establishment of pathfinder with effect from 1 October 2013 within recruitment. This will mean that 14 staff will move to the employment of BSO. • The Trust is seeking update in respect of HRPTS (functionality and costs).		

Changes to Corporate Risk Register since January 2013 to date

Date	Decision taken at	Changes to Corporate Risk Register
30th January 2013	**SMT**	Agreed removal of Corporate Risk No. 13 'Implementation of new regional on-call arrangements – will be managed as Directorate risk issue. Consideration to be given to escalation of Risk No. 15 'Financial impact of Transforming Your Care' from moderate to high risk in light of unresolved gap.
27th February 2013	**SMT**	Agreed to escalate 'Financial impact of Transforming Your Care' from moderate to high risk. Although Financial Plan in place, there are a number of risks aligned to this and the Trust will also require a contingency in each of the years of the CSR period. Agreed to downgrade Risk No. 5 'Lack of compliance with RQIA recommendations in relation to the supervision and administration of medication by Trust/independent agency domiciliary care workers, day care workers and Trust staff in Supported Living and Residential Homes' from high to moderate risk on the basis that the Trust has taken all possible actions within its control and is now escalating to regional level. Risk No. 9 'Asbestos and compliance with legislation' to be reviewed at end of March 2013 when surveys have been completed. Agreed additional element to 'Implementation of BSTP' Risk No. 19.
27th March 2013	**SMT**	Agreed additional risk relating to High Pressure Hot Water System at Craigavon Area Hospital
15th May 2013	**SMT**	Combine Risk No 16 'Achievement of financial balance with Risk No. 17 'Financial Impact of Transforming Your Care'
26th June 2013	**SMT**	Agreed removal of Risk No 5 'RQIA recommendations in relation to the supervision and administration of medication by Trust/independent agency domiciliary care workers, day care workers and Trust staff in Supported Living Accommodation and Residential Homes' on the basis that the Trust has taken all possible actions within its control and has now escalated to regional level.

		Agreed additional risk (NO. 14) that Laboratory at Craigavon Area Hospital will not maintain its Biochemistry Accreditation status
28th August 2013	**SMT**	Review of risks and agreed no changes to status of current risks at this point in time. Discussed the risk that current levels of activity within Acute and OPPC Directorates are not funded by the Commissioner and agreed to include this under Risk No. 16 (financial risk). The following areas were highlighted for review at next SMT as regards downgrade/removal from the Corporate Risk Register:- Care Management processes Implementation of Business Systems Transformation Programme Asbestos Protection of Vulnerable Adults Business Continuity Planning

Investment Proposal Template (IPT3)
Revenue funding > £500,000 < £1,500,000
(unless in exceptional circumstances and approved by Commissioner for >£1,500,000)
Commissioner's Statement

Reference Number	
Commissioner Representative	**Mrs Lyn Donnelly**
Title	**Assistant Director of Commissioning for the SLCG**
Contact Tele No. & Email	Personal Information redacted by USI
Date	**December 2011**

1. **Strategic Context – (if provider requires to add any further information for strategic context this should be added to box 14 in the main proposal attached)**
Outline of Strategic Context within which the Commissioner is seeking service proposals. Reference should be made as appropriate to:
   - Priorities for Action.
   - HWIP.
   - Strategy, Policy or Service Review documents, Local, Regional, National.
   - Compliance with NICE, SMC and other appropriate recognised guidance on effectiveness.
   - Likely Board/LCG service shares.
   - Legislative/Statutory requirements.

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

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

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

and assessment for suspected urological cancer patients.

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

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

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

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

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

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

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

Network Development

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

Activity Assumptions

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

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

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

Team South Proposed FCE Activity		
	DC	**Admissions**
MY	877	248
AOB	877	248
MA	877	248
Cons4	877	248
Cons5	877	248
Total	4385	1240
Less Travel Impact		40
Overall Total	**4385**	**1200**

Pathway Development

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

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

Performance Indicators

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

Objectives

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

3. **Funding -**Summary of sources and amounts of available funding including:
   - Recurrent and/or non recurrent funding from commissioners (detailed by LCGs as appropriate)
   - Potential recurrent/non-recurrent funding from other agencies e.g. Supporting People monies from NIHE.
   - Capital funding where appropriate.

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

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

4. **Timescale and process for submitting**
Timescale within which providers should submit the completed investment decision making proformas to commissioners.
Timescales which providers will be advised of the commissioner's decision.
Arrangements for submitting completed documents.

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

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

PROVIDER SECTIONS

Provider	Southern Health and Social Care Trust	Submission date	**06 Feb 12**
Scheme Title	Urology Team South Business Case **FINAL V1.0 (Approved SMT 08 Feb 12)**		
Responsible Officer - including title	Mrs Heather Trouton, Assistant Director of Acute Services, Surgery and Elective Care		
Contact Details – Tele no. & Email	Personal Information redacted by USI Personal Information redacted by USI		

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

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

Background

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

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

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

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

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

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

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

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

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

2a) Objective(s) of this development - these will be examined in more detail in section 10 and 11)
Please complete the list below - please note that this list is not exhaustive but is a ***minimum requirement***

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

[1], [2] British Association of Urological Surgeons

catchment area		

2b) What are the Constraints of the Project?

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

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

Current Service Model

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

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

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

The Urology Team

The integrated urology team comprises:

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

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

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

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

Current Sessions

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

Table 1: Current Urology Sessions

	Craigavon	South Tyrone	Banbridge	Armagh	Total
Consultant Led OPs					
General	2.75 per week[1]	1 per month	2 per month	2 per month	4 per week
Stone Treatment	1 weekly				1 week

GPwSI & Specialist Nurse	**Weekly**
Prostate Assessment	1.5
Prostate Biopsy	1
Prostate Histology	1.5
LUTS	3
Haematuria	2
Andrology	2.5
General Urology/Uro Oncology	2.5
	14

Main Theatres (CAH)	**Weekly**	
	6	3 all day lists

	Craigavon	South Tyrone
Day Surgery		
GA	1 weekly	1 monthly
Flexible Cystoscopy	1.5 weekly[2]	
Lithotripsy	2 weekly	

1) 1 consultant led outpatient clinic at CAH is every week except the 3rd week in the month
2) 2 lists/1 list on alternate weeks

Current Activity

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

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

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

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

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

3) Option one: Status Quo or Base Case

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

Advantages

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

Disadvantages

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

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

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

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

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

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

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

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

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

Advantages

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

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

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

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

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

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

Disadvantages

Additional recurrent revenue investment will be required.

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

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

Advantages

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

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

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

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

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

Disadvantages

Additional non recurrent revenue investment will be required.

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

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

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

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

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

7) Identify and evaluate the overall benefits of all of the options

Consider costs and benefits to other parts of the public and private sectors

PLEASE LIST & SCORE BENEFITS THEN SHOW RANK OF OPTIONS

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

Robustness/Bias Test (Sensitivity Analysis)	If benefits are not delivered as expected above would the ranking change? There is a considerable difference between the total scores of options 2 and 3 which suggests that the ranking is relatively robust. The biggest risk to the scores achieved by the preferred option is around the ability to appoint one or more of the consultant urologists (this risk is addressed in more detail in section 13 below). However, it is the Trust's view that any detrimental effect on the benefits would be short term – ie if both consultant posts cannot be filled immediately, they will be able to be filled later. How much would costs increase before VFM (Ref Box 9 is impacted?

8) Financial Quantification of chosen option

Express Costing in total rather than incremental terms to expose full resource consequences

Please note which option is the preferred option -

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

Note: Detail to be contained in costing appendix.

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

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

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

Notes:-

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

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

9) Value for Money

A) Efficiency Savings (Where applicable)

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

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

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

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

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

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

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

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

10) Preferred Option (Insert option number)

Please rank costs and benefits and summarise reasons for selection.

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

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

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

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

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

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

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

2 additional consultants and associated support staff would be appointed;

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

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

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

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

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

SBA Activity

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

1) New outpatient appointments comprise 2328 slots at consultant led clinics & 1,620 at support staff clinics.
2) Review outpatient appointments comprise 3,681 slots at consultant led clinics & 1,724 at support staff clinics.

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

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

13) Assess Risks and Uncertainties
Identify the main risks associated with the proposal and how can these be mitigated – these should be scored using the Providers recognized risk scoring method

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

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

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

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

The consequence and likelihood are combined to provide a risk rating

Risk Rating

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

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

Inability to Appoint Consultant Urologists

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

Inability to Appoint Other Key Staff

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

Activity Projections are Not Achieved

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

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

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

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

Timetable for Implementation

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

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

15) Other relevant information

Please note any other appendices or attachments

HSCB Costing Schedule
Appendix 1 Team South Staffing and Costs
Appendix 2 Estimated Team Costs form the 'Review of Urology Services in NI, A Modernisation & Investment Plan'

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

Trust Authorising Officer		Date
Title		

Trust Director of Finance Signature		Date
Trust Chief Executive Signature		Date

17) Approval or rejection (Local/Regional Commissioning Use only-HSCB and PHA)

	Approved	Rejected (if yes detail reasons)	Approved in Principle (if yes detail reasons)
Yes/No			

Responsible Person

Signature Date Position

Authorising Person

Signature Date Position

Director of Finance Authorisation or delegated officer

Signature Date Position

Chief Executive Authorisation

Signature Date Position

SUMMARY OF FUNDS APPROVED – IF THIS DIFFERS FROM PREFERRED OPTION PLEASE DETAIL

TO BE UPDATED BY THE RESPONSIBLE OFFICER FOR TRAFFACS	**FYE of project (£)**	**CYE of project (£)**	**Non Recurrent (£)**
SOURCE OF FUNDS			

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

Commissioner Use only
Sign and Date for TRAFFACS update

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

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

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

Urology Staffing and Costs

v0.1 updated 12 Jan 2012

APPENDIX 1

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

Notes:-

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

Appendix 2

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

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

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

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

3.18% inflation

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

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

*2 – 0.5 allocated to each Team as per the Specialist Nurse
*3 – 0.5 allocated to each Trust Unit within each Team
*4 – 1 wte allocated to Belfast – for increased demand for pathology

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

Health and Social Care Board

Review of Urology Services in Northern Ireland

A modernisation and investment plan

March 2009

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1. SUMMARY OF RECOMMENDATIONS

Section 2 – Introduction and Context

1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.

2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.

3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

Section 3 – Current Service Profile

4. Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.

5. Northern Ireland Cancer Network (NICaN) Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.

6. Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model.

7. Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.

8. Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.

9. Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week.

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

Section 4 – Capacity, Demand and Activity

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

Section 5 – Performance Measures

12. Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

13. Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

14. Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

15. Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

16. Trusts should review their outpatient review practice, redesign other methods/staff (telephone follow-up/nurse) where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.

17. Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

Section 7 – Urological Cancers

18. The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.

19. By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.

20. Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

Section 8 – Clinical Workforce Requirements

21. To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.

22. Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.

23. At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010.

Section 9 – Service Configuration Model

24. Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.

25. Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.

26. Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

2. INTRODUCTION AND CONTEXT

Introduction

2.1 A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet Cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services.

2.2 A multi-disciplinary and multi-organisational Steering Group was established under the Chairmanship of Mr H. Mullen, Director of Performance and Provider Development and this group met on five occasions between September 2008-March 2009. Membership of the group is included in Appendix 1.

2.3 An External Advisor, Mr Mark Fordham, a Consultant Urologist, Royal Liverpool and Broadgreen University Hospital Trust, was appointed and attended all Steering Group meetings and a number of other sub group sessions.

2.4 Terms of Reference were agreed (Appendix 2), with the overall purpose of the review being to;

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

2.5 A literature search of guidance and policy documents was undertaken. This included consideration of reports on previous reviews in Northern Ireland. A list of the key documents considered during this review is included as Appendix 3. Sections in italics within this report are direct quotes from these documents.

2.6 During the course of the review, a significant number of discussion papers, detailed information and datasets were collated, copies of which are not included in this report but are available on request.

Context

2.7 The speciality of Urology predominately covers the assessment, diagnosis and treatment of Urogenital Conditions involving diseases of the Kidney, Bladder, Prostate, Penis, Testis and Scrotum. Bladder dysfunction, Male and Female Continence Surgery and Paediatric Peno-Scrotal Conditions make up the rest.

2.8 Thirty years ago the field of Urology was one of the many that was the province of the General Surgeon. Since that time, Urology has developed and evolved as a separate surgical specialty. Higher specialist training in General Surgery no longer covers Urology, which now has its own training programme.

2.9 Prior to 1992, fully trained dedicated Urologists were based only at the Belfast City (BCH) and Royal Victoria (RVH) Hospitals providing a unified service to these two sites and a referral service for the rest of Northern Ireland. In 1992, Urologists were

appointed at Craigavon, Mater and Altnagelvin Hospitals. By 1999 there were ten full time Urologists in post, providing services on the above sites along with Lagan Valley and Coleraine Hospitals. In addition to these ten Urologists, there were two Consultant General Surgeons (one based in Mater, one based in Ulster) who were accredited as Urologists and whose workload was increasingly in the field of Urology. Since 2002, further appointments were made in the Belfast Hospitals, Altnagelvin and Craigavon Hospitals, along with the development of a Urology Service based in Causeway Hospital. At the time of this review 2008/2009, there is a funded establishment of 17 wte Consultant Urologists, which is in line with the recommendations of the 2000 Northern Ireland Review. However, the 2000 Review envisaged the Northern Board area Urology Services being based in Antrim Area Hospital rather than at Causeway Hospital.

2.10 Urology work can be divided into two categories;

- Medical and surgical treatment of the urinary tract, (kidneys, bladder, ureters, urethra, prostate), with these surgical procedures known as 'M'code (OPCS 4.4)
- Medical and surgical treatment of the genital and reproductive system (peno-scrotal), with these surgical procedures known as 'N'code (OPCS 4.4)

2.11 Both categories comprise elective and non-elective and cancer and non-cancer elements, albeit there are much fewer non elective and cancer cases in the 'N' code category.

2.12 In recent years, with the retirement of General Surgeons who historically undertook a substantial amount of Urology work, the number of General Surgeons who undertake urinary tract operative procedures (M Code) has significantly reduced. A small number continue to undertake diagnostic cystoscopies, which to varying degrees represents a substantial proportion of their workload. Should any subsequent treatment be required, the patient is referred into the Urology Team. A General Surgeon in the Northern Trust continues to undertake Inpatient and Day Case "M" code work in the Mid-Ulster Hospital.

Recommendation

1. Unless Urological procedures (particularly operative 'M' code) constitute a substantial proportion of a surgeon's practice, (s)he should cease undertaking any such procedures. Any Surgeon continuing to provide such Urology services should do so within a formal link to a Urology Unit/Team.

2.13 Peno-scrotal operative procedures ('N' Code) continue to be undertaken by many General Surgeons predominately based outside of Belfast. This position is not surprising given the current number of urologists in the Southern, Western and Northern Trust areas.

2.14 Table 1 below identifies the type, volume and surgical speciality for N Code work.

Table 1 - Analysis of 'N' Code (Male Genital) Surgical Operations and Procedures Undertaken by Urologists and General Surgeons (2007/08)

Trust	Total Activity	General Surgeons	Urologists	% of 'N' Code undertaken by Urologists	Number / % undertaken as day case		V	C	H
NHSCT	807	767	40	5%	701	87%	517	129	35
SHSCT	612	521	91	15%	493	81%	314	135	36
WHSCT	614	544	70	11%	528	86%	318	143	38
SEHSCT	1244	650	594	48%	1148	92%	860	147	45
BHSCT	674	103	571	85%	407	60%	209	164	49
Total	**3951**	**2585**	**1366**	**35%**	**3277**	**83%**	**2218**	**718**	**203**

V Vasectomy
C Circumcision
H Hydrocele

2.15 Consultant General Surgeons have gained substantial experience and expertise in these procedures over the years and it is not envisaged that Trust's should make any immediate plans to pass this work onto Urologists. However, it is likely that future appointees to Consultant General Surgeon Posts, will have had little experience in undertaking such procedures and therefore Trust's will need to plan and consider the implications of impending retirements in General Surgery.

Recommendation

2. Trusts should plan and consider the implications of any impending retirements in General Surgery, particularly with regard to the transfer of "N" Code work and the associated resources to the Urology Team.

2.16 Gynaecology is another specialty which undertakes urinary tract diagnostic and operative 'M' code procedures and medical treatments for female bladder dysfunction (non cancer) and incontinence. The surgical specialty of Uro-Gynaecology has developed in the last decade, with most Trusts now having trained surgeons in post, for whom, such surgical procedures, represent a significant proportion of their surgical workload.

2.17 More complex surgical procedures are referred to Urologists and this aspect of Urology is termed as female/functional Urology. The demand for these specialist surgical services is increasing and there is a need, in some cases, to have joint working e.g. complex cancer Gynaecological Surgery and complex Urological Surgery.

2.18 Female continence (stress and urge incontinence) services (non surgical) are provided in Primary Care, Community Services and in Gynaecology Secondary Care. However, *there is evidence of large undeclared demand for continence services which is held in check by the embarrassment factor* (Action On Urology). Current services in NI are fragmented, disparate and are not managed in accordance with NICE Guidelines –Urinary Incontinence: The Management of Urinary Incontinence in Women (2006).

2.19 The referral review exercise undertaken as part of the review demonstrated that GP's are not generally referring these patients into urology and as 80-90% of such patients will not require surgical intervention, it was agreed that this service would not be considered as part of this review. However, it is clear from developments

elsewhere in the UK, that continence services can be significantly enhanced and redesigned within a multidisciplinary team model (GP's, Urologists, Gynaecologists, Physiotherapists and Nurse Practitioners) and is very suitable for development in a non secondary care environment.

Recommendation

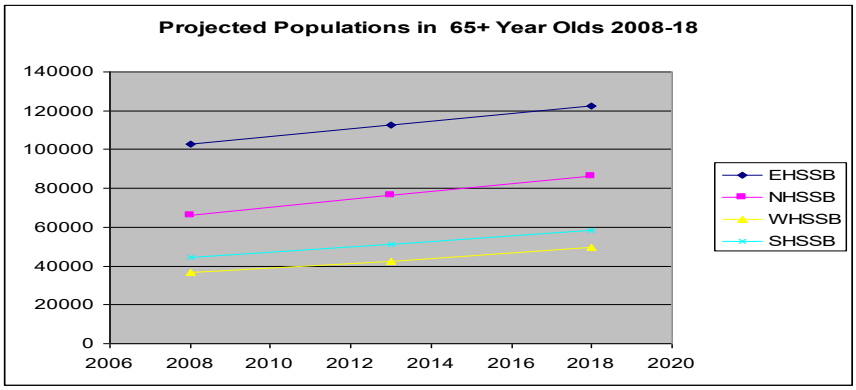
3.	A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

Demography

2.20 The current population in Northern Ireland is 1.76 million with a projected rise to 1.89 million by 2018. The greatest increase will be seen in the 65+ year age group from 249,663 in 2008 to 316,548 (+27%) in 2018. This is particularly relevant for Urology as it is the ageing population that makes the heaviest demands upon Urology care (cancer and non cancer).

Figure 1

Demography 65+ years (Health and Social Services Boards)



Source NISRA

Total	249,663	282,877	316,548

3. CURRENT SERVICE PROFILE

Location of Urology Services

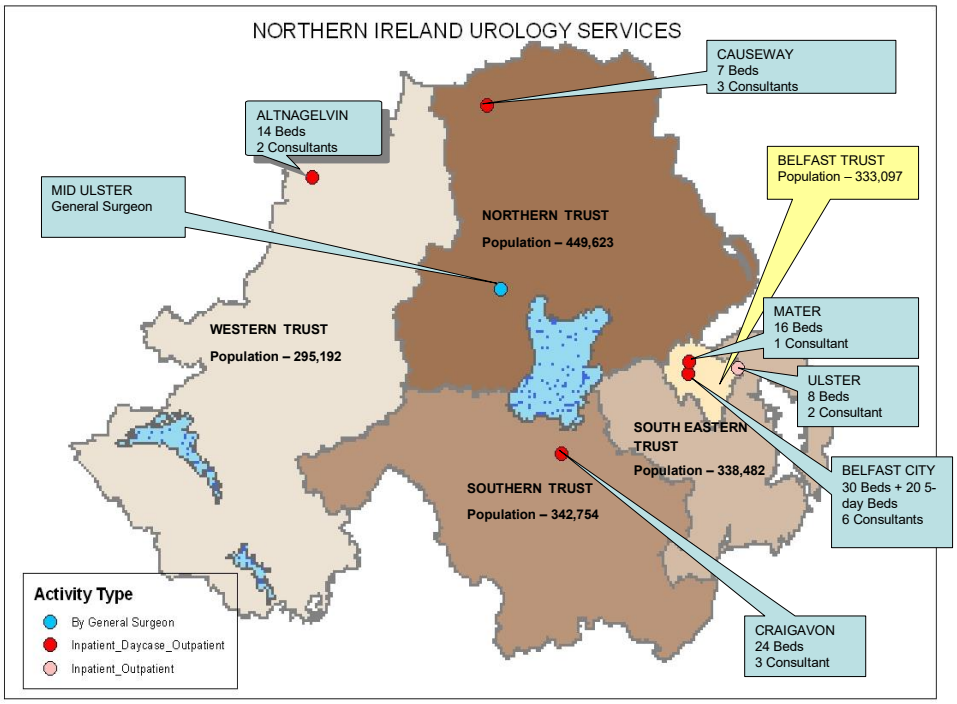
3.1 Consultant led Adult Urology Services are provided in each of the five Trusts. Table 2 below outlines the number of Consultants, Specialist Nurses and Main Hospital bases.

Table 2 – Consultant/Nurse Staffing and Inpatient Units

	Northern	Southern	South Eastern	Western	Belfast	Total
Consultants	3	3	2	2	7	17
Specialist Nurses	3	2	1	3 (2.6 WTE)	3	12 (11.6 WTE)
Hospital Base	Causeway	Craigavon	Ulster	Altnagelvin	BCH/ Mater	

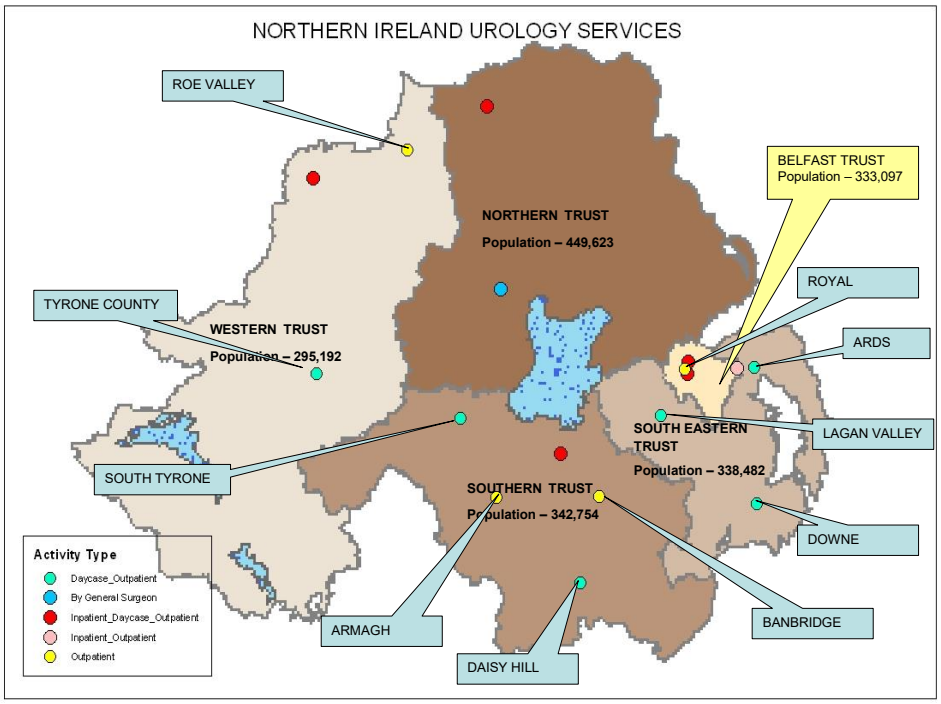
3.2 Figure 2 depicts the five Trusts, their respective resident population, and location and number of Inpatient beds.

Figure 2 – Urology Services – Inpatient Services



3.3 Figure 3 layers on the additional sites within each Trust which provide a range of Outpatient, and Day Surgical Services.

Figure 3 – Urology Services – Outpatients, Day Surgery



3.4 Figures 2 and 3 identified the resident populations for each of the 5 Trusts, however, the actual catchment populations significantly differ when adult only services and patient flows are considered. Table 3 indentifies the inpatient and day case population served by each Trust/Consultant.

Table 3 – Catchment populations served by each Trust

	Consultant urological surgeons number	Inpatient catchment population	Inpatient catchment population per consultant	Daycase catchment population	Daycase catchment population per consultant
BHSCT	7	873,000	124,700	646,000	92,300
NHSCT	3	218,000	72,700	245,000	82,000
SEHSCT	2	130,000	65,000	321,000	160,000
SHSCT	3	305,000	102,000	287,000	96,000
WHSCT	2	236,000	118,000	262,000	131,000
Total	**17**	**1,762,000**	**103,000**	**1,762,000**	**103,000**

3.5 This analysis demonstrates a significant flow of inpatient/day case work (and therefore outpatient/assessment and diagnostic workup) from the Northern Trust area to Belfast. It also demonstrates that although South Eastern Trust services a significant catchment population for day case work (and outpatient, assessment and diagnostics) it serves a smaller proportion of its population with inpatient care. This is due to the fact that a significant volume of outpatients, diagnostics and day surgery is undertaken in the Lagan Valley Hospital by a Consultant Urologist outreached from Belfast. Any subsequent inpatient treatment is then carried out in BCH.

Outpatient (new) Services

3.6 A referral review exercise was held in December 2008, at which a number of primary and secondary care clinicians (5 General Practitioners and 5 Consultant Urologists) and Trust Managers undertook a quantitative and qualitative analysis of all new outpatient referrals received (368) in Urology for a full week in November 2008.

Table 4 - Analysis of Urology Referral Letters

Gender	Belfast	Northern	Western	Southern	SE	Regional
Male	111	39	34	42	55	**281**
Female	33	13	10	11	18	**85**
Blank	0	1	1	0	0	**2**
Total	**144**	**53**	**45**	**53**	**73**	**368**

Age Range	Belfast	Northern	Western	Southern	SE	Regional
0-14	2	0	0	1	0	**3**
15-30	17	4	5	3	7	**36**
31-40	19	4	5	8	4	**40**
41-50	29	9	4	7	5	**54**
51-60	18	13	9	6	4	**50**
60+	59	22	22	28	9	**140**
Blank	0	1	0	0	44*	**45**
Total	**144**	**53**	**45**	**53**	**73**	**368**

Urgency	Belfast	Northern	Western	Southern	SE	Regional
Red Flag	6	2	3	3	4	**18**
Urgent	30	11	10	10	12	**73**
Routine	108	40	32	40	57	**277**
Blank	0	0	0	0	0	**0**
Total	**144**	**53**	**45**	**53**	**73**	**368**

Named Cons	Belfast	Northern	Western	Southern	SE	Regional
Y	35	13	6	12	15	**81**
N	109	40	39	41	58	**287**
Total	**144**	**53**	**45**	**53**	**73**	**368**

Ref Source	Belfast	Northern	Western	Southern	SE	Regional
Non-GP ref's	15	12	1	5	14	**47**
GP Ref's	129	41	43	48	59	**320**
Blank	0	0	1	0	0	**1**
Total	**144**	**53**	**45**	**53**	**73**	**368**

* 44 out of 73 referrals in SET had DOB deleted-therefore not possible to record age range.

** Data on percentages is **Appendix 4**

3.7 Regionally 76% of the referrals were male, which was to be expected. 87% of the referrals were from GPs with the remaining 13% spread across Consultant to Consultant (internal and external), A&E referrals and other sources. 78% of the referrals were referred into Urology as a specialty, with only 22% having a named Consultant. Regionally (excluding SET) 63% of the referrals related to the over 50's age range. Referrals marked by GPs as red flag or urgent represents 25%.

3.8 A breakdown of the referrals by presenting symptoms/conditions is in Table 5 below. Data on percentages is included in Appendix 5. Clinicians have indicated that this outcome is fairly representative of the nature and type of referrals they receive.

Table 5 - Analysis of presenting symptoms/conditions

Presenting Symptom/Condition		Belfast		Northern		Western		Southern		SE		Regional	
Haematuria (ALL)		**19**		**10**		**10**		**5**		**12**		**56**	
	frank		*11*		*3*		*4*		*2*		*6*		*26*
	microscopic		*6*		*5*		*6*		*2*		*6*		*25*
	blank		*2*		*2*		*0*		*1*		*0*		*5*
Prostate/raised PSA		**14**		**7**		**8**		**9**		**12**		**50**	
Other		**21**		**4**		**5**		**8**		**8**		**46**	
Ncode procedure (All)		**21**		**2**		**1**		**3**		**14**		**41**	
	vasectomy		*11*		*0*		*1*		*1*		*4*		*17*
	foreskin		*1*		*0*		*0*		*2*		*7*		*10*
	epididymal cyst		*3*		*2*		*0*		*0*		*3*		*8*
	hydrocele		*4*		*0*		*0*		*0*		*0*		*4*
	varicocele		*1*		*0*		*0*		*0*		*0*		*1*
	blank		*1*		*0*		*0*		*0*		*0*		*1*
Recurrent UTI's		**17**		**9**		**4**		**6**		**4**		**40**	
LUTS		**11**		**7**		**2**		**5**		**7**		**32**	
Prostate/BPH/prostatitis		**11**		**5**		**4**		**6**		**2**		**28**	
Renal stones/colic/loin pain		**11**		**5**		**1**		**2**		**4**		**23**	
Testicular/ Scrotal lumps or swelling		**8**		**0**		**5**		**0**		**8**		**21**	
Andrology (ALL)		**7**		**2**		**3**		**6**		**2**		**20**	
	erectile dysfunction		*2*		*2*		*0*		*3*		*1*		*8*
	Peyronie's disease		*2*		*0*		*2*		*0*		*0*		*4*
	blood in ejaculate		*3*		*0*		*0*		*0*		*0*		*3*
	ulcer/lesion on gland		*0*		*0*		*1*		*1*		*0*		*2*
	balanitis/discharge		*0*		*0*		*0*		*2*		*0*		*2*
	Blank		*0*		*0*		*0*		*0*		*1*		*1*
Unknown		**3**		**1**		**1**		**2**		**0**		**7**	
Ca Bladder/Kidney		**1**		**1**		**0**		**1**		**0**		**3**	
Blank		**0**		**0**		**1**		**0**		**0**		**1**	
Total		**144**		**53**		**45**		**53**		**73**		**368**	

3.9 The categorisation of patients by presenting symptoms/condition is a useful process and the outcomes of this exercise should assist Urology teams in determining the nature and frequency of assessment and diagnostic clinics. There was an overlap in symptoms for some patients e.g. many patients with enlarged prostate, known benign prostatic hyperplasia (BPH) or prostatitis have a range of lower urinary tract symptoms (LUTS). However, for the purposes of this exercise, if prostatic disease was identified on the referral letter, these patients were recorded as such, whereas patients presenting with just LUTS were categorised as such. Where LUTS

services are in place, both of these groups of patients are seen and treated within the same pathway.

3.10 General comments;

- A small number of the referrals (<10) were not for a new outpatient appointment but were asking for a review appointment, which was overdue, to be expedited. In addition, a small number of referrals (<10) were for patients who had been discharged from outpatients due to not responding to a booking letter or had DNA'd and who had subsequently visited their GP and asked for another referral to be processed.

- In overall terms, the quality and appropriateness of the referrals was deemed to be good. Internal referrals (A&E, inpatient etc) were often handwritten and were not as structured as GP referral letters.

- The exercise included looking at the time between the date recorded on the referral letter and the hospital date stamp indicating receipt. A significant variance between these two dates was noted in internal referrals (Consultant to Consultant). There did not appear to be any significant delays with regard to GP referrals.

Recommendation

4.	Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system.

- Consultants indicated that they would routinely upgrade a significant number of routine and urgent referrals (GP) to urgent or red flag. This is particularly relevant when considering the service capacity requirements to assess and investigate potential cancers within cancer standard timescales. This has been confirmed in a recent Cancer Registry, full year analysis of the cancer waiting times database, with a total of 700 red flag GP referrals and 875 referrals which Consultants upgraded to red flag at triage recorded.

- It has been noted that the development of agreed referral guidelines/criteria for suspected Urological cancers is a priority piece of work for the recently formed NICaN Group and this should work should be advanced as soon as possible.

Recommendation

5.	NICaN Urology Group in conjunction with Urology Teams and Primary Care should develop and implement (by September 2009) agreed referral guidelines and pathways for suspected Urological Cancers.

Areas of Urology

3.11 As a specialty, Urology can be sub-divided into a number of special interest areas, most of which also comprise elements of general or 'core' Urology work.

3.12 **Core Urology** includes the assessment, diagnosis, medical treatment and (non complex and/or endoscopic) surgical treatment of diseases/conditions of the kidney,

bladder, prostate, penis and scrotum. LUTS, BPH, haematuria, simple stones, erectile dysfunction (ED) and 'N' code work are considered to be core Urology. Urologists in NI, regardless of special interest area, all provide core Urology services. Over 80% of all 'M' and 'N' code inpatient and daycase procedures are peno-scrotal, cystoscopy, TURBT (trans urethral resection of bladder tumour), TURP (trans urethral resection of prostate) and urethral catheterisation.

3.13 **Uro-Oncology.** Around 40% of Urology work is cancer related and most of the assessment, diagnostics and medical/ simple surgical treatments are appropriately undertaken at local level. Less than 10% of Urological cancers require radical/complex surgery. (see section 7).Specialist cancer services are based in BCH, where there are three designated 'cancer' Urologists. One Urologist in Altnagelvin and one/two in Craigavon would also be considered to have a special interest in cancer.

3.14 **Stones/Endourology** includes the management and treatment of renal and ureteric calculi. This involves open surgery, endoscopic intervention or stone fragmentation using multimodal techniques such as laser, lithoclast with or without US (ultrasound) and ESWL (Extracorporeal shock wave lithotripsy). Craigavon has the only fixed-site lithotripter, with BCH and Causeway serviced by a mobile facility on a sessional basis. With regard to special interest Urologists, there are currently two in Belfast Trust and one in each of the other four Trusts.

3.15 **Andrology** includes the treatment of erectile dysfunction, particularly post prostate surgery, penile curvatures and deformities (Peyronie's disease) and other conditions of the male reproductive organs. Currently all Consultants provide andrology services within their commitment to core Urology. The service would benefit from having a specialist Urologist to manage and treat the more complex cases, including penile prostheses work.

3.16 **Reconstruction,** which is often combined with the functional side of Urology, includes reconstruction of urinary continence in men, bladder reconstruction after oncological surgery and in a neuropathic bladder, e.g. spina bifida, spinal cord injury, bladder reconstruction in congenital and developmental LUT pathology (adolescent), urethral reconstruction for strictures and reconstruction prior to transplantation. There are currently two Consultants (one on long term sick leave) in Belfast who specialise in this area, working closely with the Uro-oncology team and with supra regional support provided by University College Hospital London.

3.17 **Female/functional** relates to the management and treatment of incontinence and bladder dysfunction in women, which on some occasions overlaps with reconstruction surgery. Some of this work is undertaken by Urologists however, the majority is undertaken by Uro-Gynaecologists as outlined in section 2. There is a shared view among Urologists that each Urology team should have at least one Urologist with a special interest in female/ functional Urology, and who for this aspect of their work, should work within a multidisciplinary team of Gynaecologists, physiotherapists and nurse practitioners in providing care for urinary incontinence, prolapse and fistula repair.

Recommendation

6.	Deployment of new Consultant posts (both vacancies and additional posts arising from this review) should take into account areas of special interest that are deemed to be required in the service configuration model

Non-Elective Services

3.18 There are approximately 2,500 non-elective FCE's (coded as Urology on admission or discharge) per annum (approximately 7 a day) with little variation in these numbers from year to year.

3.19 In broad terms, non-elective admissions fall into the following categories;

- Testicular torsion/infections
- Renal colic/Acute kidney obstruction
- Infection—recurrent UTI's/ pyelonephritis
- Urinary retention /haematuria

3.20 The majority of admissions fall into urinary retention and renal colic which do not usually require an immediate surgical operation, neither does treatment of infections. Testicular torsion and acute kidney obstruction require emergency (often surgical) intervention.

3.21 There are currently 15 hospitals in NI with A&E Departments (varying opening times) and acute medical and surgical facilities. With the implementation of DBS (Developing Better Services) this position will change in future years. However, for the purposes of this review the profile of services and location of non-elective Urology patients is assumed to be as is at present.

3.22 The majority of non-elective admissions are admitted to the 'presenting' acute hospital and unless it is BCH or CAH are admitted (out of hours) under General Surgery, until transfer to the care/specialty of Urology, if appropriate, on the next working day.

3.23 Even in a redesigned Urology service it is not envisaged that these arrangements will change for the foreseeable future, as it would not be viable to provide 24/7 onsite Urology cover in all 15 hospitals. However, the requirement to have clearly defined protocols and pathways in place for the management of these admissions has been identified.

Recommendations

7.	Urologists, in collaboration with General Surgery and A&E colleagues, should develop and implement clear protocols and care pathways for Urology patients requiring admission to an acute hospital which does not have an acute Urology Unit.

8.	Urologists, in collaboration with A&E colleagues, should develop and implement protocols/care pathways for those patients requiring direct transfer and admission to an acute Urology Unit.

9.	Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of Urology advice/care by telephone, electronically or in person, also 7 days a week.

ICATS (Integrated Clinical Assessment and Treatment Services)

3.24 ICATS was launched in NI in 2005/06, as one element of the Department's Outpatient Reform Programme and in response to very lengthy waiting times for first outpatient appointments.

3.25 ICATS were designed to provide services, in a variety of primary and secondary care settings by integrated multidisciplinary teams of health service professionals, including GPs with a special interest, specialist nurses and allied health professionals. One of the fundamental elements was that many patients didn't need to be seen or assessed by a hospital Consultant at an outpatient clinic and that quick triage of referral letters and assessment and diagnostics by the most appropriate health care professional within ICATS teams, with onward referral to secondary care, only if required, would divert large numbers of outpatient referrals from hospital consultants. Another fundamental design principle was that non urgent referrals would, in the first instance, go to ICATS to be triaged and that all subsequent flows to secondary care consultants would be from the ICATS team.

3.26 It was agreed that, to begin with, ICATS would be implemented in a small number of core specialities (4) and these were identified based on those specialities with the highest volumes and longest waiting times in 2005/06. Urology was one of the 4 initial specialties identified. Across all ICATS specialties £2m was allocated in 2006/07, increasing to £9m recurrently from 2007/08.

3.27 The design of ICATS included 5 possible next steps/pathways for patients referred into the service-

- to diagnostics,
- for direct treatment on an inpatient/day case list,
- for return to primary care with advice on further management,
- to tier 2 outpatient services (non Consultant assessment and treatment) or
- to hospital (Consultant) outpatients.

3.28 For a variety of reasons, the development of Urology ICATS has been difficult, slower than planned and somewhat fragmented with regard to service model design, which differs significantly in each of the Board areas.

3.29 Table 6 below outlines the progress to date in Urology ICATS.

Table 6 - Urology ICATS - Current Position

Board Area	Current Position	Ring fenced funding/ Investment Made	Comments
NHSSB	Hospital based (Causeway) Nurse specialists undertaking mostly cystoscopies. Consultant led referral triage.	£642K	Original intention to expand nurse service to LUTS/haematuria/prostate clinics and review/follow-up clinics.
SHSSB	GPSI and specialist nurse Tier 2 clinics for haematuria, prostate, LUTS, stones, andrology. ICATS in separate building on Craigavon Area Hospital site. Consultant led referral triage.	£240K	Oncology review and urodynamics clinics being established.
WHSSB	Nurse led clinics (LUTS, prostate) and single visit haematuria clinics with nurse specialists/staff grade in place for some years. Predominately hospital based (Altnagelvin). Consultant led referral triage.	£211K	ICATS plan now approved – expanding diagnostic, LUTS services and involving GPSI'S in referral triage process in order to improve links with primary care and improve referral information and patterns.
EHSSB	SET – plan approved by EHSSB late 2008. Nurse specialist undertaking cystoscopies for some time outwith any ICATS model. BELFAST – no progress but nurse led services in place for some time and single visit haematuria clinic established late 2008. Consultant led referral triage in both SET +Belfast	£350K	GPSI'S appointed some time ago but posts not yet activated.

3.30 It is clear that Urology services have been developing non Consultant delivered outpatient, assessment and diagnostic services, such as haematuria, LUTS, ED, prostate, stones etc for some years prior to the launch of ICATS. These services were/are largely provided by nurse specialists, staff grades and radiology staff in a hospital environment.

3.31 Consultant Urologists unanimously consider that referral triage should be led by Consultants. With over 40% of referrals being cancer related (and with many not red flagged or marked urgent) they believe that they are best placed and skilled to undertake the triage process. They also believe that despite the volume of referrals, this is not a particularly time consuming process.

3.32 They indicate that they are fully committed to developing further non Consultant assessment, diagnostic and some treatment services and supportive of *providing appropriate, safe and sustainable, cost effective care closer to home, so that urology services are delivered in the right setting, with the right equipment, performed by the appropriate skilled person* (NHS, Providing Care for Patients with Urology Conditions- Guidance).

3.33 This approach was evident during the referral review exercise in December 2008, with Consultants readily indicating that patients should be booked straight into diagnostics or nurse led clinics such as LUTS, prostate, haematuria.

3.34 Consultant Urologists are very clear that the need to ensure that whoever the specialist practitioner is and wherever they work, they should be part of, or affiliated to, the local Urology team, led by a Consultant Urologist.

3.35 In light of the already changing shape of Urology services and the further developments that will arise out of this review, it is appropriate and timely to take stock of ICATS, its design principles and future development and investment. A review of all ICATS Services is planned for the first quarter of 2009/10 year and the outcomes of this review should guide the future direction of travel for ICATS services within Urology .

Recommendation

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

Links with Renal Transplantation

3.36 Renal transplantation is the definitive preferred treatment for end-stage renal failure. Kidneys for transplantation become available from either deceased or live donors. In 2006 the DOH commissioned a Taskforce to investigate and make recommendations to increase the level of organ donation. In 2008/09 the DHSSPS set a target for access to live renal transplantation and investment has been made to increase the live donor programme at Belfast City Hospital.

3.37 There are currently two wte transplant surgeons in post, a long-term locum transplant surgeon and in addition there is 0.2 wte input from an Urologist. The Urologist only undertakes live donor kidney retrieval using laparoscopic techniques, which is an essential quality component for the live donor programme.

3.38 Taskforce recommendations would suggest that cadaveric retrievals and transplantations should be increased to 50 per year (currently approximately 30) and within Priorities for Action there is a target for an additional 20 live donor retrievals and transplantations per year by March 2011. With the increase in laparoscopic live donor retrieval, additional input from Urologists may be needed and the current review of the renal transplantation service will need to take account of this requirement, along with the Urology input required if any reconstruction of the urinary drainage system is needed before transplantation.

4. CAPACITY, DEMAND AND ACTIVITY

4.1 Urology is a specialty that is categorised by high numbers of referrals for relatively simple initial diagnostics (often to exclude pathology) or surgical procedures. In addition, around 40% of Urology is cancer related and as more elderly patients are referred and treated, there is a need for follow-up services and patient surveillance.

4.2 The increasing demand for Urology services in Northern Ireland is similar to that being experienced in the rest of the UK.

4.3 The Action On Urology Team (March 2005) reported that:

Demand for Urology services is rising rapidly and the pattern of disease is changing.

- *There is an overall rise in demand from an ageing population especially the over 50's who make the heaviest demands upon Urology care.*
- *Prostate disease incidence is rising rapidly and PSA requests are generating further demand.*
- *Haematuria/bladder disease demand is also rising, stimulated by the combined availability of dipsticks and flexible cystoscopes.*
- *Work is shifting away from surgery towards diagnostics and medical treatment.*

4.4 In addition, there has been an increased "medicalisation" of Urology as the pharmacology of the urinary tract has become better understood and the increasing availability and ever improving range of drugs.

Activity/Demand/Capacity Analysis

4.5 During the review detailed analysis was undertaken by SDU and the Boards, and the following represents the most accurate information available at this time.

Outpatients

4.6 New outpatient referrals and attendances (activity) have been increasing year on year. Not all referrals result in attendance as many are removed for "reasons other than treatment" (ROTT) and are appropriately discharged from the system without having been seen.

4.7 The most recent analysis undertaken is estimating an 18% increase in predicted (GP) demand from 2007 to 2008 (2008 ROTT rates applied). This does not however represent a 'true' picture as during this period two Trusts changed their recording/management of activity from General Surgery to Urology. It has been difficult to quantify, with a degree of accuracy, the impact of these changes on the information, as increases, (albeit smaller), in General Surgery are also being estimated. Notwithstanding the above difficulty, it has been accepted that there is a significant increase in demand, which is likely to be between 10 and 15%. It has also been concluded that this increase is likely to be as a result of those factors outlined at the beginning of this section i.e. ageing population, patient expectation and demand with the increased emphasis on men's health, changing pattern of disease, availability of assessment and diagnostic modalities to exclude pathology, along with decreasing waiting times and previously unmet need.

4.8 A regional referrals management review, led by SDU Primary Care advisors is due to commence in April 2009.

Table 7 - Urology – Service and Budget Agreement Levels and Activity

	SBA (1)	07/08 Outturn(2+4)	Projected 08/09 Outturn (3+4)
Elective Inpatients	4,155	4,937 + 295(IS)	5,823+606(IS)
Non-elective Inpatients	2,109	2,369	2,496
Daycases	8,715	12,416 + 462 (IS)	13,252+1028(IS)
New Outpatients	5,824	7,593 + 571 (IS)	9,984 +519(IS)
Review Outpatients	12,566	15,967	19,224

(1) Information from 4 Boards SBAs
(2) 2007/08 outturn from PAS (includes in-house additional activity)
(3) Projected 2008/09 outturn (including in-house additional activity) based on November 2008 position
(4) IS information provided by EHSSB

4.9 In 2008, the Boards completed a detailed capacity and demand model across a number of specialities, inclusive of Urology. A number of assumptions/estimates were applied and both the recurrent gap against SBA and non-recurrent (backlog) was identified. The recurrent gap does not take account of growth in demand. The backlog (non-recurrent) gap relates to the in-year activity required due to the need to reduce waiting times for inpatient/day cases and outpatients to 13 and 9 weeks respectively by March 2009.

4.10 It has been agreed that the maximum elective access waiting times for 2009/10 will remain at 13 and 9 weeks and with a year of steady state, Trusts and Commissioners will therefore be better placed to assess both the 'real' demand and capacity to treat.

4.11 As part of this review EHSSB undertook further analysis of demand and capacity within urology and identified a significant recurrent gap, against SBA volumes.

Conclusion

4.12 Both the demand and activity in Urology is significantly greater than the current SBA volumes. Some of this is non-recurrent backlog created by the reducing waiting times since 2005/06 and the remainder is recurrent based on 2007/08 demand. Significant non-recurrent funding has been allocated in recent years to ensure Trusts were able to undertake this activity and to meet the elective access waiting times and cancer access standards. Within Trusts large numbers of additional clinics and theatre sessions have been funded non-recurrently and there has also been significant use of the independent sector.

4.13 Both increased and additional capacity to assess and treat patients is urgently required in Urology. However, additional recurrent investment in capacity (resources-human and physical) which is required in this speciality and is detailed later in this report is not the only solution. Trusts will also be required to ensure optimum use and efficiency of their existing capacity and will need to be creative in developing new ways of working and re-designing and modernising services to increase the capacity already in the system and to manage the increasing demand into secondary care.

4.14 The IEAP (Integrated Elective Access Protocol) provides detailed guidance on tried and tested systems and processes which ensure effective and efficient delivery of elective services, along with improvements to the patient experience. The Scheduled Care Reform Programme (2008-10) includes significant developments such as, pre-op assessment, admission on day of surgery, increasing day surgery rates, reducing cancelled operations, optimising the use and productivity of theatres, booking systems and a management of referral demand exercise. All of these will build/create additional capacity within the system.

Recommendation

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

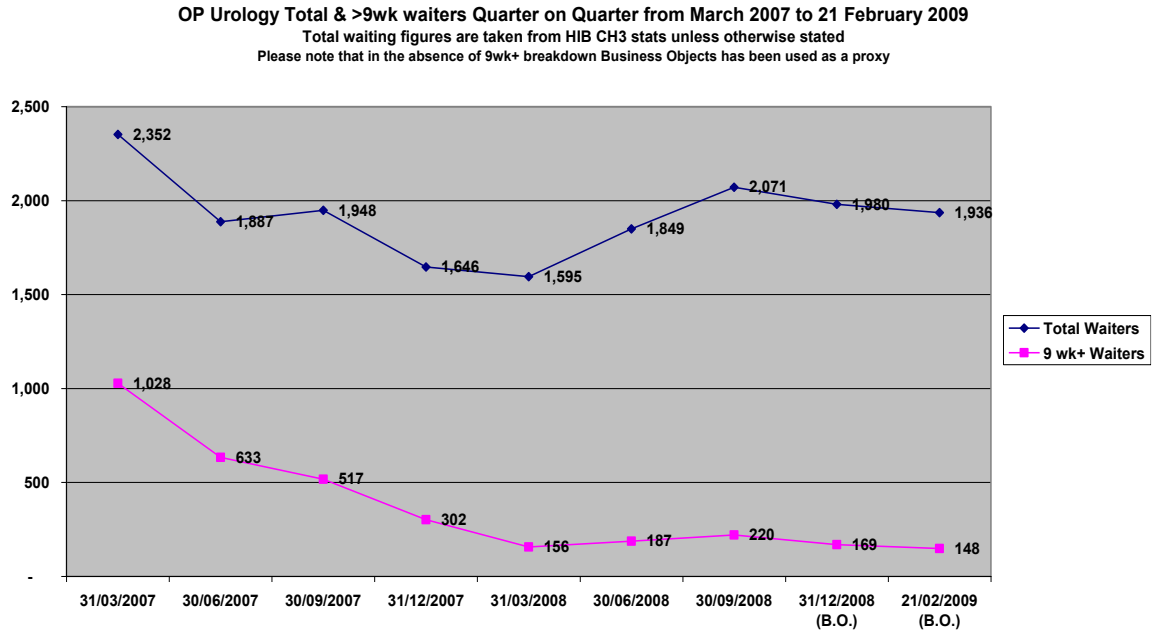
5. PERFORMANCE MEASURES

Elective access waiting times

5.1 There have been significant reductions in waiting times since 2005, in line with PFA (Priorities for action) targets and as a result of the elective reform and modernisation programme.

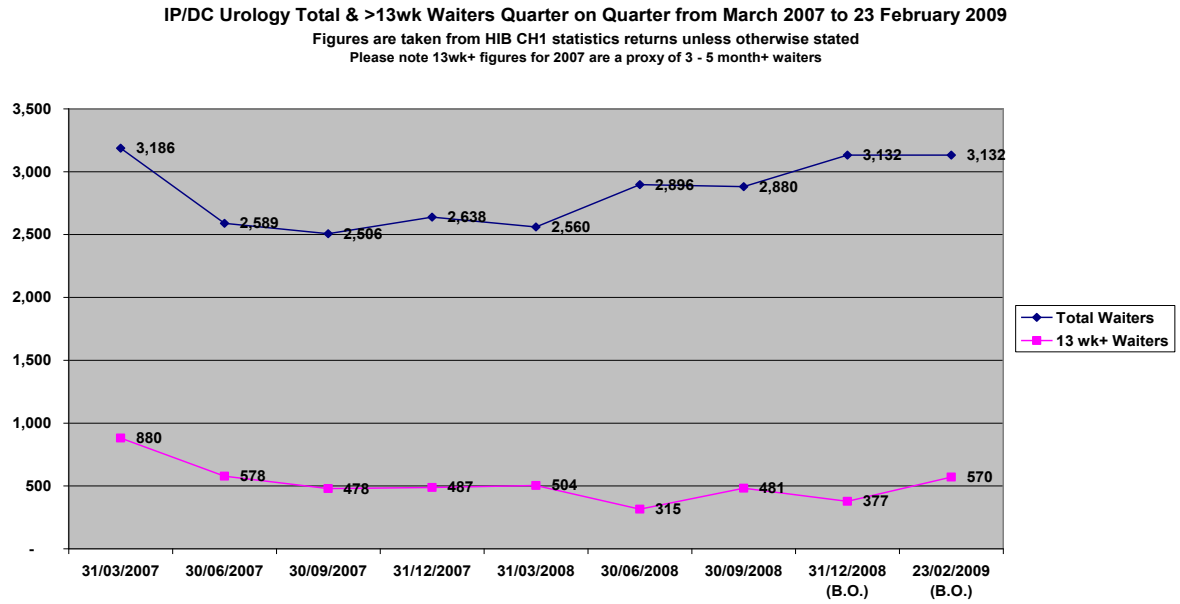
PFA 2008/2009: By March 2009, no patient should wait longer than 9 weeks for first outpatient appointment and/or diagnostics
By March 2009, no patient should wait longer than 13 weeks for Inpatient or daycase treatment.

Figure 4



(B.O. – refers to Business Objects)

Figure 5



5.2 As at February 2009, all Trusts, with the exception of Belfast, are indicating that they will meet the target waiting times for outpatients, diagnostics, Inpatients and daycases. Belfast Trust is reporting in excess of 100 anticipated breaches in Inpatient/daycase work.

Urology Cancer Performance

5.3 The Cancer Access Standards were introduced from April 2007. These introduced waiting times standards for suspected cancer patients both urgently referred by the General Practitioner or those referrals triaged by the Consultant as suspected cancer. It also set standards for those patients diagnosed with cancer and how long they should wait for treatment.

5.4 The 2008/09 Cancer Access Standards were defined as below:

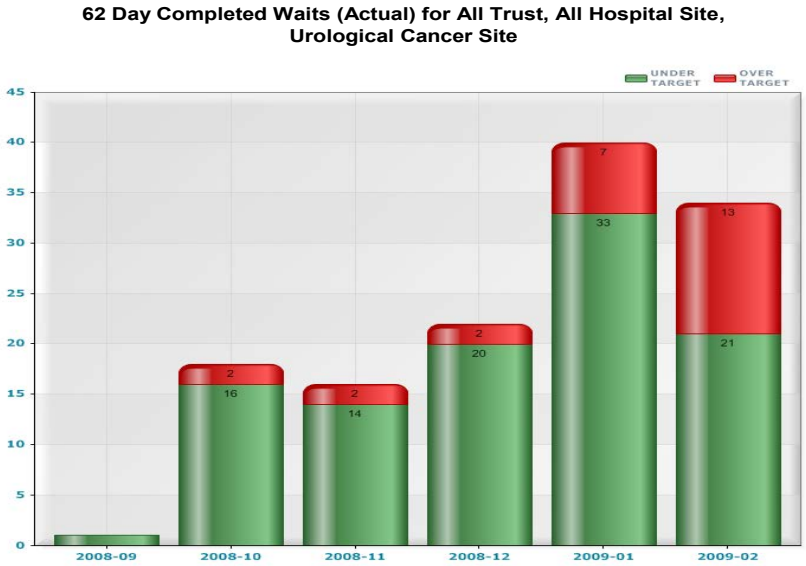
- 98% of patients diagnosed with cancer from decision to treat, should begin their treatment within a maximum of 31 days
- 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within a maximum of 62 days.

* decision to treat is the date on which the patient and clinician agree the treatment plan.

5.5 It is recognised that a considerable amount of the actions required to achieve the cancer access standards are associated with service improvement. These include the identification and agreement of the suspected cancer patient pathway, the introduction of robust administrative systems or processes and the proactive management of patients.

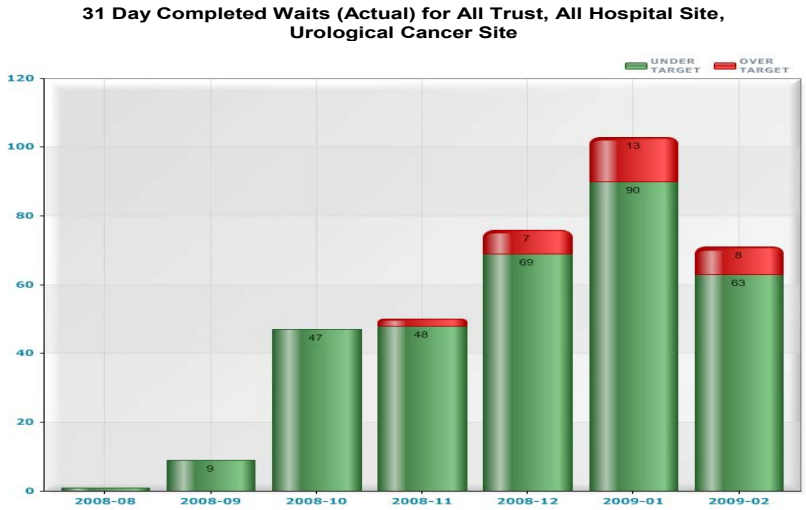
5.6 The recent cancer access standard performance in relation to the 62 day standard shows that up to 24 February 2009, across all Trusts, the number of Urological cancer patients achieving the 62 day standard is at 62%. This shows that of the 34 confirmed cancers treated up to this date, 13 of these had not been treated within 62 days.

Figure 6



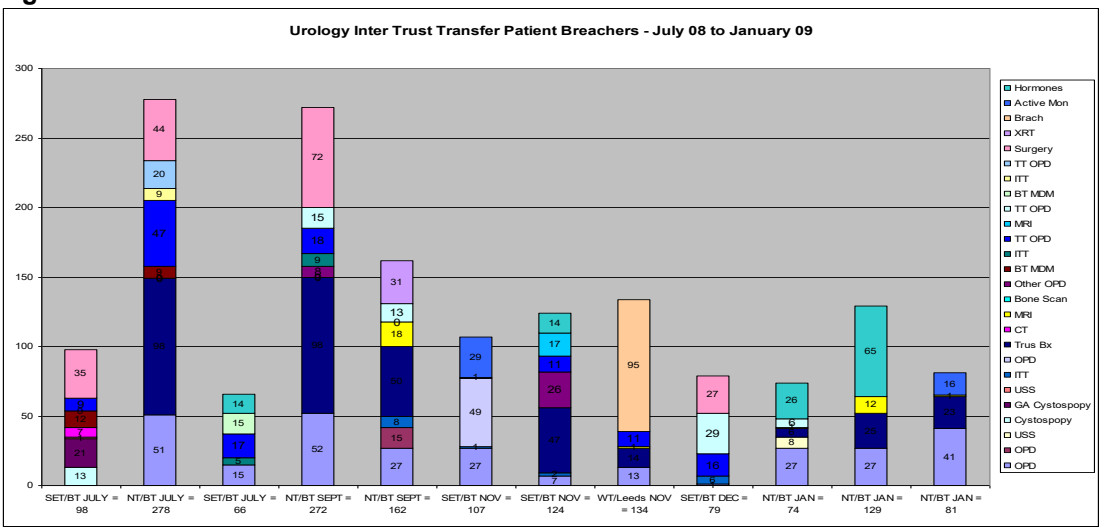
5.7 For the same period in February, the performance in relation to the 31 day standard shows that, only 87% of those Urological cancer patients (63 of 71 patients) were treated within 31 days of the decision to treat. From a sample of 9 patients that breached the 31 day standard in January 2009, they waited on average 50 days from their decision to treat to their first treatment.

Figure 7



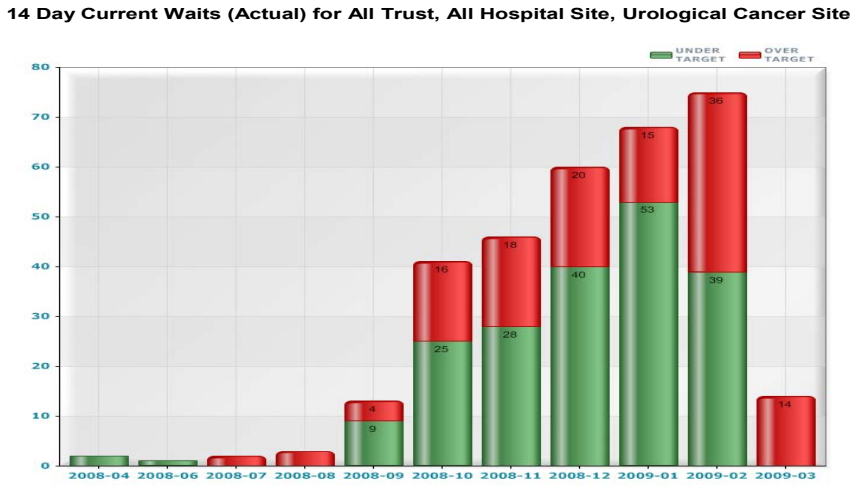
5.8 It is accepted that those patients who transfer from one Trust to another for treatment are more likely to breach the target, than those who remain within the one Trust for their complete pathway. These patients are referred to as Inter Trust Transfer (ITT) patients. These ITT patients that breach the target are analysed in more detail. The detail for the period July 2008 to January 2009 is shown on Figure 8 below. This shows that of the suspected 'red flag' cancer patients referred who breached the 62 day target, 12 of these were ITT patients and they waited from 66 to 278 days from referral to their first treatment. It is accepted as a regional standard, for all tumour sites that if the patient is to be transferred for treatment, all diagnostic investigations should be completed and the patient should be ready for transfer by day 28 of the 62 day pathway. From this evidence it shows that this is not happening in the majority of cases.

Figure 8



5.9 Whilst this analysis only refers to ITT patients, it is probably representative of the pathway for those patients that breach the target and remain only within the one Trust. For example, for the 'front end' of the patient pathway, the number of days the patient can wait for their initial outpatient appointment and subsequent investigation can be over 150 days. This has improved in recent months, but to achieve the 28 day standard this should be completed within approximately 21 days. This is further evidenced by the analysis of the 14 day waiting times for suspected Urological cancers referrals; this showed that of the referrals seen in February only 52% were seen within 14 days. As highlighted any delay at the front end of the pathway will have an impact on the Trusts ability to achieve the treatment times and the 62 day standard.

Figure 9



5.10 Whilst it is clear that some element of redesign of the pathway is required, the evidence appears to indicate that for the number of suspected 'red flag' cancer referrals received or triaged by the Consultants, additional capacity at the front end to complete timely investigations is required. For example, the introduction of one-stop clinics for investigations such as haematuria can have an impact and reduce the number of days the patient waits for investigations as well as reducing the number of times that the patient has to attend the hospital. This needs to be matched with sufficient Consultant capacity for treatments, including theatre capacity, Oncologists for oncology and radiotherapy.

5.11 All Trusts have reported that Urology is the key tumour site which they are at most risk with and their achievement of the cancer access standards by March 2009. In addition, at a recent ITT Executive Directors Services Steering Group the Belfast Trust reported they estimate 15 to 20 urological patients will breach the cancer access standards. Some of this is due to the late transfer of patients, but also due to a lack of available Consultants and theatre capacity. If the number of patients forecasted breach the target, this will mean that as a region NI will not achieve the cancer access standard.

Recommendation

12.	Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients.

NHS Better Care, Better Value Indicators

5.12 A number of better care, better value Indicators are useful performance measures to apply to Urology in assessing levels of efficiency, productivity and patient experience.

5.13 Length of stay (LOS) is one of the greatest variables between Trusts, hospitals and individual Consultants. By reviewing and improving admission and discharge processes, Trusts can improve the patient experience by reducing the number of days spent in hospital, and save bed days thus increasing capacity and saving money.

5.14 Some hospitals would expect to have longer than average LOS if they undertake more complex operations, treat patients with greater co-morbidity and patients with higher levels of social deprivation.

Table 8
Urology Episodic Average Length of Stay (06/07, 07/08, 08/09 - Apr 08 to Nov 08)

	Elective			Non Elective		
	FY2006/2007	FY2007/2008	FY2008/2009*	FY2006/2007	FY2007/2008	FY2008/2009*
Regional average LOS in days	3.7	3.4	3.2	4.8	4.7	4.6

	Elective			Non Elective		
Trust	FY2006/2007	FY2007/2008	FY2008/2009*	FY2006/2007	FY2007/2008	FY2008/2009*
Belfast Health and Social Care Trust	3.9	3.4	3.3	5.5	4.9	5.0
Northern Health and Social Care Trust	2.3	2.9	2.5	4.3	5.4	5.6
South Eastern Health and Social Care Trust	3.8	3.9	3.3	3.9	4.4	3.4
Southern Health and Social Care Trust	3.7	4.0	3.5	4.5	4.8	4.9
Western Health and Social Care Trust	3.6	2.8	3.1	3.9	3.8	3.7
Average LOS in days	**3.7**	**3.4**	**3.2**	**4.8**	**4.7**	**4.6**

	Elective			Non Elective		
Site	FY2006/2007	FY2007/2008	FY2008/2009*	FY2006/2007	FY2007/2008	FY2008/2009*
Altnagelvin Hospitals	3.6	2.8	3.1	3.9	3.8	3.7
Belfast City Hospital	4.1	3.5	3.4	5.5	4.7	5.0
Causeway	2.3	2.9	2.5	4.3	5.4	5.6
Craigavon Area Hospital	3.7	4.0	3.5	4.5	4.8	4.9
Down and Lisburn	1.0	0.0	1.2	0.0	0.0	0.0
Mater Infirmorum Hospital	3.2	2.7	2.5	5.9	6.4	5.0
The Royal Group of Hospitals	0.0	0.0	0.0	0.0	0.0	0.0
Ulster Community and Hospitals	3.8	4.0	3.5	3.9	4.4	3.4
Average LOS in days	**3.7**	**3.4**	**3.2**	**4.8**	**4.7**	**4.6**

***Information for 08/09 is cumulative from 01/04/08 to 30/11/08**

5.15 All Trusts have longer average LOS for non elective patients than elective. The Southern Trust has the longest average LOS for elective patients and for elective and non-elective combined. Northern Trust has the shortest elective LOS which reflects their lower levels of major surgery.

5.16 Hospital Episode Statistics (HES) data, which combines elective and non-elective LOS, indicates a reduction in England over a three year period from an average of 3.8 days in 2005/2006 to 3.3 days in 2007/2008. Only South Eastern and Western Trusts have an average (combined) LOS of less than 4 days.

Recommendations

13.	Trusts should implement the key elements of the elective reform programme with regard to admission on the day of surgery, pre-operative assessment and increasing day surgery rates.

14.	Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients.

Day Surgery

5.17 For any surgical operation there is a large variation in performance throughout the UK with regard to time spent in hospital. Some units favour certain procedures to be performed on a day case basis while others, for the same procedure may regard an overnight stay as the norm. (BADS Directory of Procedures 2007)

5.18 Hospitals are increasingly focussing on the short stay elective pathway. Carrying out elective procedures as day cases, where clinical circumstances and specialist equipment and training allows, saves money on bed occupancy and nursing care, as well as improving patient experience and outcomes.

5.19 The Audit Commission has identified 25 operations across a number of surgical specialties which could be carried out as day cases and has set a target of an average day case rate of 75% across the 25 procedures. This target has now been adopted within Priorities for Action, to be achieved by March 2011. Three of the procedures specifically relate to Urology (orchidopexy, circumcision, transurethral resection of bladder tumour). BADS (British Association of Day Surgery) identifies another 28 Urology operations (M and N code) which could be done as day surgery. The BADS Directory also suggests a % rate that can be achieved, which is 90% for the majority of the operations.

5.20 Table 9 below identifies the day case rates (% of all elective work undertaken as day case) in Urology by Trust and by hospital. It excludes Independent Sector activity and cystoscopies (M45) and prostrate TRUS, +/- biopsy (M70), both of which are not considered to be ‘true’ surgical operations and could equally be treated and coded as an outpatient with procedure case.

Table 9 Urology Day Case Rates excluding M45 and M70.3 & Y53.2 (06/07, 07/08, 08/09- Apr 08 to Nov 08)
Independent Sector Activity has been excluded

	FY2006/2007	FY2007/2008	FY2008/2009*
Regional Total	50.0	48.4	48.7

Trust	FY2006/2007	FY2007/2008	FY2008/2009*
Belfast Health and Social Care Trust	47.1	42.9	46.4
Northern Health and Social Care Trust	31.1	32.6	27.9
South Eastern Health and Social Care Trust	78.0	74.0	69.9
Southern Health and Social Care Trust	43.7	45.4	49.1
Western Health and Social Care Trust	47.1	51.3	42.2

Site	FY2006/2007	FY2007/2008	FY2008/2009*
Altnagelvin Hospitals	47.1	51.3	42.2
Belfast City Hospital	49.9	45.5	48.9
Causeway	31.1	32.6	27.9
Craigavon Area Hospital	43.7	45.4	49.1
Down and Lisburn	98.8	100.0	89.3
Mater Infirmorum Hospital	4.9	4.2	6.9
The Royal Group of Hospitals	100.0	100.0	100.0
Ulster Community and Hospitals	76.6	71.2	66.3

5.21 There is a significant variation in day case rates across the Trusts/hospitals, ranging from 30% in Northern to 70% in South Eastern. Some of this can be explained due to the variation in 'N' code work undertaken by Urologists as opposed to General Surgeons (see Chapter 2). Trusts have also reported that on some sites access to dedicated day surgery facilities is limited and that this hampers the development of short stay elective pathways.

5.22 The CSR (Comprehensive Spending Review) is driving Trusts to reduce inpatient costs and to redesign/remodel their bed stock. This along with day surgery targets in Priorities for Action and the HSC Board's Elective Reform Programme will require Urology services to be creative in the development of day and short stay surgery, ensuring the provision of a safe model of care that provides a quality service to patients.

5.23 Trusts will need to consider procedures currently undertaken using theatre/day surgery facilities and the appropriateness of transferring this work to procedure/treatment rooms, thereby freeing up valuable theatre space to accommodate increased day surgery. Some operations will require specialised equipment and training for clinicians and some require longer recovery or observation times and so are only possible as a true day case if performed on morning sessions. Therefore, the development and expansion of day surgery may require reconfiguration of day surgery/main theatre lists, redesign of clinical pathways and investment in appropriate equipment/technology.

Recommendation

15.	Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery.

Outpatients

Table 10

Urology Outpatient Attendances - Consultant Led (06/07, 07/08, 08/09 - Apr 08 to Nov 08) - New : Review ratios

Independent Sector has been excluded

	FY2006/2007	FY2007/2008	FY2008/2009*
Regional new to review ratio	1.93	2.04	1.93

Trust	FY2006/2007	FY2007/2008	FY2008/2009*
Belfast Health and Social Care Trust	1.68	2.14	1.97
Northern Health and Social Care Trust	1.97	1.74	1.46
South Eastern Health and Social Care Trust	1.15	1.10	1.09
Southern Health and Social Care Trust	4.04	3.27	3.85
Western Health and Social Care Trust	2.34	2.21	2.78
Average new to review ratio	**1.93**	**2.04**	**1.93**

Site	FY2006/2007	FY2007/2008	FY2008/2009*
Altnagelvin Hospitals	2.34	2.21	2.78
Belfast City Hospital	1.84	2.90	2.44
Causeway	1.97	1.74	1.46
Craigavon Area Hospital	4.04	3.27	3.84
Down and Lisburn	1.06	1.18	1.24
Mater Infirmorum Hospital	1.63	1.11	1.47
The Royal Group of Hospitals	0.83	0.91	0.88
Ulster Community and Hospitals	1.19	1.07	1.01
Average new to review ratio	**1.93**	**2.04**	**1.93**

***Information for 08/09 is cumulative from 01/04/08 to 30/11/08**

5.24 Regionally, there is an average new: review ratio of 1:2, with little variation from year to year. English HES data for 2006/07 reports a 1:2.4 new: review ratio. Variations are to be expected between hospitals and individual Consultants when case mix and complexity are taken into account e.g. BCH, due to a more complex case mix and Lagan Valley/RGH due to the fact that only day surgery is undertaken on these sites.

5.25 Craigavon Hospital is an outlier with regard to review ratios, with Altnagelvin Hospital having the second highest ratio.

5.26 It is disappointing to note that at the time of this review Trusts have reported a total of 9,386 patients for whom the (intended) date of their review has past (some by many months). This is referred to as a review backlog and if most of these patients had been seen within the same 2008/09 timeframe for the data above, then the new: review ratios would have been higher, particularly in Belfast and Southern Trusts. (Backlog; Belfast 5,599, Southern 2,309, Northern 668, South Eastern 431, Western 379). All Trusts have submitted action plans to address the review backlog that has arisen across a number of specialties.

Recommendations

16. Trusts should review their outpatient review practice, redesign other methods/staff where appropriate and subject to casemix/complexity issues reduce new:review ratios to the level of peer colleagues.

17.	Trusts must modernise and redesign outpatient clinic templates and admin/booking processes to ensure they maximise their capacity for new and review patients and to prevent backlogs occurring in the future.

6. CHALLENGES AND OPPORTUNITIES

6.1 At an early stage in the Review, an extensive round of meetings/discussion sessions were held with the various stakeholder organisations and staff to scope the challenges and opportunities of service delivery.

Challenges

6.2 A number of key themes were articulated and are summarised below:

- Increasing demand and workload pressures which were understood to be as a result of an ageing population along with people living longer, increased cancer detection and shorter waiting times arising from the elective access targets and cancer access standards, which is generating a previously unmet need in assessment and diagnostics.

- Capacity pressures (staffing), with a workforce struggling to cope with the increasing workload and meet the current targets and quality/clinical standards. This has resulted in significant reliance on independent sector and large numbers of additional clinics and theatre sessions being held internally. Both of these have been funded non-recurrently, year on year and are not sustainable in the future.

- Capacity pressures (infrastructure), on some sites, with regard to access to theatres and day surgery sessions which again results in transfer of work to independent sector. Access to elective Urology beds, in times of emergency admissions pressures, was also an issue for some sites.

- The challenges presented by the operation of 2 to 3 person Consultant teams outside of Belfast and the impact this has on on-call/cross cover arrangements, attraction and retention of clinical staff and the opportunity to develop sub specially interests and expertise. The size of the team is directly linked to its catchment population and the viability and sustainability of Urology services is dependent on a critical mass of work, of sufficient variety of conditions and treatments, to attract both training and substantive posts. The arrangements for the management and admission of acute Urological patients, particularly out of hours, in some Trusts, and the impact that the lack of such a service has on other sites was also raised as an issue.

- Impact of junior doctors hours, EWTD (European Working Time Directive) and in particular, changes to the training programme have resulted in a reduction in "the medical workforce", a shift from Consultant led services to Consultant delivered services and additional requirements on Consultants to directly provide and supervise training opportunities.

- Challenges around the cancer agenda and in particular, compliance with IOG (Improving Outcomes Guidance) and preparing for the Peer Review Exercise in 2010.

- Concerns were expressed about how service development tends to take place within and is restricted by Trust/Organisational boundaries. Also about inconsistent access/pathways for patients.

Opportunities

6.3 Within the various service and staff groups there was a strong desire and commitment to making significant improvements to Urology services in Northern Ireland.

6.4 There was general acceptance that additional investment was not the only solution: Making better use of the existing resources was also necessary and that the review of Urology services created significant opportunities to develop and re-design services, provide high quality, timely and cost effective services to patients and the community and to support and develop the individual and teams within this important specialty.

6.5 There was also a strong sense of wanting to do things differently and of the need to change and adapt to a changing landscape in terms of public expectations, targets and standards, changing pattern of disease and treatment, new technologies and techniques and employment and training legislation and entitlement.

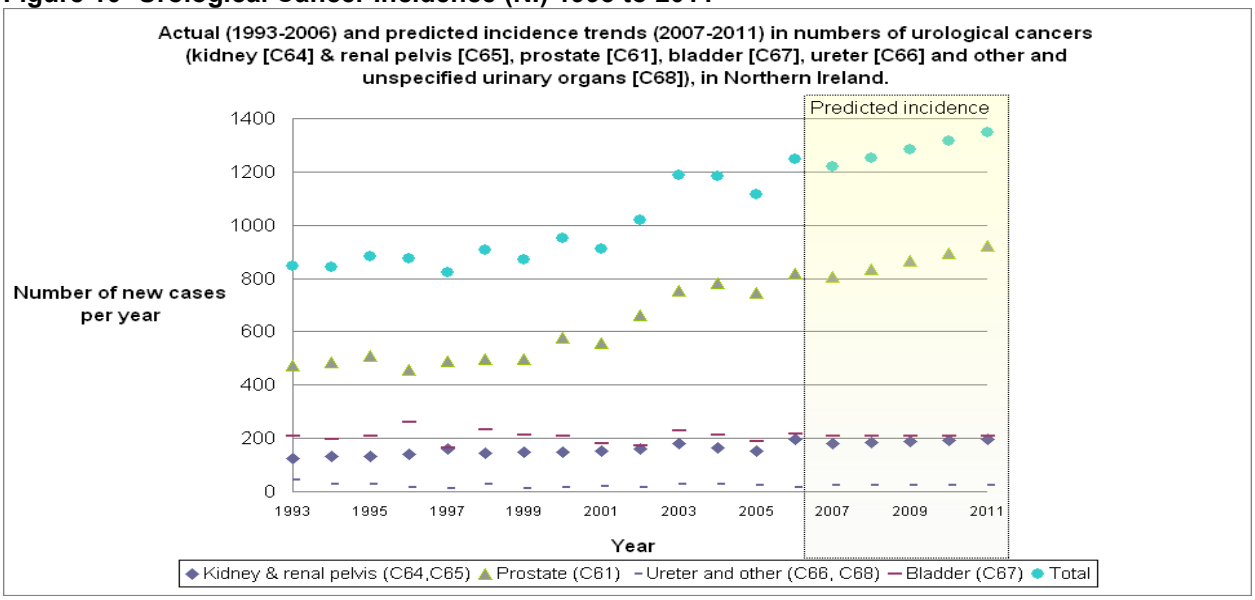
7. UROLOGICAL CANCERS

7.1 Around 40% of Urology work is cancer related and in addition to intensive assessment, diagnostics and treatment requirements, there is also a requirement for considerable patient follow-up, support and surveillance services. Cancer becomes more common with increasing age with almost 2 out of every 3 cancers diagnosed in people aged 65 and over.

7.2 Cancer of the prostate, testis, penis, kidney and bladder as a group has the highest volume of cancer incidence than any other specialty, with 1,246 incidence recorded on the cancer registry for 2007. The next highest is breast, followed by colorectal and lung.

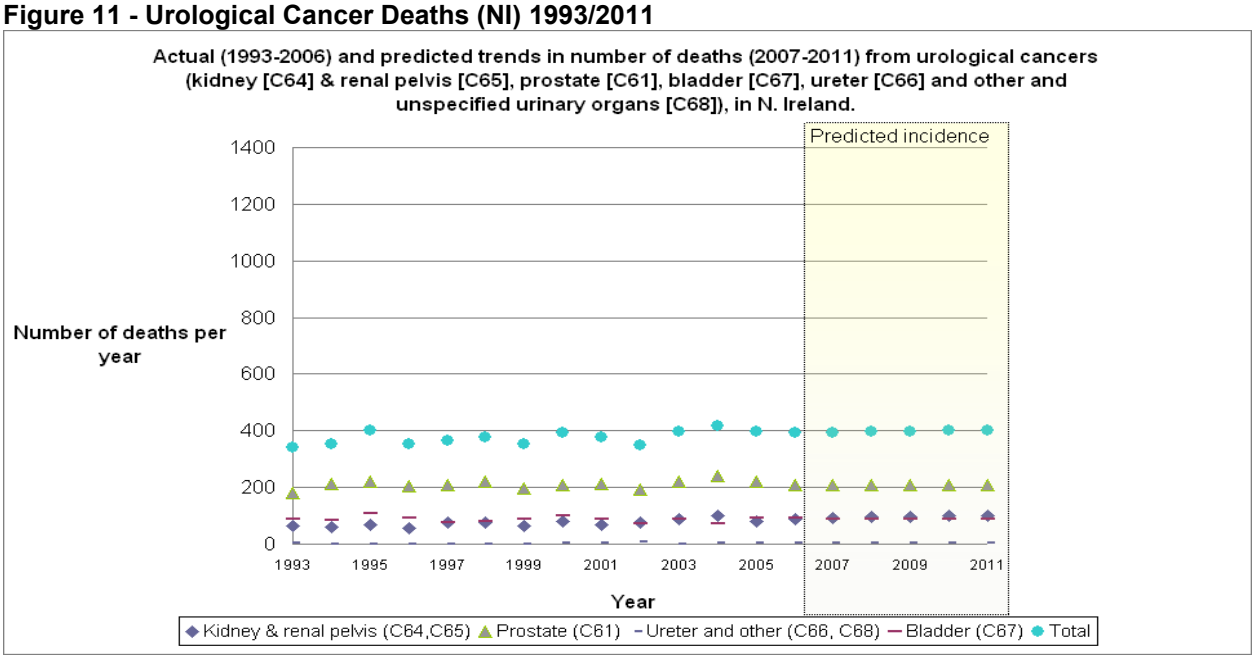
Cancer Incidence and Mortality

Figure 10- Urological Cancer Incidence (NI) 1993 to 2011



Source: NI Cancer Registry

Figure 11 - Urological Cancer Deaths (NI) 1993/2011



Source: NI Cancer Registry

7.3 Bladder and ureter incidence has been and is likely to remain stable (approximately 230).

7.4 Kidney cancer incidence has increased by almost 50% between 1993 and 2006 (196 in 2006), with a corresponding rise in deaths. By 2011, there could be further slight increases.

7.5 Prostate cancer incidence increased by 70% between 1993 and 2006 (817 in 2006). By 2011, it is predicted to increase by a further 20% compared with current incidence, but the number of deaths remains stable.

7.6 Prostate cancer is the second most frequently diagnosed cancer among men of all ages; testicular cancer, although relatively infrequent, is nevertheless the most common cancer in men under 45 years of age. Cancer of the penis, by contrast, is rare. Cancers of the kidney and bladder are roughly twice as common among men.

7.7 The main presenting symptoms of primary urological tumours fall into 3 groups:

- Lower urinary tract symptoms
- Haematuria and
- Suspicious lumps.

7.8 Haematuria is the most common symptom of both bladder and kidney cancer, although kidney cancer is often asymptomatic until it reaches a later stage.

7.9 Early, asymptomatic prostate cancer is being diagnosed more in recent years due to increase use of PSA testing and men's health awareness programmes.

Guidance and Standards

7.10 The NI Report "Cancer Services: Investing in the Future" (The Campbell Report) published in 1996 recommended that delivery of cancer services should be at three levels: Primary Care, Cancer Units and the Cancer Centre. The 2000 Review of Urological Services in Northern Ireland endorsed the principles of the Campbell Report and took account of them in their recommendations.

7.11 In 2002, NICE published guidance on cancer services-"Improving Outcomes in Urological Cancers-The Manual" (IOG).

7.12 The key recommendations from IOG are in Appendix 6. The recommendations relate to the requirement to have dedicated, specialist, multidisciplinary Urological cancer teams, making major improvements in information and support for patients and carers, with nurse specialist having a key role in these services, and having specific arrangements in place to undertake radical surgery for prostate and bladder cancer.

7.13 In 2008, under the auspices of NICaN (Northern Ireland Cancer Network) a new Urological tumour group was set up and has to date met on three occasions. Mr H Mullen chairs this group with Mr P Keane, Consultant Urologist, Belfast Trust, serving as the lead clinician. Mr Keane is also a member of the Review Steering

Group (as a NICAN lead) along with Dr D Hughes, NICaN Medical Director and Mrs B Tourish, NICaN, Clinical Network Co-ordinator.

7.14 The NICaN Group has agreed priority areas of work, based on IOG, including the development and implementation of formal dedicated MDTs / MDMs, implementing referral guidelines and agreed pathways for diagnostics and treatment of each of the cancers, developing patient information and guidance and ensuring suitable arrangements are in place prior to the Peer Review planned for 2010.

Recommendation

18.	The NICaN Group in conjunction with each Trust and Commissioners should develop and implement a clear action plan with timelines for the implementation of the new arrangements/enhanced services in working towards compliance with IOG.

7.15 A key element of IOG is the requirement to undertake radical pelvic surgery on a single site, serving a population of 1 million or more, in which a specialist team carries out a cumulative total of at least 50 such operations (prostatectomy (M61)and cystectomy (M34) per annum.

7.16 Tables 11 and 12 outline the number of radical pelvic operations carried out in 2006/07 and 2007/08 by Trust and Consultant.

Table 11 – Radical Pelvic Surgery 2006/07

Trust	Consultant	M34 Bladder	M61 Prostate	Total
BHSCT	Cons A	3	11	*14*
	Cons B	8	14	*22*
	Cons C	9	11	*20*
	Cons D	5	0	*5*
Total		**25**	**36**	***61***
SHSCT	Cons A	3	1	*4*
	Cons B	8	5	*13*
	Cons C	2	5	*7*
Total		**13**	**11**	***24***
WHSCT	Cons A	3	17	*20*
Total		**3**	**17**	***17***
Grand Total		**41**	**64**	***105***

Table 12 – Radical Pelvic Surgery 2007/08

Trust	Consultant	M34 Bladder	M61 Prostate	Total
BHSCT	Cons A	6	12	*18*
	Cons B	7	18	*25*
	Cons C	20	12	*32*
	Cons D	3	0	*3*
	Cons E	1	0	*1*
Total		**37**	**42**	***79***
SHSCT	Cons A	0	1	*1*
	Cons B	3	1	*4*
	Cons C	5	3	*8*
	Cons D	0	3	*3*
Total		**8**	**8**	***16***
WHSCT	Cons A	0	7	*7*
Total		**0**	**7**	***7***
Grand Total		**45**	**57**	***102***

7.17 The Northern and South Eastern Trust do not undertake such operations and patients requiring/choosing radical surgery are referred to BCH.

7.18 In 2007/08 77% of radical pelvic operations were undertaken in Belfast Trust (BCH). Neither the Southern or Western Trust (separately or together) undertake the required number (50) of such operations. Four of the existing Consultants undertake small (<5) numbers of each of the procedures. With a total of just over 100 procedures a year, a population less than 2 million and, with the potential for this activity to reduce with the implementation of a brachytherapy service in the next year, a single site for radical pelvic surgery is considered to be the appropriate way forward if IOG compliance is to be achieved.

Recommendations

19.	By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties.

20.	Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).

8. CLINICAL WORKFORCE REQUIREMENTS

Consultant staffing

8.1 In 1996, BAUS (British Association of Urological Surgeons) recommended a Consultant: Population ratio of 1:80,000 by 2007. In 1999 the ratio in Northern Ireland was 1:167,000 population reducing to 1:103,000 population at the time of the review in 2009, with a funded establishment of 17 wte Consultants.

8.2 In the 2000 "Report of a working group on Urological Services in Northern Ireland" a ratio of 1:100,000 population was recommended due to Northern Ireland's younger age profile. BAUS had indicated that the demand for Urological Services is related to the age structure of the population and specifically with the proportion of 65 years.

8.3 In 1996, the percentage of those aged 65 years and over in Northern Ireland was 12.85% and at this time was considerably lower than in England (15.8%) and Wales (15.2%). By 2007 Northern Ireland's percentage of over 65 had risen to 14.1% and is predicted to rise further to 16.7% by 2018.

8.4 A total population of 1.76 million in 2008 and a Consultant to population ratio of 1:80,000, would equate to a funded establishment of 22 wte Consultant Urologists.

8.5 The NI Urology SAC (Specialist Advisory Committee), in estimating the number of higher specialist trainees required by 2018, have used a Consultant Urologist workforce of 38 wte by 2018. In projecting future staffing, SAC took account of "Developing a Modern Surgical Workforce" published by the Royal College of Surgeons in England (2005) and subsequent interim review of October 2006. The Royal College suggests that for a population of 1 million the requirement will be 8-9 specialist surgeons and 8-10 generalists.

8.6 Based on an average age of retirement of 60 years of age, the anticipated retirements in Urology between 2009 - 2018 is four. Taking this into account along with the Royal Colleges projected future staffing requirements, SAC have recommended an increase in the number of higher specialist trainees from the current 8 at ST3+ (year 3 and above) to up to 15 by 2018.

8.7 SAC have confirmed that they are content, at this time, with the Consultant to population ratio proposals within this review i.e. 1:80,000.

Consultant Programme

8.8 Guidelines for a Consultant job plan (agreed by the Royal College of Surgeons and adopted by the Association of Surgeons of Great Britain and Ireland) are based on a commitment of 10 notional half days.

8.9 The traditional Consultant contract has 6 + 1 (special interest) fixed sessions with 3 flexible sessions. BAUS Council recommend a 5 + 1 fixed session contract with 4 flexible sessions for Consultant Urologists.

"A Quality Urologist Service for Patients in the New Millennium - Guidelines on Workload, Manpower and Standards of Care" (BAUS 2000) recommends a typical job plan as outlined below:

Operating Theatre	3 NHD
Outpatient Clinics	2 NHD
Specialist Interest	1 NHD
Ward Round plus on-call	1 NHD
Post Graduate Education:	1NHD

To Include:

- Audit, teaching
- Pathology and X-ray meetings
- Clinical Governance
- Quality Assurance
- Mortality and Morbidity meetings

Flexible commitment	2 NHD

On-call rota 1:5

- *Special interest sessions may be used to provide additional operating, specific outpatient clinics, uro dynamics, lithotripsy or to supervise the research activities of the Department.*
- *Involvement in clinical management, audit and clinical governance will occupy significant clinical time and provision must be made for these activities within the job plan.*
- *Flexible sessions cover duties, which may be performed at different times, over different weeks and even sometimes outside standard working hours. These will include clinic administration, travel, inter-departmental referral and continuing clinical responsibility. They will also include time spent after operating sessions and clinics "tidying the desk", talking to patients relatives, visiting patients on the ward prior to operation, reviewing patient notes, results and ensuring that these are made known to patients and to the relevant medical practitioners.*

Workloads

8.10 Both BAUS and The Royal College of Surgeons outline similar workloads/activity that can be expected from a Consultant's working week, based on a 42 week working year.

8.11 **Outpatients (new and review) -** A Consultant working alone should see between 1176 and 1680 patients per annum. *Consultants with a major sub specialty interest e.g. oncology, will see significantly fewer patients due to case complexity and a need to allocate more time to each patient. Teaching, particularly under graduates and house officers, will also reduce the number of cases per clinic.*

8.12 To allow sufficient time for proper assessment and counselling, it is accepted practice to allow approximately 20 minutes for a new patient consultation and 10 minutes for a follow-up consultation. Therefore in a standard clinic an Urologist, working on his own should see 7 new patients and 7 follow-up patients. This can be adjusted locally depending on case complexity up to a maximum of 20 patients (new and review) per clinic.

8.13 **In patient/day case activity -** *The average Consultant Urological Surgeon, and his team, should be performing between a 1000 and 1250 inpatient and day patient FCEs per annum. The exact number will depend on sub specialty interest, case mix, the number of operating sessions in the job plan and whether the Urologist has an obligation to train a specialist registrar. For example, some specialists in oncology, who perform lengthy complex procedures, would be expected to have fewer FCEs than their generalist counterparts.*

8.14 The activity analysis outlined in section 4 of the report outlines projected activity of 21,571 episodes in 2008/09. This figures includes in-house additional activity provided by Trusts but excludes activity sent out to the Independent Sector. With no further reduction in elective waiting times in 2009/10, it will be possible to make a more robust assessment of recurrent demand during the year.

8.15 The activity delivered by Trusts in 2008/09 equates to 21.5 wte consultant staff, taking account of the average workload figures above. However, due to complexity/casemix issues not all Consultants will perform the average number of FCEs. For example, with the creation of single site for radical pelvic surgery there will be a requirement for an additional Uro-oncology Consultant at the BCH.

Recommendation

21.	To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte.

8.16 This level of investment in staffing infrastructure will allow Urology services to be recurrently provided at 2008/09 outturn levels. In terms of future proofing, Trusts will be required to look at further efficiencies within existing capacity with a view to increasing the average workload per Consultant to the higher level in the context of changing demographics with an older population which will place additional demands on Urology services over the coming years. This is particularly relevant to the Northern and Southern Trusts where Consultant workloads are significantly below their peer colleagues and BAUS guidelines.

Recommendation

22.	Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans.

Nurse Staffing

8.17 The additional nursing and support staff requirements to support the additional clinics and theatre sessions that will be implemented with the appointment of new Consultants are included in the estimated costing in Appendix 7.

8.18 To ensure high quality nursing services and effective and efficient use of highly specialised equipment and instruments it is essential that nurses working in Urology

wards, theatres and other departments are fully trained and competent in the field of Urology.

8.19 Specialist nurses and practitioners have a key and expanding role to play in a modern Urology Service. There are many examples of nurses, within and outwith ICATS teams, undertaking assessment, diagnostic, treatment and follow-up of areas of Urology such as erectile dysfunction, LUTS (Lower Urinary Tract Symptoms), haematuria clinics, stones etc.

8.20 Specialist (Uro-Oncology) nurses must be dedicated, fully participating members of any cancer MDT, actively represent the patient's interests at MDM's and have a key role to play in carrying out detailed assessment of patients needs in order to provide, or coordinate good care. They have a particular role to play at "results" clinics and in assisting patients and carers in making informed decisions and choices regarding treatment options, the management of and living with the symptoms and consequences of their cancer and the treatments/interventions.

8.21 Under the auspices of NICaN, in collaboration with the senior nurses for cancer services across the Northern Ireland and English networks, a number of cancer site specific, clinical nurse specialist benchmarking censuses have been completed. There are a total of 12 specialist nurses in Urology in Northern Ireland at this time. However, few of these staff are solely dedicated to cancer care and therefore an estimate of the wte (whole time equivalent) has been made. In November 2008 there were estimated to be 4 wte oncology nurse specialists -1.5 in BCH, 2 in Altnagelvin and .5 in the Ulster.

8.22 Table 13 below outlines the results of a benchmarking exercise completed in November 2008, in which each of the cancer networks identified the incidence of cancer and calculated an average caseload per Clinical Nurse Specialist (CNS).

Table 13 - CNS caseload benchmarking data

	Lung	Breast	Urology	Colo-rectal	Gynae	Upper GI	Haem	Skin	Head & Neck	Brain
Cancer incidence	845	1,031	1,246	995	450	562	411	208	127	109
Total no CNS in post 2008	7.5	14	4	3	2	1	3	3	2	1
NI mean caseload	112	73	311	331	225	562	137		63	109
England mean caseload	122	81	131	89	77	98	70		66	81
Additional nos needed	3	2	5	4	4	3.5	5	1	2.5	1
Future NI mean caseload	80	64	138	142	75	125	52		51	54.5

8.23 There are higher numbers of Urological cancer incidences than in any other speciality and these CNSs have the third highest (upper GI is the highest at 562) mean caseload at 311, which is more than double the English mean caseload.

8.24 This shortfall will need to be addressed if significant improvements are to be made in the cancer pathways, waiting times, support and follow-up for Urology patients in Northern Ireland.

Recommendation

23.	At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNSs should be undertaken in mid 2010.

Radiology Staffing

8.25 The assessment and diagnostics of Urological diseases/conditions involves intensive and high volumes of radiology services across a broad range of modalities-ultrasound (KUB, TRUS), IVP, CT and MRI scans, along with the provision of an interventional radiology service. As Urology services are redesigned and streamlined, radiology services will be required to respond and adapt to the new service models and pathways and in particular accommodate more single visit haematuria, LUTS, prostate and stones clinic.

8.26 In addition to any further investment, radiology services will be required to ensure optimum and enhanced use of current available capacity by modernising and reforming the systems and processes currently in place.

8.27 In recognition of the significant capacity gap in Urology to meet the growing demand, a number of additional Consultants will be appointed and a significant number of additional patients will need to be assessed and treated internally. Additional radiology staffing to support these appointments (included in the estimated costs in Appendix 7) has been calculated using the Adenbrookes formula of .3 wte Consultant Radiologist per wte Consultant Urologist and a ratio of 6 wte band 5 Radiographers per wte Radiologist.

Pathology and Radiotherapy Services

8.28 It is recognised with the volumes of Urological cancers, the Urology service is a high user of both pathology and radiotherapy services. However, given the work being undertaken by NICaN, within the Cancer Services Framework and the supporting cancer investment plan, and the Pathology Services Review, published in December 2007, it was agreed that the current Urology review would not include a detailed assessment of these services. Investment in an additional band 7, BMS is however included in the estimated costs in appendix 7, in recognition of the increased diagnostic workload associated with growing PSA work and the centralisation of radical pelvic surgery on the BCH site.

9. SERVICE CONFIGURATION MODEL

9.1 In section 6 the key challenges currently being faced by the service were outlined. In summary, these related to the capacity to deliver a modern, quality service and the ability to achieve and sustain long term stability and viability, with a stable workforce that can continue to attract the necessary expertise across all of the professions.

9.2 It has been recognised that investment in additional capacity and staff will not on its own resolve the challenges relating to long term service stability. This will require a reconfiguration of teams/services into more sustainable units thus enabling the service to make the best use of any investment made.

9.3 A number of models (6) for future service delivery were developed. These ranged from 5 teams in NI, with each Trust having its own discrete urology service and its staffing and workload based on its current catchment population, to 2 teams in NI.

9.4 A sub group of clinicians, Trust and Board Managers developed criteria and a weighted scoring system against which each of the models could be assessed. The 5 criteria (Appendix 8) were:

- Service stability/sustainability (population, team size, dedicated skilled radiology and nursing staff, rotas and EWTD.
- Feasibility (ease and speed of implementation).
- Compliance with DHSSPS policy/strategy, commissioner intent/support, compatibility with Trusts strategic development plans and impact on other services.
- Inpatient accessibility.
- Organisational complexity.

9.5 At the Steering Group meeting on 20 January 2009, each of the 6 models was evaluated against the agreed criteria. Model 3 (Appendix 9) was agreed as the preferred model and was deemed to be the most appropriate way forward for urology services.

Recommendation

24.	Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability.

9.6 Model 3 comprises 3 teams, which for ease of description are called Team North, Team South and Team East. Table 14 below outlines the main elements of each of these teams.

Table 14 Elements and Arrangements in Three Team Model

Teams	Geographical Area/ Catchment Population	Consultant Staffing/Suggested Special Interest Areas**	Arrangements for Elective and Non Elective Services
Team North	Upper2/3rd of Northern* and Western integrate to form one Team/Network. Catchment population circa 480,000	Six wte All core Urology Uro-oncology – 2 Stones/endourology – 2* Functional/female Urology – 1 Andrology – 1	One on-call rota (1:6) Main acute elective and non elective inpatient unit in Altnagelvin Approximately 7 elective beds in Causeway(Selected minor/intermediate cases) Day surgery – Altnagelvin, Causeway, Tyrone County Outpatients – Altnagelvin, Causeway, Tyrone County, Roe Valley May wish to consider outreach outpatient and/or day case diagnostics in Mid-Ulster *Mobile ESWL (Lithotripter) on Causeway site
Team South	Lower 1/3rd Western (Fermanagh) and all of Southern integrate to form one Team/Network. Catchment population circa 410,000	Five wte All core Urology Uro-oncology – 2 Stones/endourology – 2* Functional/female Urology – 1	One on-call rota (1:5) Main acute elective and non elective inpatient unit in Craigavon Day surgery – Craigavon, South Tyrone, Daisy Hill Outpatients – Craigavon, South Tyrone, Daisy Hill, Banbridge, Armagh May wish to consider outreach outpatients and/or day case diagnostics in Erne/ Enniskillen *Static/fixed ESWL (lithotripter) on Craigavon site.
Team East	SET + Belfast integrate to form one Team/Network-continue to provide service to patients from Southern sector of Northern Trust (Newtownabbey, Carrickfergus, Larne, ?Antrim). Catchment population circa 870,000 Complex cancer catchment 1.76m	Twelve Wte All core Urology Uro-oncology/cancer centre – 4 Stones/endourology – 3* Functional/female Urology – 2 Reconstruction – 3	One on-call rota (1:12) (may wish to consider 2nd tier on-call) Main acute elective and non elective unit in BCH, with elective also in Mater and Ulster Day surgery – BCH, Mater, Lagan Valley, Ards, Downe Outpatients – BCH, Ulster, Mater, Royal, MPH, Ards, Lagan Valley, Downe Should provide outreach outpatient, day case diagnostics and day surgery in Antrim and/or Whiteabbey/Larne *Mobile ESWL lithotripter on BCH site.

*Population estimates for local District Council areas in Appendix 10. Precise catchment 'lines' on map to be clarified.
** Suggested special interest areas derived from discussions with clinicians and from BAUS guidelines.

9.7 In response to concerns expressed at the Steering Group Meeting in January 2009, Speciality Advisor (local and 'Island of Ireland') advice was sought around the issue of a single handed Consultant doing on-call from home covering elective and non elective patients on different sites. The advice has confirmed that such arrangements are possible and that a similar situation exists in other specialties e.g. Trauma and Orthopaedics.

9.8 Urologists have advised that there are very few occasions when a Consultant's presence is required, out of hours, to deal with an elective post operative complication/event. Equally, as described in the previous section of this report, the vast majority of non elective admissions, out of hours, do not require a Consultant's intervention. However, surgeons undertaking elective inpatient surgery on a site other than the main acute unit should use morning lists so as to further ameliorate the impact of out of hour's events. They can minimise the impact further through careful choice of the nature and type of surgery undertaken.

Recommendations

25.	Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements.

26	Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served.

10. IMPLEMENTATION ISSUES

10.1 To implement the review recommendations a recurrent (full year) investment of £2.875m has been estimated (Appendix 7). Commissioners will need to consider the method of allocating funding to support the full implementation of the recommendations, particularly with regard to aligning the allocation to the additional Consultant distribution profile.

10.2 Trusts and Commissioners will need to take forward discussions with General Practitioners around referral pathways and patient flows in the context of the proposed three team model.

10.3 Trusts will be required to submit detailed business cases prior to funding being released.

10.4 Trusts and Commissioners will need to agree timescales and the measurable outcomes in terms of additional activity, improved performance, a phased reduction in Independent Sector usage and service reform and modernisation plans.

10.5 The implementation of the recommendations of the review may/ will require capital investment to put in place additional physical infrastructure such and to fund equipment associated with technologically driven sub-specialty areas. e.g. endo-urology, reconstruction, laser surgery. Where capital requirements are identified, Trusts should process these bids through their normal capital and business planning cycle.

10.6 The new Teams (Trust partnerships) will be required to submit project plans for implementation of the new arrangements which is envisaged to be on a phased and managed basis. The new Health and Social Care Board will establish an Implementation Board to oversee the process.

GLOSSARY OF TERMS/ABBREVIATIONS

BADS- British Association of Day Surgery

BPH – Benign Prostatic Hyperplasia
A non –cancerous condition in which an overgrowth of *prostate* tissue pushes against the *urethra* and the bladder, restricting or blocking the normal flow of urine. Also known as benign prostatic hypertrophy. This condition is increasingly common in older men.

Biopsy
Removal of a sample of tissue or cells from the body to assist in diagnosis of a disease.

Bladder reconstruction
A surgical procedure to form a storage place for urine following a *cystectomy*. Usually, a piece of bowel is removed and is formed into a balloon-shaped sac, which is stitched to the *ureters* and the top of the urethra. This allows urine to be passed in the usual way.

Brachytherapy
Radiotherapy delivered within an organ such as the prostate.

CNS
Clinical Nurse Specialist

Cystectomy
Surgery to remove all or part of the bladder.

Cystoscope
A thin, lighted instrument used to look inside the bladder and remove tissue samples or small tumours.

Cystoscopy
Examination of the bladder and *urethra* using a *cystoscope*.

ED
Erectile dysfunction

EWTD
European Working Time Directive

Genital
Referring to the external sex or reproductive organs.

Haematuria
The presence of blood in the urine. Macroscopic haematuria is visible to the naked eye, whilst microscopic haematuria is only visible with the aid of a microscope.

HES/Hospital Episode Statistics
HES is the national statistical data warehouse for England of the care provided by NHS hospitals and NHS hospital patients treated elsewhere.

Incontinence
Inability to control the flow of urine from the bladder (urinary) or the escape of stool from the rectum (faecal)

IVP – Intravenous Pyelogram
An x-ray examination of the kidneys, ureters and urinary bladder that uses iodinated contrast material injected into veins.

KUB
Kidney, Ureter, Bladder (Ultrasound)

Laparascopic surgery
Surgery performed using a laparascope; a special type of endoscope inserted through a small incision in the abdominal wall.

LUTS
Lower Urinary Tract Symptoms

MRI - Magnetic resonance imaging
A non-invasive method of imaging which allows the form and metabolism of tissues and organs to be visualised (also known as nuclear magnetic resonance).

MDMs
Mutli-disciplinary meetings

MDTs
Mutli-disciplinary teams

NICaN
Northern Ireland Cancer Network

Oncology
The study of the biology and physical and chemical features of cancers. Also the study of the causes and treatment of cancers.

Prostatectomy
Surgery to remove part, or all of the *prostate gland*. Radical prostatectomy is the removal of the entire *prostate gland* and some of the surrounding tissue.

Prostate gland
A small gland found only in men which surrounds part of the urethra. The prostate produces semen and a protein called *prostate specific antigen (PSA)* which turns the semen into liquid. The gland is surrounded by a sheet of muscle and a fibrous capsule. The growth of prostate cells and the way the prostate gland works is dependent on the male hormone *testosterone*.

PSA – Prostate Specific Antigen
A protein produced by the *prostate gland* which turns semen into liquid. Men with prostate cancer tend to have higher levels of PSA in their blood (although up to 30% of men with prostate cancer have normal PSA levels). However, PSA levels may also be increased by conditions other than cancer and levels tend to increase naturally with age.

Radical treatment
Treatment given with curative, rather than *palliative* intent.

Radiologist
A doctor who specialises in creating and interpreting pictures of areas inside the body. The pictures are produced with x-rays, sound waves, or other types of energy.

Radiotherapy
The use of radiation, usually x-rays or gamma rays, to kill tumour cells. Conventional external beam radiotherapy also affects some normal tissue outside the target area. Conformal radiotherapy aims to reduce the amount of normal tissue that is irradiated by shaping the x-ray beam more precisely. The beam can be altered by placing metal blocks in its path or by using a device called a multi-leaf collimator. This consists of a number of layers of metal sheets which are attached to the radiotherapy machine; each layer can be adjusted to alter the shape and intensity of the beam.

Renal
Of or pertaining to the Kidneys.

Resection
The surgical removal of all or part of an organ.

Scrotum
The external sac that contains the testicles.

Testicle or testis (plural testes)
Egg shaped glands found inside the scrotum which produce sperm and male hormones.

TRUS Tran-rectal ultrasound (TRUS)
An *ultrasound* examination of the prostate using a probe inserted into the rectum.

Trans-uretharal resection (TUR)
Surgery performed with a special instrument inserted through the urethra.

Trans-urethral resection of the prostate (TURP)
Surgery to remove tissue from the prostate using an instrument inserted through the urethra. Used to remove part of the tumour which is blocking the urethra.

Ultrasound
High-frequency sound waves used to create images of structures and organs within the body.

Ureters
Tubes which carry urine from the kidneys to the bladder.

Urethra
The tube leading from the bladder through which urine leaves the body.

Urogenital system
The organs concerned in the production and excretion of urine, together with the organs of reproduction.

Urologist
A doctor who specialises in diseases of the urinary organs in females and urinary and sex organs in males.

Urology
A branch of medicine concerned with the diagnosis and treatment of diseases of the urinary organs in females and the urogenital system in males.

Uro-oncologist
A doctor who specialises in the treatment of cancers of the urinary organs in females and urinary and sex organs in males.

Vasectomy
Surgery to cut or tie off the two tubes that carry sperm out of the *testicles*.

WTE
Whole Time Equivalent

APPENDICES

Appendix 1

Regional Urology Steering Group

Membership

Mr Hugh Mullen (Chair)	SDU, Director of Performance and Provider Development
Mr Mark Fordham	External Advisor, Consultant Urologist
Ms Catherine McNicholl	SDU, Programme Director (Project Manager)
Mr Paul Cunningham	SDU, Performance Manager
Dr Hubert Curran	SDU, Primary Care Advisor
Dr Windsor Murdock	SDU, Primary Care Advisor
Dr Miriam McCarthy	DHSS&PS, Director Secondary Care
Dr Dermot Hughes	NICaN, Medical Director
Mr Patrick Keane	Belfast Trust, Lead Clinician NICaN Urology Group
Dr Diane Corrigan	SHSSB, Consultant Public Health
Dr Janet Little	EHSSB, Acting Director Public Health
Dr Christine McMaster	EHSSB, Specialist Registrar, Public Health
Dr Adrian Mairs	NHSSB, Consultant Public Health
Mr Alan Marsden	NHSSB, Elective Care Commissioning Manager.
Dr Bill McConnell	WHSSB, Director Public Health
Mrs Rosa McCandless	WHSSB, Information Manager
Mrs Karen Hargan	Western Trust, Assistant Director Surgery/Acute Services
Mr Colin Mulholland	Western Trust, Consultant Urologist
Ms Carmel Leonard	Western Trust, Lead Nurse Surgery
Mr Paul Downey	Northern Trust, Consultant Urologist
Mr Martin Sloan	Northern Trust, Director Elective and

	Acute Services
Dr Brian Armstrong	Belfast Trust, Co-Director Specialist Services
Mr Chris Hagan	Belfast Trust, Consultant Urologist
Mr Brian Duggan	Belfast Trust, Consultant Urologist
Mr Brian Best	South Eastern Trust, Consultant Urologist
Mr John McKnight	South Eastern Trust, Consultant Urologist
Mrs Diane Keown	South Eastern Trust, Assistant Director Surgery.
Ms Joy Youart	Southern Trust, Acting Director Acute Services
Mr Michael Young	Southern Trust, Consultant Urologist
Mrs Jenny McMahon	Southern Trust, Nurse Specialist.

Appendix 2

Regional Review of Urology Services

Terms of Reference

Overall Purpose

To develop a modern, fit for purpose in the 21st century, reformed service model for Adult Urology services which takes account of relevant Guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician, through the entire pathway from Primary Care to Intermediate to Secondary and Tertiary Care.

It is anticipated that the Review Report will be available for submission to the Department in December 08, subject to Steering Group approval. A multi-disciplinary, key stakeholder Steering Group, chaired by Mr Hugh Mullen will meet to consider and approve the review findings and proposals.

The Review will include the following;

1. Baseline assessment of current service model identifying what is provided where, by whom, performance against access standards and the current profile of investment.

2. Expand on the current capacity/demand modelling exercise to take account of case mix with a view to identifying capacity gaps and informing future investment plans.

3. Develop a service model with agreed patient pathways which informs the distribution of services. The model will also outline proposals for optimising safe, effective and efficient Urology services which meet both access and quality standards/outcomes. The following aspects of the service will be considered;

    - Management of referrals and diagnostics including urodynamics.
    - Development and use of ICATS services
    - Management of acute urological admissions
    - Core Urology (secondary care) Services
    - Andrology Services
    - Interventional Uro-Radiology
    - Endourology/Stone Service
    - Uro-oncology Services
    - Relationship with Uro-gynaecology Services
    - Reconstruction and Neurourology Service
    - Acute Urological management of nephrology patient

4. Make recommendations, as appropriate, on the relationship with the Transplant service and waiting time targets for live donor transplantations.

5. Review workforce planning and training / development needs of the service group and ensure any proposals take account of the need to comply with EWTD (European Working Time Directive.

Appendix 3

UROLOGY REPORTS/ REVIEWS

Northern Ireland Review Reports

Report of the EHSSB Sub Group on Urological Cancer	Sept 1997
Report of the Working Group on Urology Services in Northern Ireland	May 2000
Update on Urology Cancer Services in the EHSSB	Oct 2001
External Review of Urology Services for Craigavon Area Hospital Group	Aug 2004
Draft Service Framework for Cancer Prevention, Treatment and Care – (Urology section)	Version 7 June 2008

National Reports

BAUS – A Quality Urological Service for Patients in the New Millennium	Oct 2000
BAUS – The Provision of Urology Services in the UK	Feb 2002
NICE – (Guidance on Cancer Services) Improving outcomes in Urological Cancers	Sept 2002
Modernisation Agency – Action on Urology – Good Practice Guide	Mar 2005
Providing Care for Patients with Urological Conditions: guidance and resources for commissioners (NHS)	2008
NICE – Urinary Incontinence: the management of urinary incontinence in women	2006
NICE – Prostate Cancer: diagnosis and treatment	2008
NICE – (Urological) Referral guidelines for suspected cancer	2005

Appendix 4

GP REFERRAL EXERCISE - PERCENTAGES

Gender	Belfast	Northern	Western	Southern	SE	Regional Average
Male	77	74	76	79	75	**76**
Female	23	25	22	21	25	**23**
Blank	0	2	2	0	0	**1**
Total	**100**	**100**	**100**	**100**	**100**	**100**
Age Range	**Belfast**	**Northern**	**Western**	**Southern**	**SE**	**Regional Average**
0-14	1	0	0	2	0	**1**
15-30	12	8	11	6	10	**10**
31-40	13	8	11	15	5	**11**
41-50	20	17	9	13	7	**15**
51-60	13	25	20	11	5	**14**
60+	41	42	49	53	12	**38**
Blank	0	2	0	0	60*	**12**
Total	**100**	**100**	**100**	**100**	**100**	**100**
Urgency	**Belfast**	**Northern**	**Western**	**Southern**	**SE**	**Regional Average**
Red Flag	4	4	7	6	5	**5**
Urgent	21	21	22	19	16	**20**
Routine	75	75	71	75	78	**75**
Blank	0	0	0	0	0	**0**
Total	**100**	**100**	**100**	**100**	**100**	**100**
Named Cons	**Belfast**	**Northern**	**Western**	**Southern**	**SE**	**Regional Average**
Y	24	25	13	23	21	22
N	76	75	87	77	79	78
Total	**100**	**100**	**100**	**100**	**100**	**100**
Ref Source	**Belfast**	**Northern**	**Western**	**Southern**	**SE**	**Regional Average**
Non-GP ref's	10	23	2	9	19	**13**
GP Ref's	90	77	96	91	81	**87**
Blank	0	0	2	0	0	**0**
Total	**100**	**100**	**100**	**100**	**100**	**100**

* 44 out of 73 referrals in SET had DOB deleted-therefore not possible to record age range.

Appendix 5

GP REFERRAL EXERCISE – PRESENTING SYMPTOMS (PERCENTAGES)

Presenting Symptom/Condition		Belfast		Northern		Western		Southern		SE		Regional	
Haematuria (ALL)		**13**		**19**		**22**		**9**		**16**		**15**	
	frank		*58*		*30*		*40*		*40*		*50*		*46*
	microscopic		*32*		*50*		*60*		*40*		*50*		*45*
	blank		*11*		*20*		*0*		*20*		*0*		*9*
Prostate/raised PSA		**10**		**13**		**18**		**17**		**16**		**14**	
Other		**15**		**8**		**11**		**15**		**11**		**13**	
Ncode procedure (All)		**15**		**4**		**2**		**6**		**19**		**11**	
	vasectomy		*52*		*0*		*100*		*33*		***29***		***41***
	foreskin		*5*		*0*		*0*		*67*		***50***		***24***
	epididymal cyst		*14*		*100*		*0*		*0*		***21***		***20***
	hydrocele		*19*		*0*		*0*		*0*		***0***		***10***
	varicocele		*5*		*0*		*0*		*0*		***0***		***2***
	blank		*5*		*0*		*0*		*0*		***0***		***2***
Recurrent UTI's		**12**		**17**		**9**		**11**		**5**		**11**	
LUTS		**8**		**13**		**4**		**9**		**10**		**9**	
Prostate/BPH/prostatitis		**8**		**9**		**9**		**11**		**3**		**8**	
Renal stones/colic/loin pain		**8**		**9**		**2**		**4**		**5**		**6**	
Testicular/ Scrotal lumps or swelling		**6**		**0**		**11**		**0**		**11**		**6**	
Andrology (ALL)		**5**		**4**		**7**		**11**		**3**		**5**	
	erectile dysfunction		*29*		*100*		*0*		*50*		*50*		*40*
	peyronie's disease		*29*		*0*		*67*		*0*		*0*		*20*
	blood in ejaculate		*43*		*0*		*0*		*0*		*0*		*15*
	ulcer/lesion on gland		*0*		*0*		*33*		*17*		*0*		*10*
	balanitis/discharge		*0*		*0*		*0*		*33*		*0*		*10*
	blank		*0*		*0*		*0*		*0*		*50*		*5*
Unknown		**2**		**2**		**2**		**4**		**0**		**2**	
Ca Bladder/Kidney		**1**		**2**		**0**		**2**		**0**		**1**	
Blank		**0**		**0**		**2**		**0**		**0**		**0**	
Total		**100**		**100**		**100**		**100**		**100**		**100**	

Appendix 6

NICE – Improving outcomes in Urological Cancers (IOG) – The Manual (2002)

Key Recommendations

The key recommendations highlight the main organisational issues specific to urological cancers that are central to implementing the guidance. As such, they may involve major changes to current practice.

- All patients with Urological cancers should be managed by multidisciplinary Urological cancer teams. These teams should function in the context of dedicated specialist services, with working arrangements and protocols agreed throughout each cancer network. Patients should be specifically assured of:
    - Streamlined services, designed to minimise delays;
    - Balanced information about management options for their condition;
    - Improved management for progressive and recurrent disease.
- Members of Urological cancer teams should have specialised skills appropriate for their roles at each level of the service. Within each network, multidisciplinary teams should be formed in local hospitals (cancer units); at cancer centres, with the possibility in larger networks of additional specialist teams serving populations of at least one million; and at supra-network level to provide specialist management for some male genital cancers.
- Radical surgery for prostate and bladder cancer should be provided by teams typically serving populations of one million or more and carrying out a cumulative total of at least 50 such operations per annum. Whilst these teams are being established, surgeons carrying out small numbers (five or fewer per annum) of either operation should make arrangements within their network to pass this work on to more specialist colleagues.
- Major improvements are required on information and support services for patients and carers. Nurse specialist members of urological cancer teams will have key roles in these services.
- There are many areas of uncertainty about the optimum form of treatment for patients with urological cancers. High-quality research studies should be supported, with encouragement of greater rates of participation in clinical trials.

Appendix 7

Estimated Cost of Implementation of Recommendations.

Staffing	**Number**	**Band/Grade**	**Unit Cost**	**Total**
Consultant Urologist	6	Consultant	£104,000	£624,000
Consultant Anaesthetist @ 0.6 wte per Con. Urologist	3.6	Consultant	£104,000	£374,400
Consultant Radiologist @ 0.3 wte per Con. Urologist	1.8	Consultant	£104,000	£187,200
Radiographer @ 6 per wte Con Radiologist	10.8	Band 5	£27,995	£302,346
Nursing @ 1.8 wte per Con. Urologist	10.8	Band 5	£27,995	£302,346
Nursing @ 0.46 wte per Con. Urologist	2.7	Band 3	£19,856	£53,611
Specialist Nursing	5	Band 7	£41,442	£207,210
Nursing @ 0.64 wte (day surgery)	0.64	Band 5	£27,995	£17,917
Pers. Secretary @ 0.5 wte per consultant urologists	3	Band 4	£23,265	£69,795
Admin support to radiologists at 0.5 wte per Radiologist	1	Band 3	£19,856	£19,856
Admin Support to Specialist Nurses @ 0.5 wte per Nurse	3	Band 3	£19,856	£59,568
Medical Records support 0.5 per unit	2.5	Band 4	£23,265	£58,162
MLSO – Bio-medical Science	1	Band 7	£41,442	£41,442
Support Costs				
Surgical G&S @ £94,500 per Con. Urologist	X 6		£95,400	£567,000
Theatre Goods/Disposables @ £50,000 per Con.Urologist	X 6		£50,000	£300,000
Radiology G&S per Con. Urologist	X 6		£2,500	£15,000
CSSD @ £32,000 per Con. Urologist	X 6		£32,000	£192,000
Outpatients Clinics @ 2 per Con. Urologist	X 12		£10,000	£120,000
Sub Total				**£3,511,853**
Less Consultant funded in 2008				**(£437,076)**
Sub Total				**£3,074,777**
Less 2008/09 Cancer Funds				**(£200,000)**
FINAL TOTAL				**£2,874,777**

Appendix 8

Evaluation Criteria

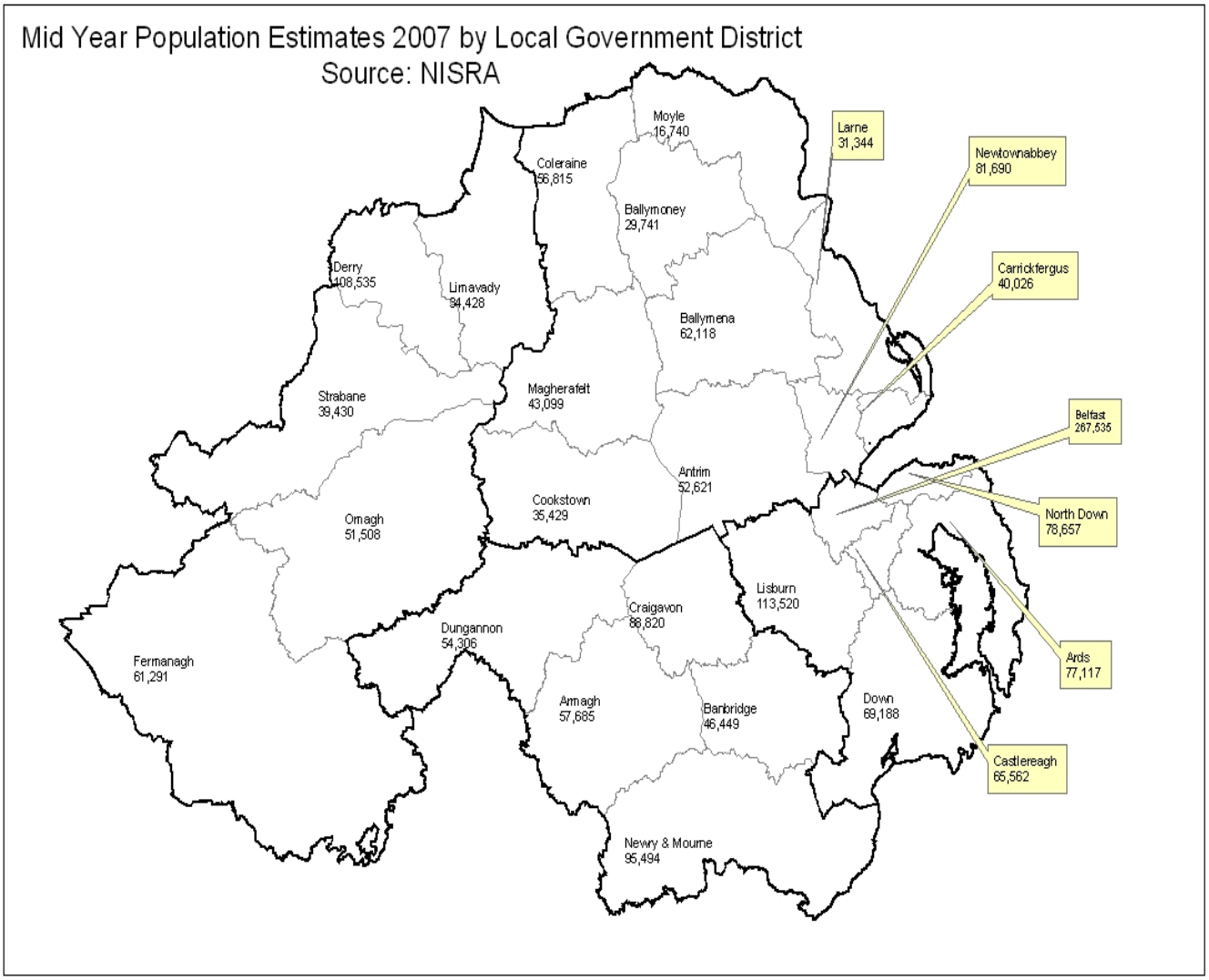
Criteria	Definitions
1. Service Stability / Sustainability	This is the criterion of the highest priority/value. The long term stability and hence viability and success of the service depends on a stable workforce – a workforce that can develop the service further and continue to attract the necessary expertise across all its professions. The criterion is sub-divided into four closely related sub-categories. a. Population – smaller catchment populations restrict the generation of a critical mass of work (cancer and non cancer). Using BAUS recommendations of 1 consultant per 80,000, each team should serve a catchment population of no less than 400,000. b. Team Size – A team of at least five to six consultants is preferred. This will improve long term attractiveness of each team in terms of recruitment and retention. It will also enable at least 2-3 to sub specialise, with dedicated sessions in the sub specialty e.g. uro-oncology, endourology/stones, female urology c. On site interventional radiology and trained urological nursing – These are key quality aspects. On site radiology to ensure timely access to interventions for emergency and urgent cases and sufficient total activity to justify 24 hour urology nursing experience in wards and theatres. This is to enhance multi-disciplinary working and support the development of nurse-led services. d. Commitment to Rotas and Working Time Directive – The service must be capable of sustaining adequate and acceptable on-call arrangements (elective and emergency), compliance with EWTD and equitable provision of emergency care.
2. Feasibility (ease and speed of implementation)	This criterion concerns the need to maximise the use of existing capital infrastructure (beds, theatres, equipment, clinic accommodation). The additional activity required and the appointment of additional Consultants and Nurse Specialists will require additional access to clinical facilities (as described above). It is assumed that the more new capital development is required, the longer the lead in time for starting new teams, and the longer the reliance on the independent sector. Preference will be given to those models that require the least capital resources and restructuring of premises. Consideration of the availability of trained staff will also be given. A particular model will lose points if it is unlikely that trained staff will be available in the numbers required to fill necessary posts.
3. Compliance with DHSSPS Strategy / Commissioner Support / Compatibility with Trust Strategic Plans/impact on other services	A model will lose points if it does not reflect specific regional health and wellbeing strategies/policies – DBS (the location of major hospitals with inpatient care), Cancer Framework (location of cancer units and Cancer Centre). Models should also attract commissioner support. Alignment with Trust Strategic Plans and impact on other services should also be considered.
4. Accessibility for Inpatient Elective Care	It is assumed that each model will be able to facilitate the flexible locating of outpatient and diagnostic service and will therefore be difficult to discriminate scores on this basis. Agreed pathways for emergency care is also assumed. Variation in local provision of elective inpatient care is more discriminatory. A model will lose points if it requires significantly greater travel time (from the do nothing case) for a substantial number of patients.
5. Organisational Complexity	A service should have unambiguous clinical and managerial leadership and accountability arrangements. Some potential models will need to transcend Trust organisational boundaries. This criterion concerns how complicated such arrangements are likely to be and weights each model accordingly – the more complicated the fewer the points awarded.

Appendix 9

Model 3: Three Teams/Networks

Team North and West:	• Upper 2/3rds of Northern and Western integrate to form one Team/Network • Main base Hospital - Altnagelvin • Potential for small number of inpatient beds in Causeway Hospital to be used for selected elective work subject to satisfactory arrangements for the post-operative management of these patients
Team South and West:	• Lower 1/3rd of Western (Fermanagh) and all of Southern integrate to form one Team/Network • Main base Hospital – Craigavon
Team East:	• SET and Belfast integrate to form one Team/Network • Continue to provide services to the southern sector of Northern population by outreach – Outpatient/Diagnostics/Day Surgery in Antrim and Whiteabbey hospitals with inpatients going to Belfast

Appendix 10



Wright, Elaine

From: Wright, Elaine [redacted]
Sent: 19 July 2012 09:26
To: McAlinden, Mairead
Subject: FW: Chairs visits to Ward 1 North, CAH and Thorndale Unit, CAH
Attachments: LEADERSHIP WALK-AROUND TOOL - Chairs visit to Thorndale Unit Craigavon Area Hospital 230512 RESPONSE.doc

From: Stinson, Emma M
Sent: 18 July 2012 16:56
To: Comac, Jennifer; Wright, Elaine
Subject: Chairs visits to Ward 1 North, CAH and Thorndale Unit, CAH

Dear both

Please see attached for your information.

Emma

Emma Stinson
PA to Dr Gillian Rankin
Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

Tel: [redacted]
Fax: [redacted]

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

From: Corrigan, Martina
Sent: 16 July 2012 10:10
To: Rankin, Gillian
Cc: Stinson, Emma M; Reid, Trudy
Subject: FW: Chairs visits to Ward 1 North, CAH and Thorndale Unit, CAH

Dear Dr Rankin,

Please see attached with my comments in response to issues raised in the Chair's visit to Thorndale Unit.

Many thanks

Martina

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

Telephone: Personal Information redacted by USI (Direct Dial)
Mobile: Personal Information redacted by USI
Email: Personal Information redacted by USI southerntrust.hscni.net

From: Rankin, Gillian
Sent: 27 June 2012 11:18
To: Reid, Trudy
Cc: Corrigan, Martina
Subject: FW: Chairs visits to Ward 1 North, CAH and Thorndale Unit, CAH

Trudy,

Please let me have the responses to issues raised here by Monday 16th July.

Thanks
Gillian

From: McAlinden, Mairead
Sent: 26 June 2012 11:00
To: Rankin, Gillian
Subject: FW: Chairs visits to Ward 1 North, CAH and Thorndale Unit, CAH

Gillian, FYI/response to Chair and I as necessary

Mairead

From: Comac, Jennifer
Sent: 25 June 2012 16:02
To: McAlinden, Mairead
Cc: Wright, Elaine
Subject: Chairs visits to Ward 1 North, CAH and Thorndale Unit, CAH

Dear Mairead

Please find attached, for your information, Chair's reports following her visits to Ward 1 North, CAH on 16/4/12 and the Thorndale Unit, CAH on 23/5/12.

Kind regards

Jennifer

Jennifer Comac
PA to Mrs Roberta Brownlee, Chair
Southern Health and Social Care Trust
Tel: Personal Information redacted by USI

Wright, Elaine

From: Wright, Elaine [redacted]
Sent: 27 August 2013 11:51
To: McAlinden, Mairead
Subject: FW: [redacted] Ref - CAHB [redacted]

-----Original Message-----
From: Complaints
Sent: 23 August 2013 12:00
To: Wright, Elaine
Subject: FW: [redacted] Ref - CAHB [redacted]

FYI

-----Original Message-----
From: Cardwell, David On Behalf Of ClientLiaison, AcutePatient
Sent: 22 August 2013 14:52
To: Paul.Berry [redacted]
Cc: Complaints
Subject: FW: Mr Martin John Oldham Ref - CAHB161313

Dear Cllr Berry

Thank you for your email in relation to Mr [redacted]

This patient was added to the waiting list on 30 April 2013 and is waiting for a TURP under Mr O'Brien. He is currently waiting 16 weeks and Mrs Corrigan, Head of Urology has checked and there are 43 patients also requiring TURP's in front of him. The longest waiter is 49 weeks so at this point we would be unable to provide a date for when Mr [redacted] will have his surgery.

If in the meantime, Mr [redacted] condition deteriorates he should re-attend his General Practitioner for a reassessment of his condition and if appropriate the General Practitioner may contact the Consultant about the clinical urgency of Mr [redacted] condition.

David Cardwell
Governance Officer
Directorate of Acute Services

Telephone: [redacted]
Email: David.Cardwell [redacted]

-----Original Message-----
From: McAlinden, Mairead
Sent: 12 August 2013 13:07
To: 'Paul.Berry [redacted]
Cc: Complaints
Subject: Re: Mr [redacted] Ref - CAHB [redacted]

Dear Paul,

Thank you for contacting me with Mr [redacted] concerns. Unfortunately the Urology service in Craigavon, in common with the other Urology services provided in other parts of NI, is experiencing increased demands. However our Consultants do their best to treat patients with clinical priorities.
Your correspondence will be shared with the Urology service and I hope to respond to you within the next 2 weeks when Mr [redacted] case has been looked in to.

In the meantime, if Mr [redacted] GP has concerns about the clinical urgency of his condition, he should contact the consultant.

Mairead

----- Original Message -----
From: Paul Berry <Paul.Berry[redacted]
To: McAlinden, Mairead
Cc: Wright, Elaine
Sent: Mon Aug 12 12:07:33 2013
Subject: Mr [redacted] Ref - CAHB[redacted]

Dear Mairead,
I am emailing you in relation to [redacted] and his date of birth is [redacted].
From the beginning of this year [redacted] has had Prostrate problems and has been in and out of Hospital as a result of this. In February this year he had a catheter fitted hoping that this would resolve his problems but sadly it has been unsuccessful and it was tried again but no benefit to him. From February the catheter has been constantly blocking and causing much discomfort fro Mr [redacted] and he has been in to see Mr O'Briens Deputy to explain his problems. After this he was informed that he was on a list to have a minor operation to rectify the prostrate.
His local GP Dr [redacted] has been very proactive and requested that urgent attention be considered as the operation is minor and it would resolve Mr [redacted] distress once and for all but most regrettably to date he has not been called for this minor operation.
I have met him and his wife at their home and he is just recovering from an hernia operation but he would really need this prostrate one to enable him to have a full recovery and get back to a normal way of life. The fact that he has to get medical help when the catheter blocks is also a waste of everyone's time when all it takes is a minor operation.
Clearly waiting from February for such a minor operation that would change his way of living for the good is too long to wait and I am requesting that you investigate this case as soon as possible.
Thank you for your time and I look forward in hearing from you.

Regards
Councillor Paul Berry

Southern Health and Social Care Trust

Policy Checklist

Name of Policy:	Policy for the Management of Complaints (Working Draft)
Purpose of Policy:	To ensure that Trust staff are informed and aware off the Trust's complaints handling process and to provide service users, patients and clients with the information they require to make a complaint.
Directorate responsible for Policy	Chief Executive's Office
Name & Title of Author:	Joscelyn Magennis, Corporate Complaints Officer
Does this meet criteria of a Policy?	Yes/No/Not Applicable
Trade Union consultation?	Yes/No/Not Applicable
Equality Screened by:	
Date Policy submitted to Policy Scrutiny Committee:	
Members of Policy Scrutiny Committee in Attendance:	
Policy Approved/Rejected/ Amended	
Policy Implementation Plan included?	
Any other comments:	
Date presented to SMT	
Director Responsible	
SMT Approved/Rejected/Amended	
SMT Comments	
Date received by Employee Engagement & Relations for database/Intranet/Internet	
Date for further review	2 year default

POLICY DOCUMENT – VERSION CONTROL SHEET	
Title	Title: Policy for the Management of Complaints Version: Reference number/document name:
Supersedes	Supersedes: Policy for the Management of Complaints, November 2010 Description of Amendments(s)/Previous Policy or Version: Reviewed and updated in-line with changes to the Governance structures within the Trust and to ensure continuing compliance with regional complaints procedures.
Originator	Name of Author: Joscelyn Magennis Title: Corporate Complaints Officer
Scrutiny Committee & SMT approval	Referred for approval by: Date of Referral: ScrutinyPolicy Committee Approval (Date) SMT approval (Date)
Circulation	Issue Date: Circulated By: Issued To: As per circulation List (details below)
Review	Review Date: Responsibility of (Name): Title:

Southern Health and Social Care Trust

Quality Care - for you, with you

Policy for the Management of Complaints (Working draft)

Authors	***Joscelyn Magennis, Corporate Complaints Officer***
Directorate Responsible	***Chief Executive's Office***
Date of Issue	
Review Date	***July 2015***

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SECTION ONE: INTRODUCTION, PURPOSE AND SCOPE

1.0 *Introduction to Policy*

The Policy for the Management of Complaints has been based on *Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning*, which was published by the DHSSPSNI on 1st April 2009 (and updated June 2011 and June 2013). The policy also reflects the ongoing regional work with HSC to ensure best practice in the management of complaints.

A separate specific policy and procedure is in place for the management of complaints regarding services to children and young people in accordance with the *Children (NI) Order 1995 Representation and Complaint Procedure*.

1.1 *Policy Statement*

The Southern Health and Social Care Trust (hereafter referred to as the "Trust") believes that patients, relatives and carers have a right to have their views heard and acted upon. The Trust welcomes feedback on all aspects of service and recognises the value of complaints in improving service provision for patients and the public through listening, learning and improving.

1.2 *Purpose and Aims*

The Trust is committed to developing a culture of responsible openness and constructive criticism, and to encouraging all service users to contribute views on all aspects of the Trust's activities. It has introduced this policy to enable service users to raise any concerns they may have at an early stage and in the right way.

The aim of this policy is to:

- Inform staff of the Trust's processes for complaints handling; and
- Provide service users, patients and clients with the information they require to make a complaint.

1.3 *Scope of Policy*

This Policy is applicable to all services provided by the Trust with the following exception for which alternative procedures are already in place: *Children (NI) Order 1995 Representation and Complaints Procedure*.

1.4 *Legislative Compliance, Relevant Policies, Procedures and Guidance*

The *Health and Social Care Complaints Procedures Directions (Northern Ireland) 2009* requires HSC organisations to make arrangements in accordance with the provisions of the directions for

the handling and consideration of complaints. The *Regional Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning* conform to this legislative framework.
Trust staff must also take cognisance of relevant professional standards and guidance to their own profession.

The Regulation and Quality Improvement Authority (RQIA) is the independent Health and Social Care regulatory body for Northern Ireland. In its work the RQIA encourages continued improvement in the quality of these services through a programme of inspections and reviews. RQIA have a duty to assess how Health and Social Care bodies handle complaints in light of the criteria drawn down from the standards and regulations laid down by the Department of Health, Social Services and Public Safety.

1.5 *Equality and Human Rights Consideration*

This policy has been screened for equality implications as required by Section 75, Schedule 9, of the *Northern Ireland Act 1998*. Equality Commission for Northern Ireland Guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be targeted at them.

Using the Equality Commission's screening criteria; no significant equality implications have been identified. This policy will therefore not be subject to an equality impact assessment.

This policy has been considered under the terms of the *Human Rights Act 1998*, and deemed to be compatible with the *European Convention Rights* contained in that Act.

This policy will be included in the Trust's register of screening documentation and maintained for inspection whilst it remains in force.

1.6 *Alternative Formats*

This document is available on request in alternative formats which include large print, audio disc and in other languages to meet the needs of those who are not fluent in English. These formats can be requested from the Corporate Complaints Officer. P*lease refer to **Appendix 3** for contact details*.
We Value Your Views leaflets, which provide service users/clients with an overview of the Trust's complaints procedures and contact details, is available from the Trust Intranet in large print and other languages (http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/PandP.html).

SECTION TWO: ROLES AND RESPONSIBILITES

2.0 *Role of the Chief Executive*

Our Chief Executive is responsible for ensuring that our complaints procedure is effective and that our approach ensures that appropriate investigations and actions have been completed before a response sent following the formal investigation of a complaint.

However, the responsibility for managing the requirements of this policy is delegated to the Assistant Director of Clinical and Social Care Governance. The Chief Executive must maintain an overview of the issues raised in complaints and be assured that appropriate organisational learning has taken place and that action is taken in the light of the outcome of any investigation.

2.1 *Role of the Assistant Director of Clinical and Social Care Governance*

It is role of the Assistant Director of Clinical and Social Care Governance (CSCG) to work with the Trust's operational, executive and corporate Governance Leads and support leads on the ongoing development of systems and procedures to monitor the implementation and effectiveness of changing professional, clinical and operational practice in improving the safety and quality of care, which takes due regard of evidence-based practice, lessons learned from reviews, complaints, incidents, accidents and public inquiries, and to provide recommendations and advice to SMT Governance on the Governance Action Plan and priority areas for action.

The Assistant Director of CSCG also ensures that a 'Lessons Learned' strategy and process is in place that identifies learning from clinical and social care incidents, lead the implementation and embedding of learning through co-ordination of agreed actions and integrated support from clinical and social care governance staff and workforce development and training leads, ensuring systems are in place for effective feedback to staff where issues of concern have been raised and actions identified to address same.

2.2 *Role of Executive Directors*

It is the role of the Executive Directors to refer any professional issues, about which they have concerns to the relevant professional body.

2.3 *Role of Operational Directors, Assistant Directors and Heads of Service*

All Operational Directors are responsible and accountable for the proper management of accurate, effective and timely responses to complaints received in relation to the services they manage. This responsibility also includes the prompt instigation of local investigations at an appropriate level determined by the seriousness of the complaint.

All Operational Directors will endeavour to ensure that those tasked with investigating and responding to complaints, implementing and sharing learning and improvement have the necessary resources, the co-operation of all staff and the support of senior management.

It is the responsibility of all Trust Directors, Assistant Directors, Service Heads and Senior Managers to utilize the information and trends from complaints within their governance processes to ensure learning and improvement, and to develop and monitor action and learning plans in response to issues identified from complaints.

It is the role of the Assistant Director, in complaints where concerns are raised about clinical treatment and care, to share and agree the proposed draft response to the complaint with the relevant clinician prior to it being submitted to the Director for approval.

2.4 ***Role of Line Managers and Front-Line Staff***

Complaints may be made to any member of staff. Staff must be trained and empowered to deal with complaints as they arise. Appropriately trained staff will recognise the value of the complaints process and as a result will welcome complaints as a source of learning. Advice and assistance for staff regarding the handling of complaints is available from the relevant Directorate Governance Team or the Corporate Complaints Officer.

The first responsibility of a staff member who receives a complaint is to ensure that, where applicable, the service user's immediate health and social care needs are being met before taking action on the complaint. Thereafter, the complainant's concerns should be recorded and dealt with rapidly and in an informal, sensitive and confidential manner.

Some complainants may prefer to make their initial complaint to a member of staff who has not been involved in the care provided. In these circumstances, the complaint should be dealt with by an appropriate member of senior staff (i.e. line manager). The Corporate Complaints Officer and Directorate Governance Team are available to support and advise front-line staff on the handling of complaints.

Where a complainant raises a clinical or professional matter an appropriately qualified person should be asked to review it in light of the investigation and advise on accuracy and details prior to the proposed complaint response being finalised.

All staff are required to promote and maintain service user and staff confidentiality and to comply

with the requirements of legislation, for example the Data Protection Act. The need for sensitivity and confidentiality is paramount.

2.5 ***Role of Corporate Complaints Officer***

The Corporate Complaints Officer (CCO) is responsible for providing a first contact for service users, signposting the service users around the organisation, assisting them in problem solving and facilitating them to access and use the Trust's complaints process.

The CCO is also responsible for screening service user contacts and determining if these are enquiries or complaints. The CCO will facilitate either resolution of the enquiry or complaint, or they will help facilitate the complainant in their use of the Trust's formal complaints procedure by directing the complaint to the relevant Directorate Governance Team. The CCO will then update Datix with all relevant information and actions taken. The CCO will provide the same support and consideration for those enquiries and complaints from third parties, such as MLAs and the Minister's office. The CCO will alert the Directorate Governance Teams to significant issues at an early stage.

2.6 ***Role of Governance Co-ordinators and Governance Officers***

The Governance Co-ordinators will lead their Directorate Governance Team in ensuring that at each level of the Directorate staff have access to timely, high quality and appropriate information in relation to complaints, and that within each service team this information is being acted upon appropriately in order to mitigate risk, improve quality of care and patient/client safety.

The Governance Co-ordinators will co-ordinate via the Directorate Governance Team the timely and appropriate responses to complaints on behalf of the Directorate. The Co-ordinators will ensure that the complaints process is conducted in accordance with Regional and Trust complaints procedures.

The Directorate Governance Team will:

- Manage all complaints received within their respective Directorates;
- Maintain a comprehensive IT system (Datix) of all complaints received;
- Provide support and advice to staff investigating/responding to complaints;
- Take account of any corroborative evidence available relating to the complaint;
- Identify training needs of staff and ensuring that appropriate programme are organised in conjunction with line managers;
- Provide the Directorate and the organisation with analysis and intelligence on complaints received to ensure that trends are identified as well as appropriate responses to individual complaints;

- Comply with Controls Assurance Standards criteria in respect of complaint management; and
- Be aware of the availability of and advise complainants about:
  - the support available from the Patient Client Council;
  - the role and availability of conciliation, advocacy, independent experts and lay persons; and
  - the Ombudsman/Commissioner for Complaints.

SECTION THREE: MAKING A COMPLAINT

3.0 *What is a complaint?*

The Trust aims to provide the highest possible standard of care and treatment to all service users, at all times, but sometimes things do not always go according to plan. When this happens, it is important for us to put things right quickly.

A complaint is **"an expression of dissatisfaction that requires a response"**.[1] Complainants may not always use the word "complaint". They may offer a comment or suggestion that can be extremely helpful. It is important to recognise those comments which are really complaints and need to be handled as such.

3.1 *Who can complain?*

Any person can complain about care or treatment, or about issues relating to the provision of health and social care.

This policy may also be used to investigate a complaint about any aspect of an application to obtain access to health or social care records for deceased persons under the Access to Health Records (NI) Order 1993 as an alternative to making an application to the courts.

Complaints may be made by:

- a patient or client;
- former patients, clients or visitors using Trust service and facilities;
- someone acting on behalf of existing or former patients or clients, providing they have obtained the patient's or client's consent;
- parents (or persons with parental responsibility) on behalf of a child; and
- any appropriate person in respect of a patient or client unable by reason of physical or mental capacity to make the complaint himself or who has died e.g. the next of kin.

It is important to note that making a complaint does not affect the rights of the patient/client and will not result in the loss of any services the patient/client have been assessed as requiring.

[1] *Complaints in Health and Social Care: Standards & Guidelines for Resolution & Learning* (April 2009)

3.2 *Issues this guidance does not cover*

3.2.1 This Policy for the Management of Complaints does not deal with complaints about:

- private care and treatment or services, including private dental care[2] or privately supplied spectacles; or
- services not provided or funded by the Trust, for example, provision of private medical reports.

3.2.2 Complaints may be raised within the Trust which we need to address, but which do not fall within the scope of this policy. While the Policy for the Management of Complaints does not cover the issues listed below the Trust has in place procedures to ensure that such concerns are dealt with. Such issues include:

- staff grievances;
- an investigation under the disciplinary procedure;
- an investigation by one of the professional regulatory bodies;
- services commissioned by the HSC Board;
- a request for information under Freedom of Information;
- access to records under the Data Protection Act 1998;
- an independent inquiry;
- a criminal investigation;
- the Children Order Representatives and Complaints Procedure;
- protection of vulnerable adults;
- child protection procedures;
- coroner's cases;
- legal action.

If any complaint received by the Trust indicates a need for referral under any of the issues above in section 3.3.2, they should immediately be passed to the relevant Directorate Governance Team for onward transmission to the appropriate department. If any aspect of the complaint is not covered by the referral it will be investigated under this Complaints Policy. In these circumstances, investigation under this Complaints Policy will only be taken forward if it does not or will not, compromise or prejudice the matter under investigation under any other process. The complainant will be informed of the need for referral.

While the Trust does not investigate complaints made regarding the Northern Ireland Ambulance Service (NIAS), any complaints received by the Trust in relation to the NIAS will be passed onto the NIAS Complaints Officer.

Complaints received by the Trust in relation to GP practices and services will be passed onto the Complaints Manager at the Health and Social Care Board (HSCB).

[2] The Dental Complaints Service deals with private dental and mixed health service and private dental complaints. The Dental Complaints Service can be contacted via the General Dental Council at http://www.gdc-uk.org/

3.3 *Complaints about Regulated Establishments/Agencies and Independent Service Providers*

On occasions the Trust may make use of Regulated Establishments/Agencies and Independent Service Providers (ISP), e.g. residential nursing homes, domiciliary care providers; to provide services for patients/clients. This form of treatment and/or care is subcontracted to the Regulated Establishment/Agency or ISP and funded by the Trust.

Regulated Establishments/Agencies and ISPs are contractually obliged to have in place appropriate governance arrangements for the effective handling of, management and monitoring of all complaints. This should include the appointment of designated officers of suitable seniority to take responsibility for the management of the in-house complaints procedures, including the investigation of complaints and the production of literature, which is available and accessible to patients/clients, which outline the establishment's complaints procedure. On commissioning of the services it would be good practice if the commissioner (i.e. Trust staff) informs the patient/client and relatives/carers that the Regulated Establishment/Agency or ISP will have a complaints procedure in place.

If a patient/client or relative/carer has a concern or complaint relating to the contracted services provided by a Regulated Establishments/Agency or ISP they should raise the concern/complaint directly with the provider of care in the first instance. However, where complaints are raised with the Trust, the Trust must establish the nature of the complaint and consider how best to proceed. It may simply refer the complaint to the ISP for investigation, resolution and response or it may decide to investigate the complaint itself where the complaint raises serious concerns or where the Trust deems it in the public interest to do so.

The Regulated Establishment/Agency or ISP is required to investigate the concern or complaint and provide a written response to the complainant which should be copied to the Trust. If there is a delay in responding to the complainant within the target timescales[3] the complainant will be informed and a revised date for conclusion of the investigation will be provided.

The response letter from the Regulated Establishment/Agency or ISP must advise the complainant that they can progress their complaint to the Trust for further consideration if they remain dissatisfied. The Trust will then determine whether the complaint warrants further investigation and who will be responsible for conducting the investigation. The Trust will work closely with the

[3] Under SHSCT complaints procedure a written response should be issued to the complaints within 20 working of the establishment's receipt of the complaint. If the establishment is unable to meet these timescales the complainant should be informed, in writing, as to the reasons why.

Regulated Establishment/Agency or ISP to enable appropriate decisions to be made.

The complainant must also be informed by the Regulated Establishment/Agency or ISP of their right to refer their complaint to the Ombudsman should they remain dissatisfied with the outcome of the complaints procedure. It is possible that referrals to the Ombudsman where complaints are dealt with directly by the Regulated Establishment/Agency or ISP without Trust participation in local resolution will be referred to the Trust for investigation and action by the Ombudsman.

The Trust has agreed arrangements in place to ensure that Regulated Establishments/Agency or ISPs provide information to annual review meetings relating to all complaints received and responded to directly by them.

It is the role of Trust staff, such as Key Workers, to ensure that patients/clients and relatives/carers are aware of the importance of raising concerns or complaint as close to the source as possible, as this allows for early resolution through discussion and negotiation. The general principle in the first instance therefore would be that the Regulated Establishment/Agency or ISP investigates and responds directly to the complainant.

Should patients/clients or relatives/carers lack confidence in the Regulated Establishments/Agencies or ISPs' complaints handling procedures or are not happy with the response they had received from the provider of care, they can refer their complaint to the Trust's Corporate Complaints Officer so that an investigation can begin. *Contact details for the Trust's Corporate Complaints Officer are listed below.*

Corporate Complaints Officer
Southern Health and Social Care Trust,
Trust Headquarters,
Craigavon Area Hospital,
Portadown,
BT63 5QQ

Telephone: (028) [redacted]

Email: Irrelevant information redacted by the USI

The Regulation and Quality Improvement Authority (RQIA) will monitor how complaints are handled and investigated by regulated services and the Trust. *For contact details please refer to **Appendix 3**.*

3.4 ***Complaints about Family Practitioners*** *(family doctors, dentists, pharmacists, opticians)*
All Family Practitioner Services (FPS) are required to have in place a practice-based complaints procedure for handling complaints. The practice-based complaints procedure forms part of the local resolution mechanism for settling complaints. A patient may approach any member of staff with a complaint about the service or treatment he/she has received.

Alternatively, the complainant has the right to lodge his/her complaint with the HSC Board's Complaint's Manager if he/she does not feel able to approach immediate staff. The HSC Board has a responsibility to record and monitor the outcome of those complaints lodged with them.

Complainants must be advised of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome if the practice-based complaints procedure.

*Please refer to **Appendix 3** for contact details.*

3.5 ***How can complaints be made?***
Complaints can be made to a member of Trust staff at the point of service delivery
It is important that the Trust works closely with its service users to find an early resolution to complaints when they arise. Every opportunity should be taken to resolve complaints as close to the source as possible through discussion and negotiation, and by following the guidance in section 4.3 of this Policy.

It is important that front-line staff are trained and supported to respond sensitively to the comments and concerns raised by service users and are able to distinguish those issues which would be better referred elsewhere. Staff across the Trust can assess the "Policy for the Management of Complaints" and "Complaints in Health and Social Care: A Need to Know Guide for Staff" through the Trust's Intranet.

Where possible complaints should be dealt with immediately and front-line staff should follow the procedures below in their handling of complaints received at point of service delivery:

1. The complaint is raised by or on behalf of the service user at the point of service delivery.

2. The member of staff who first learns of the complaint should respond immediately and directly in an attempt to resolve the matter informally, speedily and appropriately.

Where appropriate if the member of staff attempting to resolve the matter feels it would be

beneficial to involve a patient's advocate at this stage, they should seek advice from the relevant Directorate Governance Team.

3. If a member of staff has resolved a complaint 'at point of service delivery' they should complete all sections on the *Complaints at Point of Source Delivery* form and return to the Corporate Complaints Officer. A *Complaints at Point of Service Delivery* form can be located on the Trust Intranet under Policies & Procedures, Clinical & Social Care Governance.

If the person remains dissatisfied, they should be offered a copy of the Trust's 'We Value Your Views' leaflet and advised that they may wish to contact the Corporate Complaints Officer to make a formal complaint.

It is important that if you are in this situation, you ask your supervisor or line manager for assistance, if necessary.

3.5.1 *Formal Letter of Complaint received at Point of Service Delivery*

If a formal letter of complaint is received by staff at a point of service delivery' it should be sent by email the same day to the Trust's Corporate Complaints Officer so that an investigation can begin. *Please refer to* ***Appendix 3*** *for contact details.*

3.5.2 *Complaints can be made to the Corporate Complaints Officer*

Complaints may be made verbally or in writing and will also be accepted via other methods such as the telephone (including voicemail) or electronically (e.g. e-mail). It is helpful to establish at the outset what the complainant wants to achieve to avoid confusion or dissatisfaction and subsequent letters of complaint. The Trust is mindful of technological advances and has in place local arrangements which ensure that there is no breach of patient/client confidentiality. Contact details for the Trust's Corporate Complaints Officer are listed below.

Corporate Complaints Officer
Southern Health and Social Care Trust,
Trust Headquarters,
Craigavon Area Hospital,
Portadown,
BT63 5QQ

Telephone: (028) [redacted]

Email: [redacted]

3.5.3 *What information should be included in a complaint?*

A complaint need not be long or detailed, but it should include:	
Relevant Contact Details	✓ Complainants name, address (including postcode) and telephone number ✓ If you are making this comment/complaint on behalf of another person, please provide the following details: ▪ Their name, their address (including postcode) and their date of birth (if known) ▪ And please indicate your relationship to this person
Who or what is being complained about?	✓ Department/ward/facility where the issues occurred ✓ Hospital site, e.g. Craigavon, Lurgan, Newry, etc. ✓ Include the names of staff, if known
When the events of the complaint happened	✓ Details of the issue(s) relevant to the complaint ✓ Please include dates
Where possible, what remedy is being sought	✓ Such as an apology, an explanation or changes to be made to our services

3.6 *Complaints made by a 3rd Party (including those made by MPs, MLAs and Local Councillors) and Consent*

Confidentiality must be respected at all times and complaints by a third party should be made with the written consent of the patient/client concerned. If consent does not accompany the complaint the Trust will seek consent from the patient/client concerned or their next of kin where necessary. There will be situations where it is not possible to obtain consent, such as:

- where the individual is a child and not of sufficient age or understanding to make a complaint on their own behalf;
- where the individual is incapable (for example, rendered unconscious due to an accident; judgement impaired by learning disability, mental illness, brain injury or serious communication problems);
- where the subject of the complaint is deceased.

The relevant Governance Team will be able to provide further advice and guidance in relation to this matter. Consent forms can be obtained from the Complaints and User Views section of the Southern Health and Social Trust website.
(www.southerntrust.hscni.net/pdf/Patient_Client_Consent_form_May_2012(2).pdf)

Third party complainants who wish to pursue their own concerns can bring these to the Trust without compromising the identity of the patient/client. The Trust will consider the matter, investigate and address, as fully as possible, any identified concerns. A response will be provided to the third party on any issues which it is possible to address without breaching the patient's/client's confidentiality.

3.7 *Complaints made by staff*

As staff in the Southern Trust, we all have a responsibility to protect our service users, fellow members of staff, the public and the Trust. If you have a concern as a member of staff about any aspect of the quality and safety of our services, another member of staff or about any of the functions of the Trust, those concerns can be raised as per the Trust's *Whistleblowing Policy*. Staff can access the *Whistleblowing Policy* via the Trust's Intranet (http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/WhistleblowingPolicyFINALREVIEWEDonintranetMay2012.pdf).

3.8 *Anonymous Complaints*

If someone approaches the Trust with a complaint we will request their name and contact details. This will enable us to acknowledge their complaint, confirm the issues causing concern and clarify or seek further information and provide information on the outcome of our investigation.

Any request to remain anonymous will be respected as all complaints received by the Trust are treated with equal importance regardless of how they are submitted. However, complaints received with anonymity may mean that a detailed investigation may not always be possible, for example when there is a need to access medical records. Also, a complaint response cannot be issued.

All complaints submitted to the Trust, whether anonymous or not, are viewed as a significant source of learning within the organisation and help us to continue to improve the quality of our services and safeguard high standards of care and treatment. The number of complaints and trends emerging from complaints are continually monitored by each Directorate's Governance meeting and at the Patient/Client Experience Committee meetings.

3.9 *What are the timescales for making a complaint?*

A complaint should be made as soon as possible after the action giving rise to it, normally within **six months** of the event. If a complainant was not aware that there was cause for complaint, the complaint should normally be made within **six months** of their becoming aware of the cause for complaint, or within **twelve months** of the date of the event, whichever is earlier.

In any case where the Trust has decided not to investigate a complaint on the grounds that it was not made within the time limit, the complainant can request the Ombudsman to consider it. The complainant will be advised of the options available to him/her to pursue this further.

The Trust will consider the content of complaints that fall outside the time limit in order to identify any potential risk to public or patient safety and, where appropriate, the need to investigate the complaint if it is in the public's interest to do so or refer to the relevant regulatory body.

3.10 ***Support for complaints***

Some people who wish to complain do not do so because they do not know how, doubt they will be taken seriously or simply find the prospect too intimidating. Support and advocacy services are an important way of enabling people to make informed choices. These services help people gain access to the information they need, to understand the options available to them and to make their views and wishes known.

The Southern Trust's ***Patient Support Services*** is a confidential service for patients, families and carers within the **Acute Directorate**, i.e. Emergency Department, surgical wards, intensive care, etc. It provides:

- on the spot advice ;
- answers to your queries and questions ;
- information on the Trust and the services it provides ;
- information on local health services and support groups;
- support, when needed;
- information on making a complaint;
- a way for you to tell us what you think of our services so that we can improve them.

The Patient Support Services offices are located on both the Craigavon and Newry sites, with the support available at Craigavon from Monday to Friday and available on the Newry site Monday and Thursday. Contact details are listed below.

Craigavon Contact Details:
Patient Support Service
Craigavon Area Hospital
68 Lurgan Road
Portadown BT63 5QQ
Telephone: (028) Irrelevant information redacted by the USI

Email: Irrelevant information redacted by the USI

Newry Contact Details:
Patient Support Service
Daisy Hill Hospital
5 Hospital Road
Newry BT35 8DR

Telephone: (028) [redacted]

Email: [redacted]

Niamh (***Northern Ireland Association for Mental Health***) is the largest and longest established independent charity focusing on mental health and wellbeing services in Northern Ireland. Niamh is structured as a group consisting of three elements: Compass, beacon and Carecall. ***Beacon*** offers an independent advocacy service which is designed to listen to the compliments, concerns, problems or issues that people may be experiencing whilst using mental health services. An advocate can provide patients/clients with information in relation to the options available to them under four broad areas: clinical, legal, treatment and environment. An advocate will help patients/clients to express any concerns and to pass these on to relevant professionals. Advocates will support the individual to be heard and all discussions will be treated confidentially. *Please see below for contact details.*

80 University Street,
Belfast,
BT7 1HE

Telephone: [redacted]
Email: [redacted]

In the Southern Health and Social Care Trust, ***Disability Action***'s Centre on Human Rights provides an advocacy service specifically for people with learning disabilities. This service is confidential, provided free of charge and independent. The advocate supports people with learning disabilities to understand their rights and encourages them to speak up if they are unhappy about how they have been treated. The advocate will listen to the person's issue and identify the options available to them and will support the patient/client to take action.

The advocate also provides non-instructured advocacy, when a patient/client cannot give a clear indication of their views or wishes in a specific situation, e.g. when a person has a profound learning disability. In these cases, the advocate works to uphold the person's rights, ensure fair and equal treatment and access to services and make certain that decisions are taken with due consideration for the patient/client's individual preferences and perspectives. Please see below for contact details.

Human Rights Advocate,
Disability Action's Centre on Human Rights,
Disability Action,
Portside Business Park,
189 Airport Road West,
Belfast,
BT3 9ED

Telephone: (028) Irrelevant information redacted by
Textphone: (028) Irrelevant information redacted b
Email: Irrelevant information redacted by the USI

VOYPIC (***Voice of Young People in Care***) offers advocacy for children and young people with care experience aged 25 and under. This is a confidential and independent service where children and young people can get advice, information and support outside of Social Services. The service can:

- provide you with information and advice on your rights;
- Go to meetings with a child or young person;
- Help children/young people ask for a service;
- Help children/young people speak out about decisions that affect you; and
- Help children/young people make a complaint.

Please see below for contact details.

Voice of Young People In Care
Flat 12, Mount Zion House
Edward Street
Lurgan
BT66 6DB

Telephone: (028) [Irrelevant information redacted by]
Website: www.voypic.org

The **Northern Ireland Commissioner for Children and Young People**'s (**NICCY**) Legal and Investigations team deal with queries and complaints from children, young people, their carers and relevant professionals about the services they receive from public bodies. This team can:

- investigate complaints against public bodies (schools, hospitals, etc) on behalf of children and young people;
- help a child or young person bring their complaint to a public body; and
- help children and young people in legal proceedings against public bodies.

Please see below contact details.

Legal and Investigations Team
Northern Ireland Commissioner for Children and Young People
Equality House
7-9 Shaftesbury Square
Belfast
BT2 7DP

Telephone: (028) [Irrelevant information redacted by]
(Monday – Friday: 9:00am to 5:00pm)
Email: [Irrelevant information redacted by the USI]
Website: www.niccy.org

The ***Age NI*** Advice and Advocacy Service offer free, independent and confidential support to older people, their families and carers. The Age NI team provides advocacy support to people experiencing difficulties:

- negotiating the health and social care system
- accessing appropriate levels of community care
- dealing with issues relating to residential and nursing care
- those who have experienced or are at risk of abuse.

Please see below for contact details.

Age NI
3 Lower Crescent
Belfast
BT7 1NR

Telephone: [redacted]
(8:00am to 7:00pm, 7 days a week)
Email: [redacted]
Website: www.ageni.org/advice

The ***Patient Client Council*** (PCC) is an independent non-departmental public body and its functions include:

- representing the interests of the public;
- promoting involvement of the public; and
- providing assistance to individuals making or intending to make a complaint.

If a person feels unable to deal with a complaint alone the staff of the PCC can offer a wide range of assistant and support. This assistance may take the form of:

- information on the complaints procedure and advice on how to take a complaint forward;
- discussing a complaint with the complainant and drafting letters;
- making telephone calls on the complainants behalf;
- helping the complainant prepare for meetings and going with them to meetings;
- preparing a complaint to the Ombudsman;
- referral to other agencies, for example, specialist advocacy services; and
- helping in accessing medical/social services records.

All advice, information and assistance with complaints is provided free of charge and is confidential. *Please see below for contact details.*

Quaker Buildings,
High Street,
Lurgan,
BT66 8BB

Telephone: [redacted]
Email: [redacted]

Website: www.patientclientcouncil@hscni.net

The Trust's Corporate Complaints Officer and Directorate Governance Teams will also be able to offer advice and support complainants and explain the Trust's complaints procedure, as well as attempt to resolve the complaint. *For contact details of these services please refer to* ***Appendix 3****.*

3.11 *Making a compliment*

The staff who provide services do their best to meet your individual expectations and are often working in difficult circumstances. Therefore we are always keen to know when things have worked out well for our patients/clients and what aspect has made a positive experience for them.

Those patients/clients wishing to make a compliment can do so by completing a *We Value Your Views* leaflet and returned to the Trust's Corporate Complaints Officer. Alternatively, you can contact the Corporate Complaints Officer directly to make your compliment. (*Contact details can be found in* ***Appendix 3***) These compliments, which highlight good practice, will be forwarded to the relevant staff and departments.

SECTION 4: HANDLING COMPLAINTS

4.0 *Accountability*

Accountability for the handling and consideration of complaints rests with the Chief Executive. The Assistant Director of Clinical and Social Care Governance is the Trust's designated senior person within the organisation who takes responsibility for the local complaints procedure and to ensure compliance with the regulations and that action is taken in light of the outcome of any investigation. All staff within the Trust are made aware off and must comply with the requirement of this complaints procedure. These arrangements ensure the integration of complaints management into the Trust's governance arrangements.

4.1 *Co-operation*

Arrangements are in place within the Trust to ensure a comprehensive response to the complainant and to that end there is necessary co-operation in the handling of complaints and the consideration of complaints between:

- all HSC organisations;
- Regulatory authorities, e.g. professional bodies, DHSSPS Pharmaceutical Inspectorate;
- NI Commissioner for Complaints (the Ombudsman); and
- the Regulation and Quality Improvement Authority (RQIA).

This duty to co-operate includes answering questions, providing information and attending any meeting requested by those investigating the complaint.

4.2 *Actions on receipt of a complaint*

All complaints received by the Trust are treated with equal importance regardless of how they are submitted. Complainants are encouraged to speak openly and freely about their concerns and are reassured that whatever they have to say will be treated with appropriate confidence and sensitivity. Complainants will be treated courteously and sympathetically and where possible involved in decisions about how their complaint is handled and considered. On receipt of a complaint the first responsibility of Trust staff is to ensure that the service user's immediate care needs are being met.

The Trust will involve the complainant throughout the consideration of their complaint as this provides for a more flexible approach to the resolution of the complaint. An early provision of information and explanation of what to expect is provided by the Trust to the complainant at the outset to ensure they are informed about the process and of the support that is available.

Each complaint received by the Trust is taken on its own merit and responded to appropriately. It

may be appropriate for the entire process of local resolution to be conducted informally. Overall, arrangements should ensure that complaints are dealt with quickly and effectively in an open and non-defensive manner.

4.2.1 *Informal Complaint*

It is important that the Trust works closely with its service users to find an early resolution to complaints when they arise. Every opportunity should be taken to resolve complaints as close to the source as possible through discussion and negotiation.

Staff across the Trust can access 'Complaints in Health and Social Care: A Need to Know Guide for Staff' via the Trust's Intranet.

Point of Service Delivery

When a complaint is raised at the point of service delivery staff should follow the procedures laid out below.

1. The complaint is raised by or on behalf of the service user at the point of service delivery.
2. The member of staff who first learns of the complaint should respond immediately and directly in an attempt to resolve the matter informally, speedily and appropriately.

   Where appropriate if the member of staff attempting to resolve the matter feels it would be beneficial to involve a patient's advocate at this stage, they should contact the advocate directly with the patient/client's consent or seek advice from the relevant Directorate Governance Team.
3. If a member of staff has resolved a complaint 'at the point of service delivery' they should complete all sections on the *Complaints at Point of Source Delivery* form located on the Trust Intranet under Policies & Procedures, Clinical & Social Care Governance.

   If the person remains dissatisfied, they should be offered a copy of the Trust's **'We Value Your Views'** leaflet and advised that they may wish to contact the Corporate Complaints Officer to make a formal complaint.

   It is important that staff in this situation ask their supervisor or line manager for assistance, if necessary.

Complaints made directly to the Trust's Corporate Complaints Officer

The Corporate Complaints Officer will facilitate either resolution of the complaint or they will facilitate the service user in accessing the Trust's formal complaints procedure.

4.2.2 ***Formal Complaints***

This is the starting point for anyone is dissatisfied with attempts to resolve their complaint at the point of service delivery or any complainant who expects to receive a written (or alternative format) response from the Trust. The complainant should receive a full response within **20 working days** of the Trust's receipt of the formal complaint.

Acknowledgement

1. The Corporate Complaints Officer is to forward the complaint to the relevant Governance Co-ordinator's office within **1 working day**.

2. The relevant Governance Team should clarify the details of the complaint raised directly with the complainant if required and acknowledge their receipt of the complaint within **2 working days**. This acknowledgement should express sympathy or concern regarding the complaint and express thanks to the complainant for drawing the matter to the attention of the Trust. A copy of the regional "*What Happens Next?*" leaflet should be included with the acknowledgment letter.

3. If a complaint is made by a third party (including those made by MPs, MLAs and local councillors) and it refers to an individual's care the matter of knowledgeable and informed consent must be considered.

   If consent is required it should be sought from the patient at this point. Investigation of the complaint should be initiated without delay, however a response to specific issues will not be provided unless the consent of the patient is received. (*The 20 working days only starts in these instances on the day in which the consent is received*.)

4. All complaints which occur in the Trust are graded in a standardised manner using the Trust's *Risk Management Strategy*.

5. In the case of complaints which are applicable to more than one directorate, it is best practice for the Governance Team in the directorate where the complaint has first arisen to handle the complaint and seek input from other Directorate Teams where appropriate.

Investigation

1. By **day 2**, Investigating Officer(s) should be given detail of the complaint and advised that they are expected to provide their draft response as well as their action and learning plans, where actions are required following investigation of the complaint, by **day 10**. The names of the staff involved in the complaint, when identified, should be provided to the appropriate Directorate Governance Team.

   A copy of the complaint should be forwarded to the Assistant Director responsible for the service area. Where serious governance issues are identified on receipt of the complaint it must be shared with the relevant Director.

   Investigating staff can reference the Trust's 'Investigating Complaints Advice Sheet' for best practice guidance on investigations, which can be accessed via the Trust's Intranet.

   Service Managers should bear in mind that staff will often require support if a complaint is received. Support is available from the following sources:
   - line management support;
   - occupational health;
   - Care Call; and
   - the relevant Governance Team.

2. The draft response to the complainant is to be validated by the Investigating Directorate Governance Team and then forwarded to the appropriate Assistant Director by **day 15** for approval/amendment.

   The response should be clear, accurate, balanced, simple and easy to understand. It should avoid technical terms, but where these must be used to describe a situation, events or condition, an explanation of the term should be provided. The letter should:
   - address the concerns expressed by the complainant and show that each element has been fully and fairly investigated;
   - include an apology where things have gone wrong – staff should refer to the *Ombudsman's Guidance on Issuing an Apology* (May 2011) which can be found here: http://www.ni-ombudsman.org.uk/niombudsmanSite/files/2d/2dfa3d4d-2b55-4bcb-8670-bd99f76eba4e.pdf
   - report the action taken or proposals to prevent recurrence, where the need for such actions have been identified following investigation of the complaint;
   - indicate that a named member of staff is available to clarify any aspect of the letter; and
   - advise of their right to make a complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure.

3. Where a complaint involves clinical/professional issues, the draft response must be shared by the Assistant Director with the relevant clinicians/professionals to ensure the factual accuracy of the response and to ensure those staff agree with and support the draft response. The relevant Assistant Director is required to approve and return to the relevant Governance Co-ordinator by **day 17**. The Assistant Director is to indicate if they are satisfied with the content of any action and learning plans, the details of which will be captured on the Datix system.

   Should further work be required on the action and learning plan it is the responsibility of the Assistant Director to initiate this within their division and report back to the relevant Governance Co-ordinator.

4. All final responses are to be forwarded to the relevant Lead Director for approval by **day 18**.

   The Lead Director's office is required to issue the response to the complainant by **day 20**, sending the Directorate Governance Team copy of the final signed response. The exception to this are those complaint responses being sent to Elected Representations whereby the Chief Executive will, following approval by the Director, sign the final response and send a signed copy to the Lead Director and relevant Governance Team within **10 working days**. **Responses should not be issued to the complainant electronically.**

5. There is some flexibility built into the above internal timescales to allow investigating officers to complete complex complaint issues and to give the Director signing off more than 24 hours to sign if required. Where there are difficulties in gaining a response from the investigating officer the Governance Co-ordinator will escalate any breaches of the timeframes to the appropriate line manager for further action.

4.3 *Acknowledgement of delays*

Complainants must be given a written explanation of any reason for delay in responding to a complaint and this should happen as soon as it becomes apparent that the Trust will be unable to meet the 20 working days timescale. The relevant Director should be informed of any delay at this stage also.

4.4 *Further Local Resolution beyond 20 working days*

Should a complainant remain dissatisfied with the response to their complaint and unresolved issues remain consideration needs to be given to how the remaining issue(s) can be resolved. All complainants will be advised that if they remain unhappy with the Trust's response they should

contact the relevant Governance Team in the first instance to discuss options available or refer their complaint to the Ombudsman. (Please refer to **Appendix 3** for contact details) At this point all complainants should be asked to state clearly which aspect(s) of their complaint remains unresolved. On receipt of this documentation, options may include one or a number of the following:

- Further written response to outstanding issues;
- Meeting with the complainant;
- Local resolution investigation by a second team;
- Conciliation;
- Use of Lay people to assist;
- Use of independent experts.

4.4.1 *Further written response to outstanding issues*

Complainants will be advised in the first response that they should contact the organisation **within 3 months** of the Trust's response if they are dissatisfied with the response or require further clarity. There is discretion for the Governance Co-ordinator to extend this time limit where it would be unreasonable in the circumstances for the complainant to have made contact sooner.

The first step of further local resolution should then be that of an offer of a further response to the complainant. This may be in the form of a further written response signed off by the Director(s). This response should be issued **within 20 days** of the complaint being re-opened.

4.4.2 *Meeting with the Complainant*

Offer of facilitation of a meeting with the relevant staff. This will be taken forward by the existing investigation team and chaired by the Head of Service. The relevant Director(s) should be advised of the outcome of the meeting. The notes of the meeting should be agreed upon by all that were present and issued to the complainant. This meeting should take place within **30 days** of a second response being issued.

4.5 *Additional Measures*

In extreme cases where a complainant cannot be satisfied with the response provided along with the facilitation of a meeting and where the Trust has provided further information there are a number of other options available. The decision on which option to be used will be agreed by the lead Director responsible for the management of the complaint and the relevant Governance Co-ordinator, with specific terms of reference and timescales also being agreed. Complainants may wish to include the involvement of the Patient and Client Council in this process and contact

details of this service can be found in ***Appendix 3***. Once agreement is reached upon which option is to be used the decision should be acknowledged with the complainant and additional information should be provided on the option to be used. Options include the following:

- Local resolution investigation by a second team
- Conciliation
- Involvement of Lay Persons
- Involvement of Independent Experts
- Review by an Independent Panel

4.5.1 *Local resolution investigation by a second team*

Local resolution investigation by a second team should examine the initial complaint, response to it and all information gathered in formulating that response. The decision to progress to this option will be taken by the relevant Director(s) in conjunction with the relevant Governance Co-ordinator(s). The local resolution team should be chaired and led by a Manager/Clinician from another service area within the Directorate and have a Manager/Clinician from another Directorate as well as the relevant Governance Co-ordinator. This membership will provide a more detailed response with a measure of independence in responding to the complainant and make best use of Trust resources.

If the complaint progresses to this stage, the following guidelines should be adhered to as best practice.

1. A draft report on findings should be forwarded to the Assistant Director responsible for the service area within **20 days** of the decision to use this option. A copy should be provided to the relevant Governance Co-ordinator.
2. By **day 25** the Assistant Director should have discussed the content of the draft report with the relevant Director and Governance Co-ordinator.
3. A final copy of the findings of the second complaint review team will be sent by the relevant Governance Co-ordinator to the Director for issue to the complainant by **day 30** of the decision to use this option.

4.5.2 *Conciliation*

Conciliation is a process of examining and reviewing a complaint with the help of an independent person. The conciliator will assist all concerned to achieve a better understanding of how the complaint has arisen and will aim to prevent the complaint being taken further. They will work to ensure that good communication takes place between both parties involved to enable them to resolve the complaint. It may not be appropriate in the majority of cases but may be helpful in situations where staff feel the relationship with the complainant is difficult and trust has broken down as well as at times where there are ongoing healthcare issues where it is important to

maintain relationships or when there are misunderstandings with relatives during the treatment of a patient.

4.5.3 *Involvement of Lay Persons*

Lay Persons may be beneficial in providing an independent perspective of non-clinical or technical issues within the local resolution process. They are not intended to as act as advocates, conciliators or investigators, and neither do they act on behalf of the Trust or the complainant. The Lay Person's involvement is to help bring about a resolution to the complaint and to provide assurances that the action taken was reasonable and proportionate to the issues raised. Input from a Lay Person is valuable when testing issues such as communication, quality of written documents, attitudes and behaviours and access arrangements. The relevant Governance Co-ordinator will provide advice regarding the use of Lay Persons should the need arise.

4.5.4 *Involvement of Independent Experts*

The use of an independent expert in the resolution of a complaint may be requested by the complainant at any time; however the Trust reserves the right to accept/decline this request. In deciding whether independent advice should be offered, consideration must be given, in collaboration with the complainant, to the nature and complexity of the complaint and any attempts at earlier enhanced local resolution. Input will normally only be required in cases where there are major clinical issues or concerns, but the use of the option may be helpful when it is indicated there may be a risk to patient or public safety or a serious breakdown in relationships which would threaten public confidence in services and damage the Trust's reputation. The relevant Governance Co-ordinator will provide advice regarding the use of Independent Experts should the need arise.

4.5.5 *Review by Independent Panel*

In a small number of cases where complainant is not satisfied with the Trust's response, the Trust may wish to use an independent panel as a final attempt to resolve the complainant issue. This will only be used in extreme cases. An independent panel should be chaired by an operational Assistant Director with the support of an internal independent person (for example professional governance lead, clinical expert, social care expert, etc.) and an external layperson. The panel would be supported by the relevant Governance Co-ordinator.

The panel would be given clear terms of reference and provided with all the relevant information. They may wish to meet with the complainant or individual members of staff to discuss the complaint in detail and to clarify issues raised.

The panel would provide a draft report and action plan to the relevant Director(s) for discussion and issue to the complainant.

The panel may also wish to comment on other issues as they arise. For example, Trust policies and procedures, team practices, line management arrangements, etc. A separate report should be provided to the Director(s) highlighting areas of concern for further action by the Director(s).

4.5.6 *Northern Ireland Commissioner for Complaints (Ombudsman)*

Once all options available to the Trust under local resolution have been exhausted and the complainant remains unsatisfied, the complainant should be advised of the role of the Ombudsman and provided with contact details for same. It is for the Ombudsman to determine whether or not a case falls within that Office's jurisdiction. *For contact details please refer to **Appendix 3**.*

4.6 *Joint Complaint Investigations*

Where a complaint relates to the actions of more than one HSC organisation, the *Health and Social Care Trusts Interim Memorandum of Understanding Joint Working Processes for Handling Complaints* should be referred to. The relevant Governance Co-ordinator will advise on this process.

4.7 *Out of Area Complaints*

Where the complainant lives in Northern Ireland and the complaint is about events elsewhere, the Trust that commissioned the service or purchased the care for that service user is responsible for co-ordinating the investigation and ensuring that all aspects of the complaint are investigated. The Governance Co-ordinator will advise on this process.

HSC contracts include entitlement, by the Trust, to any and all documentation relating to the care of service users and a provision to comply with the requirements of the HSC Complaints Procedure.

4.8 *Confidentiality*

Trust staff are aware of their legal and ethical duty to protect the confidentiality of the patient/client's information. The legal requirements are set out in the *Data Protection Act 1998* and the *Human Rights Act 1998*. The common law duty of confidence must also be observed. Ethical guidance is provided by the respective professional bodies. A service user's consent is required of

their personal information is to be disclosed but more detailed information can be found in the HSC guidance entitled *Code Practice on Protecting the Confidentiality of Service User Information*.

When using a patient's personal information for the purpose if investigating a complaint it is not necessary to obtain the patient's express consent. However, care must be taken throughout the process to ensure that patient confidentiality is maintained (particularly when a complaint is made on behalf of another/when contributing to a response lead by another organisation) and any information disclosed is confined to that which is relevant to the investigation and only disclosed to those who have a demonstrable need to know for the purpose of the investigation. Where a complaint relates to the actions of more than one HSC organisation the complainant's consent must be obtained before sharing the details of the complaint across HSC organisation.

Complaint investigations will be conducted with appropriate consideration of the confidentiality due to the staff involved in the complaint.

4.9 *Support and advice for Trust Staff*

Support and advice should be provided to any member of Trust staff involved in either informal or formal complaints by their Supervisor and/or Line Manager at any stage of the process.

Advice and assistance is available to Trust staff at any stage in the complaints process from the Trust's Directorate Governance Teams. *For contact details please refer to* ***Appendix 3****.*

The Trust has selected Carecall as an independent source of support for staff. Carecall staff are trained to listen and can offer support, guidance and a fresh outlook on not only issues at work but also personal problems. This service is free to Trust staff and Carecall are committed to protecting your confidentiality and anonymity. Carecall is available 24 hours a day, 7 days a week, and 365 days a year, please refer to the contact details below.

CARECALL

For free, confidential and immediate support call:

Telephone: [redacted]

For further information about the service:

Website: www.carecallwellbeing.com

SECTION FIVE: POLICY FOR HANDLING UNREASONABLE, VEXATIOUS OR ABUSIVE COMPLAINANTS

5.0 *Introduction*

People may act out of character in times of trouble distress. There may have been upsetting or distressing circumstances leading up to a complaint. The Trust does not view behaviour as unacceptable just because a complainant is forceful or determined. In fact, it is accepted that being persistent can be a positive advantage when pursuing a complaint. However, we do consider actions that result in unreasonable demands on the Trust or unreasonable behaviour towards Trust staff to be unacceptable. It is these actions that the Trust aims to manage under this policy.

This policy aims:

- to make it clear to all complainants, both at initial contact and throughout their dealings with the Trust, what the Trust can or cannot do in relation to their complaint. The Trust aims to be open and not raise hopes or expectations that cannot be met;
- to deal fairly, honestly, consistently and appropriately with all complainants, including those whose actions are considered to be unacceptable. All complainants have the right to be heard, understood and respected, as do Southern Trust staff;
- to provide a service that is accessible to all complainants. However, the Trust retains the right, where it considers the actions of a complainant to be unacceptable, to restrict or change access to the service;
- and to ensure that other complainants and Trust staff do not suffer any disadvantage from complainants who are unreasonable, vexatious and/or abusive manner.

5.1 *Unacceptable Actions*

The Trust defines unacceptable action as the following:

5.1.1 *Aggressive or abusive behaviour*

The Trust understands that many complainants are angry about the issues they have raised in their complaint. If that anger escalates into aggression towards Trust staff, it will be considered unacceptable. **Any violence or abuse towards Trust staff will not be tolerated**.

Violence is not restricted to acts of aggression that may result in physical harm. It also includes behaviour or language (whether verbal or written) that may cause staff to feel afraid, threatened or abused. Examples of such behaviour include threats, physical violence, personal verbal abuse, derogatory remarks and rudeness. The Trust also considers that inflammatory statements and unsubstantiated allegations can be abusive behaviour.

The Trust expects its staff to be treated courteously and with respect. Violence or abuse towards staff is unacceptable and a *Zero Tolerance* approach must be adopted. Trust staff understand the difference between aggression and anger. The anger felt by many complainants involves the subject matter of their complaint. However, it is not acceptable when anger escalates into aggression directed towards Trust staff.

5.1.2 *Unreasonable demands*

The Trust considers these demands become unacceptable when they start to (or when complying with the demand would) impact substantially upon the work of the organisation. An example of such impact would be that the demand takes up an excessive amount of staff time and in doing so disadvantages other complainants. Examples of unreasonable demands include:

- repeatedly demanding responses within an unreasonable timescale;
- insisting on seeing or speaking to a particular member of staff when that is not possible; or
- repeatedly changing the substance of a complaint or raising unrelated concerns.

5.1.3 *Unreasonable levels of contact*

Sometimes the volume and duration of contact made to the Trust by an individual causes problems. This can occur over a short period, for example a number of calls in one day or one hour. It may occur over the life-span of the complaint when complainant repeatedly makes long telephone calls to the Trust or inundates the Trust with copies of information that has been sent already or that is irrelevant to the complaint. The Trust considers that the level of contact has become unacceptable when the amount of time spent talking to a complainant on the telephone or via emails or written correspondence impacts on its ability to deal with that complaint, or with other people's complaints.

5.1.4 *Unreasonable persistence*

It is recognised that some complainants will not or cannot accept that the Trust is unable to assist them further or provide a level of service other than that provided already. Complainants may persist in disagreeing with the action or decision taken in relation to their complaint or contact the Trust persistently about the same issue. Examples of unreasonable persistence include persistent refusal to accept a decision made in relation to a complaint, persistent refusal to accept explanations relating to what the Trust can or cannot do and continuing to pursue a complaint without presenting any new information. The war in which these complainants approach the Trust may be entirely reasonable, but it is their persistent behaviour in continuing to do that is not. The Trust consider the actions of persistent complainants to be unacceptable when they take up what the Trust regards as being a disproportionate amount of time and resources.

5.1.5 ***Unreasonable use of the complaints process***

Individuals with complaints have the right to pursue their concerns through a range of means. They also have a right to complain more than once about the Trust, with which they have a continuing relationship, if subsequent incidents occur. However, this contact becomes unreasonable when the effect of the repeated complaints is to harass, or to prevent the Trust from pursuing a legitimate aim or implementing a legitimate decision. The Trust considers access to a complaints system to be important and it will only be in exceptional circumstances that it would consider such repeated use is unacceptable – but the Trust reserves the right to do so in those exceptional circumstances.

5.2 ***How the Trust manages aggressive or abusive behaviour***

The threat or us of physical violent, verbal abuse or harassment towards Trust staff is likely to result in a termination of all direct contact with the complainant. Trust staff will directly experience aggressive or abusive behaviour from a complainant have the authority to deal immediately with that behaviour in a manner they consider appropriate to the situation in line with this policy. With the exception of such immediate decisions taken at the time of an incident, decisions to restrict contact with the Trust are only taken after careful consideration by a more senior member staff. Wherever possible, the Trust will give the complainant the opportunity to change their behaviour or action before a decision is taken.

All incidents of verbal and physical abuse will be reported to the police.

The Trust will not accept any correspondence (letter, fax or e-mail) that is abusive to staff or contains allegations that lack substantive evidence. If such correspondence is received by the Trust, we will inform the complainant that we consider their language to be offensive, unnecessary and unhelpful and will request that they refrain from using such language. The Trust will not respond the correspondence if the action or behaviour continues.

Trust staff will end telephone calls if they consider the caller to be aggressive, abusive or offensive. All staff members taking such calls have the right to make this decision.

In extreme situations, the Trust will inform the complainant in writing that their name is on a “no personal contact” list. This means that the Trust will limit contact with the complainant to either written communication or through a third party.

5.3 *Managing other unacceptable actions*

The Trust has to take action when unreasonable behaviour impairs the everyday functioning of the Trust. It aims to do this in a way that allows a complainant to progress through its process. It will try to ensure that any action it takes is the minimum required to solve the problem, taking into account relevant personal circumstances including the seriousness of the complaint and the needs of the individual.

Where a complainant repeatedly phones, visits the Trust, raises issues repeatedly, or sends large numbers of documents where their relevance is not clear, the Trust may decide to:

- limit contact or telephone calls from the complainant at set times on set days;
- restrict contact to a nominated member of Trust staff who will deal with the future telephone calls or correspondence from the complainant;
- see the complainant by appointment only;
- restrict contact form the complainant to writing only;
- return any documents to the complainant or, in extreme cases, advise the complainant that further irrelevant documents will be destroyed; or
- take any other action which the Trust considers appropriate.

Where the Trust considers correspondence on a wide range of issues to be excessive, we may inform the complainant that only a certain number of issues will be considered in a given period and ask them to limit or focus their requests accordingly. In exceptional cases, the Trust will reserve the right to refuse to consider a complaint or future complaints from an individual. It will take into account the impact on the individual and also whether there would be a broader public interest in considering the complaint further. *The Trust will always inform the complainant of what action it is taking and why.*

5.4 *How the Trust lets people know of its decision to restrict contact*

When a Trust member of staff makes an immediate decision in response to unreasonable behaviour, the complainant is advised at the time of the incident. When a decision has been made by senior management, a complainant will always be told in writing[4] why a decision has been made to restrict future contact arrangements and, if relevant, the length of time that these restrictions will be in place. This ensures that the complainant has a record of the decision.

5.5 *Appealing a decision to restrict contact*

The Trust believes that it is important that a decision can be reconsiders and it is on this basis that a complainant can appeal a decision to restrict contact. The Trust will only consider arguments that relate to the restriction and **not** to either the complaint made to the Trust or its decision to

[4] This can be supplemented if written communications are not the most appropriate form for the individual.

close a complaint. An appeal could include, for example, a complainant saying that: their actions were wrongly identified as unacceptable; or that they will adversely impact on the individual because of personal circumstances. A senior member of staff who was not involved in the original decision will consider the appeal. They have discretion to quash or vary the restriction as they think best. They will make their decision based on the evidence available to them. They will advise the complainant in writing[5] that either the restricted contact arrangements will apply or a different course of action has been agreed.

5.6 ***How the Trust records and reviews decisions to restrict contact***

The Trust records all incidents of unacceptable actions by complainants. Where it is decided to restrict complainant contact, an entry noting this is made in the relevant file and on appropriate computer records. A decision to restrict complainant contact as described above may be reconsidered if the complainant demonstrates a more acceptable approach. A member of the Senior Management Team reviews the status of all complaints with restricted contact arrangements on a regular basis.

[5] This can be supplemented if written communications are not the most appropriate form for the individual.

SECTION 6: LEARNING FROM COMPLAINTS

6.0 *Reporting and Monitoring*

The Trust has a legal duty to operate a complaints procedure and is required to monitor how we, or those providing care on our behalf, deal with and respond to complaints. This includes the regular reporting on complaints in line with the Trust's Governance arrangements and continually monitoring the effectiveness of the Trust's complaints procedures. To ensure good practice the Trust:

- regularly reviews its policies and procedures to ensure they are effective;
- monitors the nature and volume of complaints;
- seeks feedback from service users and staff to improve our services and performance; and
- ensuring that lessons are learnt from complaints and using these to improve services and performance.

The volume of complaints received is regularly monitored within the Trust through the following methods:

- Complaints figures are routinely discussed at Directorate Governance meetings/fora, SMT, the Governance Committee and at the Patient and Client Experience Committee meetings.
- Closed complaints figures are regularly sent to the Health and Social Care Board (HSCB) for consideration.
- A Trust complaints report is compiled annually and details how complaints were received and handled, and what lessons were learnt.

6.1 *Learning*

The Trust aims to manage all complaints received effectively and ensures that appropriate action is taken to address the issues highlighted by complaints. We make sure that lessons are learnt from all complaints so as to ensure the same mistakes do not re-occur within the Trust. Learning takes place at different levels within the Trust, with the individual, the team and the organisation as a whole.

Each Directorate within the Trust is provided with analysis and intelligence on the complaints received to ensure that trends are identified and acted upon.

The Trust will use issues raised through the complaints process as an important source of information for safety and quality improvement. This information will inform learning and development and will feed into the Trust's Governance systems as well as being directly fed back to the staff involved.

Within the Trust it is the responsibility of all Trust Directors, Assistant Directors, Heads of Service

and Senior Managers to utilise the information and trends from their complaints to ensure learning and development and to develop and monitor actions and learning plans.

An annual report is presented to Trust Board, which summarises the complaints we have received, how they were handled, the outcomes and lessons learnt. This is published to the public on the Trust website (www.southerntrust.hscni.net).

Learning is a critical part of the Trust Complaints Procedure and the Trust values complaints and comments as an opportunity to improve services for our patients and clients. It is for this reasons that the Trust continually contributes to and learns from regional, national and international quality improvement and patient safety initiatives, and shares intelligence gained through complaints with other HSC organisations in Northern Ireland, the RQIA and the Ombudsman.

SECTION SEVEN: REVIEW AND IMPLEMENTATION

7.0 *Consultation*

During development, this policy was considered in draft form by the Trust's Governance Co-ordinators and Officers from Acute Services, Older Persons and Primary Care, Children and Young Persons Services and Mental Health and Disability.

The Review of the Policy for the Management of Complaints was informed by focus groups held for service users and Trust staff. These discussions ensured that the reviewed Policy reflected the needs of Trust staff and service users.

7.1 *Approval*

The Policy for the Management of Complaints was presented in final draft and approved by SMT on…

7.2 *Review*

The Trust is committed to ensuring that all policies are kept under review to ensure that they remain compliant with relevant legislation.
The Policy for the Management of Complaints will be reviewed bi-annually.

7.3 *Policy Implementation*

Following approval this policy will be circulated to all Trust staff via Global email.
A copy of the Policy for the Management of Complaints will be placed on the Trust's intranet.

7.3.1 Training and Education

All Trust managers must ensure that their staff have access to this policy, understand its content, and are aware of its aims and purpose immediately upon its release.

Appendix 1

Complaints *Process*

Complaints at Point of Service

Complaint is raised by or on behalf of a service

Member of staff who first learns of complaint should respond immediately & directly in an attempt to resolve the matter informally, speedily & appropriately.

IS THE MATTER **RESOLVED**?

YES

If a member of staff has resolved a complaint 'at point of service delivery' they should complete and return all sections on the *Complaints at Point of Source Delivery form.*
(Trust Intranet >Policies & Procedures>Clinical & Social Care Governance)

NO

Formal Complaints Process

The **Formal Complaints** process is instigated. This is also the starting point for anyone who approaches the Corporate Complaints Office directly with their complaint.
The Corporate Complaints Officer will aim to de-escalate and resolve all complaints/enquires at first point of contact with the Corporate Complaints Office.

The Corporate Complaints Officer, Southern Health & Social Care Trust, Trust Headquarters, Craigavon Area Hospital, Portadown, BT63 5QQ
Telephone: 028 [redacted]

Email: [redacted]

DAY 1: Complaint is sent to the relevant Governance Co-ordinator's office.

DAY 2: Governance Co-ordinator's office to send **ACKNOWLEDGEMENT** of the complaint to the complainant.

INVESTIGATION

DAY 20: Governance Co-ordinator will issue a **RESPONSE** to the complainant.

Complainant Satisfied?

NO

Assistant Director to consider the following measures: ***Further written response*** to outstanding issues (within 20 days of complaint being re-opened); ***meeting with the complaint*** (within 30 days); enhanced local resolution ***investigation by a second team***; c***onciliation***; use of ***Lay people to assist***; or the use of ***independent experts***.

Complainant Satisfied?

NO

Where the Trust has exhausted all options available to it and there is no resolution to a complaint the complainant is advised of the procedures for contacting the ***Ombudsman's office.***

YES

Complaint file is closed.

YES

Complaint file is closed.

Appendix 2

Frequently Asked Questions

"Will my services/care be hindered in making a complaint?"	*No, making a complaint does not affect your rights and will not result in the loss of any services you have been assessed as requiring.*
"Who can make a complaint?"	*Any person can complain about any matter connected with the provision of Trust services. Complaints may be made by:* • *a patient or client;* • *former patients, clients or visitors using Trust services and facilities;* • *someone acting on behalf of existing or former patients/clients (providing they have obtained the patient/client's consent;* • *parents (or persons with parental responsibility) on behalf of a child; and* • *any appropriate person in respect of a patient/client unable by reason of physical or mental capacity to make the complainant himself or who has died, e.g. next of kin.*
"How can I make a complaint?"	*For the Trust it is important that we work closely with service users to find an early resolution to complaints when they arise.* *Initially you may wish to express your concerns to the person who is providing the care/services, or to other members of staff, such as receptionists, clinical/care staff. Every opportunity will be taken to resolve a complaint as close to the source as possible through discussion and negotiation.* *If you do this and are still not satisfied you may wish to express your concerns to someone within the relevant organisation who has not been involved in the care provided. In these circumstances, the Trust advises complainants to address their complaint to the Trust's Corporate Complaints Officer. Complaints may be made verbally or in writing, and will also be accepted via other methods, for example the telephone or electronically (e-mail).*

	Corporate Complaints Officer, ***Southern Health & Social Care Trust,*** ***Trust Headquarter,*** ***Craigavon Area Hospital,*** ***Portadown,*** ***BT63 5QQ*** ***Telephone: 028*** [redacted] ***Email:*** [redacted] *When making a complaint it is helpful to establish at the outset what the complainant wants to achieve to avoid confusion or dissatisfaction and subsequent letters of complaint.*
"Why is consent needed?"	*By law confidentiality must be respected at all times and it is for this reason that complaints made by a third party require the consent of the individual involved. Consent is required as the response to the complainant will include personal details about the individual involved.*
"How long does it take until I receive a response to my complaint?"	*The relevant Governance Office will acknowledge receipt of the complaint within 2 working days. This acknowledgement will express sympathy or concern regarding the complaint and express thanks to the complainant for drawing the Trust's attention to the issue.* *After an investigation has been carried out by the relevant Directorate the Trust aims to issue a final response to the complainant within 20 working days of the Trust's receipt of the complaint.* *In the event of the Trust being unable to meet the 20 working day target, which can be due to the complexity of a complaint, the Trust will issue a holding letter to the complainant. If this happens the Trust will remain in contact with the complainant and advise them as to when they should expect a final response in regards to the investigation of their complaint.*

"Who will investigate my complaint?"	*The complaint will be investigated by an investigating team made up of members of staff from within the Directorate where the complaint arose.*
"What if I am not satisfied with my response?"	*Should a complainant remain dissatisfied with the response to their complaint and unresolved issues remain, consideration needs to be given to providing enhanced local resolution where practicable. All complainants will be advised that if they should be advised that if they remain unhappy with the Trust's response they should contact the relevant Governance Office to discuss options available. At this point all complainants should be asked to state clearly which aspect(s) of their complaint that they feel remain unresolved. On receipt of this documentation, options may include one or a number of the following:* • *Further written response to outstanding issues;* • *Meeting with the complainant;* • *Enhanced local resolution investigation by a second team;* • *Conciliation;* • *Use of Lay people to assist;* • *Use of independent experts.* *If you are not happy with our response to your complaint, you can contact us again. We will discuss the options available which may assist in resolving any outstanding issues.* *If after this you remain unhappy, you can refer your complaint to the Northern Ireland Commissioner for Complaints (the Ombudsman). The Ombudsman will consider your complaint to determine whether it warrants investigation by the Ombudsman's office.* ***The Ombudsman,*** ***Freepost BEL 1478,*** ***Belfast,*** ***BT1 6BR*** ***Telephone:*** Irrelevant information redacted by the USI ***Email:*** Irrelevant information redacted by the USI Personal Information redacted by the USI ***Website:*** ***www.ni-ombudsman.org.uk***

"What if I don't want to make a formal complaint?"	*The Southern Trust is committed to providing a high quality service to all its users. You can help us improve our services by telling us of your experiences. Your views are much appreciated and will be treated in confidence.* *If you do not wish to make a formal complaint you can also make a comment or suggestion, which can be done by completing the 'We Value Your Views' leaflet.* *An Informal complaint can also be made by speaking to a member of staff at the point of service delivery, or by speaking to the Trust's Corporate Complaints Officer.* ***Corporate Complaints Officer,*** ***Southern Health & Social Care Trust,*** ***Trust Headquarters,*** ***Craigavon Area Hospital,*** ***Portadown,*** ***BT63 5QQ*** ***Telephone:*** Irrelevant information redacted by the USI ***Email:*** Irrelevant information redacted by th Personal Information redacted by the USI

Appendix 3

Useful Contacts

Southern Trust Contacts	
Corporate Complaints Officer	**Southern Health and Social Care Trust,** **Trust Headquarters,** **Craigavon Area Hospital,** **Portadown,** **BT63 5QQ** **Telephone: (028)** [redacted] **Email** [redacted]
Acute Services Clinical & Social Care Governance Office	**Telephone: (028)** [redacted]
Children & Young People's Services Clinical & Social Care Governance Office	**Telephone: (028)** [redacted]
Mental Health & Disability Directorate Clinical & Social Care Governance Office	**Telephone: (028)** [redacted]
Older People & Primary Care Directorate Clinical & Social Care Governance Office	**Telephone: (028)** [redacted]
Support & Advocacy Services	
Southern Trust Patient Support Service (Acute Directorate)	**Patient Support Service** **Craigavon Area Hospital** **68 Lurgan Road** **Portadown BT63 5QQ** **Telephone: (028)** [redacted] **Email** [redacted]

	Patient Support Service **Daisy Hill Hospital** **5 Hospital Road** **Newry BT35 8DR** **Telephone: (028)** [redacted] **Email** [redacted]
Disability Action	**Human Rights Advocate,** **Disability Action's Centre on Human Rights,** **Disability Action,** **Portside Business Park,** **189 Airport Road West,** **Belfast,** **BT3 9ED** **Telephone: (028)** [redacted] **Textphone: (028)** [redacted] **Email** [redacted]
Niamh (Northern Ireland Association for Mental Health)	**80 University Street,** **Belfast,** **BT7 1HE** **Telephone: (028)** [redacted] **Email:** [redacted]
VOYPIC	**Voice of Young People In Care** **Flat 12, Mount Zion House** **Edward Street** **Lurgan** **BT66 6DB** **Telephone: (028)** [redacted] **Website: www.voypic.org**
NICCY (Northern Ireland Commissioner for Children and Young People)	**Legal and Investigations Team** **NICCY** **Equality House** **7-9 Shaftesbury Square**

	Belfast **BT2 7DP** **Telephone: (028)** [redacted] (Monday – Friday: 9:00am to 5:00pm) **Email:** [redacted] **Website: www.niccy.org**
Age NI	**Age NI** **3 Lower Crescent** **Belfast** **BT7 1NR** **Telephone:** [redacted] (8:00am to 7:00pm, 7 days a week) **Email:** [redacted] **Website: www.ageni.org/advice**
Patient & Client Council	**Telephone:** [redacted] **Website:www.patientclientcouncil.hscni.net**
Carecall (*Mental Wellbeing at Work*)	**Telephone:** [redacted] **Website: www.carecallwellbeing.com**
What to do if you're still not happy?	
Northern Ireland Commissioner for Complaints (the Ombudsman)	**The Ombudsman,** **Freepost BEL 1478,** **Belfast,** **BT1 6BR** **Telephone:** [redacted] **Email:** [redacted] **Website: www.ni-ombudsman.org.uk**
Complaints about Regulated Establishments	
The Regulation & Quality	**The Regulation & Improvement Authority,**

Improvement Authority (RQIA)	**9th Floor Riverside Tower,** **5 Lanyon Place,** **Belfast,** **BT1 3BT** **Telephone: (028)** [redacted] **Fax: (028)** [redacted] **Email:** [redacted] **Website: www.rqia.org.uk**
Complaints about Family Practitioner Services **(family doctors, dentists, pharmacists, opticians)**	
HSC Board **Complaints Manager**	**Southern LCG,** **Tower Hill,** **Armagh,** **BT61 9DR** **Email:** [redacted]

14. Urology

No	Source	Site	Category	Issue Raised	Action Required	Lead and involved individuals	To Be completed by	Evidence of successful outcome	Current Position	Update
14.1	NIMDTA Deanery visit 08/05/2014	Craigavon Area Hospital	**Patient Safety**	Workload is intense during the working week.	Due to on-going recruitment problems and failed attempts to fill two vacant Speciality Doctor posts, there is additional pressure on trainees. We propose to introduce a 'Consultant of the Week' model which would reduce emergency workload on trainees and permit them to attend elective sessions. The working week would be planned so that trainees are not covering emergency while allocated to clinical sessions.	M Young & Consultant Urologists	30/09/2014		The Deanery QMG will request an update on this issue via the Southern Trust LEP Quality Report which is due for submission by **30 September 2014.**	A Consultant of the week model was introduced in September 2014. The model involves each of the six Urology Consultants being on call in turn. Formal handover takes place at the grand round on a Thursday each week. The daily weekday ward rounds are Consultant led. This permits supervised training in emergency urology for our ST's and senior input into in patient care on a daily basis.

14.2	NIMDTA Deanery visit 08/05/2014	Craigavon Area Hospital	**Delivery of Approved Curriculum including Assessments**	**Practical Experience.** Trainees do not attend any consultant-led outpatient clinics.	The current Registrar clinic runs in tandem with the Consultant clinic in the specialised urological out-patient department. A Consultant will be available throughout the clinic to provide supervision.	M Young & Consultant Urologists	31/08/2014		The Deanery QMG require clarification on the following: 1. Do trainees now attend Consultant led clinics? 2. Is there a named Consultant for the 'Registrar' clinic? This will be followed up via the Southern Trust LEP Quality Report which is due for submission by **30 September 2014.**	Following discussions between the SHSCT and HSC Commisioners, a new patient clinic structure has been introduced from October. Trainees will attend this clinic with 2 Consultants and see unselected new urology patients under supervision. The previous type of registrar clinic is being phased out over October/November. However, a named Consultant is present in an adjacent room for supervision.
14.3	NIMDTA Deanery visit 08/05/2014	Craigavon Area Hospital	**Support & Development of Trainees, Trainers & Local faculty**	**Formal Teaching.** In-house urology teaching is informal and ad hoc.	In-house teaching is currently available during weekly grand ward round and urology x-ray conference. Monthly M&M will be utilised to implement more formal in-house teaching from September 2014 with the introduction of Registrar led journal club.	AJ Glackin	30/09/2014		The Deanery QMG will request an update on this issue via the Southern Trust LEP Quality Report which is due for submission by **30 September 2014.**	A programme of educational activity has been agreed and circulated (copy provided).

14.4	NIMDTA Deanery visit 08/05/2014	Craigavon Area Hospital	**Patient Safety**	**Handover** is to the general surgery trainee in the evening and back to the urology trainee in the morning. This was said to be very informal and in need of improvement.	We will implement the use of IMMIX clinical noting electronic handover system which has been installed within the Trust to assist with handover.	M Young & Consultant Urologists	31/08/2014		The Deanery QMG require confirmation that the IMMIX clinical noting electronic handover system is now in place. This will be followed up via the Southern Trust LEP Quality Report which is due for submission by **30 September 2014.**	Daily Consultant led ward rounds have resulted in improved handover. The use of IMMIX has not yet been implemented for electronic handover. Trainees received training on IMMIX at Generic Induction, however, training would be required for Consultants and those trainees who were absent from induciton.

Southern Health and Social Care Trust
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Medical Staff Appraisal Scheme

Southern Health and Social Care Trust –
Version 4.0 [1 July 2014]

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Medical Appraisal Scheme

Southern Health and Social Care Trust

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1 Introduction

This document sets out the Trust's appraisal scheme for Consultant and SAS Doctors.

The scheme will form a critical element of the Trust's corporate and clinical governance processes. It is recommended that this document is read in conjunction with these circulars and the DHSSPS document 'Guidance for Medical Appraisal'.

The Trust makes it a requirement for its entire medical staff, including locum/temporary doctors (employed for more than 6 months), to participate in this appraisal scheme. This will satisfy the requirement for medical staff to participate in an annual appraisal and present evidence of competence in the field of practice in order to retain the GMC licence to practice.

The Trust will create an 'appropriate environment' for a doctor to have a supportive and developmental annual review. It is expected that the appraisal process and completion of the attached appraisal forms, will provide doctors with the supporting documentation necessary for GMC revalidation.

This appraisal scheme will be linked closely with job planning arrangements and the appraisal meetings will provide the opportunity to draw together information and data which shape job plans.

2 Main Purpose of Appraisal

Medical Appraisal can be defined as:

A positive process of constructive dialogue, in which the doctor being appraised has a formal, structured opportunity to reflect on his/her work and to consider how his/her effectiveness might be improved. It should support doctors in their aim to deliver high quality care whilst ensuring they are practicing within a safe and effective framework.

The aims and objectives of appraisal are to enable doctors and employers to:

- review regularly an individual's work and performance, utilising relevant and appropriate comparative performance data from local, regional and national sources
- optimise the use of skills and resources in seeking to achieve the delivery of service priorities

- consider the doctor's contribution to the quality and improvement of services and priorities delivered locally
- define personal and professional development needs and agree plans for these to be met
- identify the need for the working environment to be adequately resourced to enable any service objectives in the agreed job plan review to be met
- provide an opportunity for doctors to discuss and seek support for their participation in activities for the wider HSC
- contribute to the governance requirements of the organisation
- utilise the annual appraisal process and associated documentation to contribute to the requirements of revalidation.

In addition to the above aims, medical appraisal should:

- be delivered by competent, trained appraisers
- be consistently applied
- be undertaken annually
- not be a one-off event but a continual process and an integral part of a learning culture
- relate to **all areas** of a doctor's practice

3 Appraisal & Medical Revalidation

3.1 Revalidation

The General Medical Council (GMC) has implemented a system of revalidation for its registrants in December 2012. This change in medical regulation will provide an assurance to patients and the public that doctors are keeping up to date and are fit to practise. All registrants wishing to practise medicine have been issued with a licence to practise from the GMC. Renewal of this licence will be subject to the process of revalidation whereby a senior doctor in a healthcare organisation, known as a Responsible Officer, will make a recommendation to the GMC that those doctors with whom they have a prescribed relationship are practising to the standards defined by the GMC in Good Medical Practice[1].

[1] http://www.gmc-uk.org/guidance/good_medical_practice.asp

In order to make this recommendation, the Responsible Officer will review a range of information relating to individual doctors. Rather than the addition of another process that has potential to place an administrative burden on doctors, the appraisal process should be the platform for reviewing the supporting information required by the GMC for revalidation that demonstrates the doctor is practicing to the standards of *Good Medical Practice*.

All doctors will have been directly notified of their revalidation timeframe and the minimum requirements for revalidation. The Trust has adopted a two-staged approach to ensure doctors meet the GMC's revalidation requirements. An 'initial' meeting is held with each doctor approximately six weeks before their revalidation date to review their revalidation portfolio, with a further 'sign-off' meeting being held four weeks later after which time a recommendation is made to the GMC.

NB: The Trust can only revalidate those with whom it has have a direct contractual link <u>at their actual date of Revalidation</u>. Those who are leaving the Trust (e.g. retiring, end of temporary contract) should contact the Revalidation Support Team to obtain advice regarding alternative options for Revalidation.

4 Roles, Responsibilities and Accountabilities

4.1 Role of the Trust

- Ensure that an appraisal system is in place which covers all doctors employed by the Trust
- Ensure that the appraisal scheme meets the requirements of GMC Revalidation
- Ensure that all doctors undergo annual appraisal in line within the national framework.
- Establish workable arrangements for identifying, appointing and training appraisers.
- Ensure that appropriate mechanisms are in place to quality assure appraiser training, and to regularly review the appraisal process in the light of participant experiences and changing circumstances.
- Ensure robust processes are in place to deal with worries and complaints from individual doctors about the process or outcomes of appraisal.
- Co-ordinate the education and practice of Appraisers to ensure that objectives are focussed to meet needs of patients within Southern Trust population.
- Receive summaries of individual appraisal meetings to identify education' service needs and support required by doctors.
- Report the overall outcome of the appraisal process to the Trust Board on a yearly basis.
- Resolve concerns or disputes regarding the appraisal process.

- Lead the review and development of the Appraisal Scheme

Staff Category	Participants in Southern Trust Appraisal Scheme	Comment	Prescribed Connection to SHSCT RO
Permanent Employed Consultant Staff	Yes	Contractually obliged	Yes
Permanent Employed SAS Doctors	Yes	Contractually obliged	Yes
Locum Medical Staff [in excess of 6 months]	Yes	Contractually obliged	Yes
Doctors in Training	No	Via NIMDTA	No
Locum Medical Staff [in excess of 1 week but less than 6 months]	Yes	See Locum Medical Staff Section 5	No
GP with Special Interest/Trust Contracts	No Participate in NIMDTA GP Appraisal Scheme –	Information on SHSCT contracted work should be provided for GP Appraisal Assurance of completion of appraisal to be forwarded to Trust Medical Director	No
GP employed in Out of Hours Service	No Participate in NIMDTA GP Appraisal Scheme –	Information on SHSCT contracted work should be provided for GP Appraisal – Assurance of completion of appraisal to be forwarded to Trust Medical Director	No

4.2 Accountabilities

The Chief Executive is personally accountable to the Trust Board for overseeing the appraisal process and confirming to the Trust Board that:

- appraisals have been conducted for all medical staff;
- any issues arising out of the appraisals are being properly dealt with
- personal development plans are in place for each doctor.
- appraisers and appraisees are trained to undertake appraisal across the full range of headings within the appraisal scheme
- appointment of a Responsible Officer, normally the Medical Director to make recommendations to the General Medical Council.

The Chief Executive will operate the system through the Medical Director and Associate Medical Directors and they will be accountable for ensuring any necessary action arising from the appraisal process is undertaken

The Medical Director, on behalf of the Chief Executive, will be responsible for ensuring the integrity of the appraisal scheme and for managing potential operational difficulties so that the validity of the process is maintained.

The Medical Director will ensure the necessary links exist between the appraisal process and other Trust processes concerned with clinical governance, quality and risk management and the achievement of service priorities. In discharging this accountability, the Chief Executive and Medical Director will have confidential access to Forms 3 and 4 and personal development plans as part of the appraisal process.

Individual doctors are responsible for participating properly in the appraisal process and for undertaking any identified development.

4.3 Role of the Responsible Officer

It will not normally be the role of a Responsible officer to undertake appraisal for every doctor employed by the organisation to which they are appointed (although this may be the case where an organisation employs few doctors). Rather, the Responsible Officer must be able to demonstrate that all associated governance systems that support doctors are functioning effectively. In terms of appraisal, the Responsible Officer must ensure that the appraisal system is appropriately monitored and is of sufficient quality.

The Responsible Officer should ensure that the governance processes that support appraisal are sufficiently robust, namely:

- Accountability and oversight
- Information sharing
- Processes for escalation of concerns arising from appraisal
- Process to manage complaints in relation to the appraisal process

When the Responsible Officer is asked to make a recommendation to the GMC on revalidation, participation in, and outcomes from, appraisal will provide a key source of information upon which their recommendation will be based, alongside information obtained from clinical and social care governance systems in their organisation. Guidance on the role of the Responsible Officer has been developed and provides further information on this process. [2]

The function of appraisal, therefore, remains supportive and developmental but concurrently supports the Responsible Officer in making a recommendation to the GMC on the fitness to practice of individual doctors.

4.4 Role of the Appraisee:

[2] http://www.dhsspsni.gov.uk/index/hss/confidence_in_care.htm

- Develop an understanding of the appraisal process.
- Participate fully in appraisal
- In conjunction with Medical Management, identify an appraiser
- Make contact with appraiser to schedule appraisal meeting
- Prepare for the appraisal meeting and make the appraisal folder available to the appraiser at least 10 working days in advance of the planned appraisal meeting.
- Agree personal objectives, actions and individual development plan for the coming year.
- Identify factors that may inhibit performance.
- Prepare supporting evidence for revalidation with GMC.
- Seek to achieve defined objectives and fulfil individual learning and development plan.
- Complete form/s clearly and legibly.
- Be responsible to inform the appraiser of any performance or professional issues.
- Send the signed original of all seven forms including the Personal Development Plan [PDP] to the Medical Director's Office, Clanrye House, Daisy Hill Hospital.

4.5 Role of the Appraiser

- Undertake appropriate training in the role of an appraiser. Appraisers are required to attend an in-house Appraiser Clinic at least every 3 years.
- Undertake appraisal with a number of designated doctors – at least five but no more than eight per year.
- Prepare for appraisal and agree an agenda with the appraisee which should include an appropriate balance of personal, professional and local objectives.
- Ensure that the appraisal is conducted in line with good practice and within the national appraisal framework as defined by the DHSSPS
- Support the appraisee in considering practice over the last year.
- Agree objectives and development plan with the appraisee.
- Agree a confidential record of the appraisal meeting to be kept by appraisee and the appraiser.
- Build a positive relationship with the appraisee
- Identify any warning signs that the appraisee may be experiencing difficulties and provide further discussion with the appraisee about how this should be addressed.

- Refer to the Associate Medical Director/Medical Director if the appraiser has serious concerns about the appraisee performance or capacity to perform.

- Complete form/s clearly and legibly.

NB Where a doctor has undertakings or conditions placed on them by the GMC, the Trust's Revalidation Support Team will write to their workplace supervisor at the start of the Appraisal year in order that they can make contact with the doctor's Appraiser.

4.6 Southern Trust Medical Appraisal Structure

4.6.1 Medical Appraisal & Revalidation Group

Membership:

- Medical Director [Chair]
- Corporate Lead for Appraisal and Revalidation
- Lead Appraisers
- Associate Medical Directors
- Appraisers
- LNC Representative
- SAS Doctors LNC Representative
- Director of Human Resources and Organizational Development
- Medical Staffing Manager
- Medical Directorate Manager
- Revalidation Project Manager

4.7 Appraisal Annual Report

The Medical Director will submit an annual report on the operation of the appraisal scheme to a Public Trust Board Meeting. This information will be shared and discussed with the Trust Appraisal and Revalidation Group. The annual report will not refer, explicitly or implicitly, to any individuals who have been appraised but, rather, will highlight any Trust wide issues and action arising out of the appraisal process, for example, educational developments.

The Medical Director will formally review the appraisal process with the Chief Executive and the Director of Human Resources and Organisational Development on an annual basis.

5 Locum/Temporary Medical Staff Appraisal

Locum and temporary doctors should be actively encouraged to keep a logbook of their clinical activities, an account of their involvement in critical incidents and a record of their CPD activities.

As a general principle, locum doctors should be actively encouraged to reflect on their practice and career development and where possible locum doctors should be included in the Trust's development programmes.

5.1 Employed Less Than 6 months

An exception exit report will be completed for doctors who are employed as locum/temporary contracts [from agency] less than 6 months.

Reports of doctors contracted from locum agencies will be produced on a bi-annual basis. This will be forwarded to the relevant Associate Medical Director who will be asked to confirm that the doctors have not been involved in conduct, capability or formal serious untoward incidents/significant event investigations or are named in complaints.

Any immediate concerns should be reported on an exception basis to the relevant Associate Medical Director and Medical HR Department.

Any concerns raised through this process will be immediately reported to the relevant Associate Medical Director/Operational Director.

For Doctors employed via the Regional Medical Locums Bank, the supervising consultant sign off requires confirmation that there were no concerns about the doctor during their placement.

5.2 Employed on Initial Contracts of More Than 6 months But Less Than 1 Year

A locum/temporary doctor employed [either directly by the Trust or via agency- in either training or non-training grade posts] for periods of more than six months but less than 1 year are not included in the routine appraisal processes and may not have a prescribed connection to the Trust Responsible Officer. Click here for GMC Guidance on finding your designated body.

The Trust requires this group to undertake an 'Appraisal Induction' before the end of month 3 of their placement. The Trust Revalidation Support Team will support this process by providing relevant guidance to the doctor.

The 'Appraisal Induction' will include:

- Review of previous NHS appraisals [if available]
- Development of a Personal Development Plan
- Assessment/presentation of any complaints and incidents for the period
- Completion of Health and Probity declarations.

Any immediate concerns should be reported on an exception basis to the relevant Associate Medical Director and Medical HR Department.

5.3 Employed Via an Agency [Designated Body]

In some instances a locum doctor may be employed via an agency where the appraisal of doctors/revalidation is part of the services provided by that agency.

The doctor should confirm their arrangements at the time of appointment.

6 Appraisal for New Permanent Starts

The Trust requires details of previous appraisals from doctors previously employed in the NHS.

The Trust also requires new starts to undertake an 'Appraisal Induction' at the end of month 3 of their new appointment. The Trust Revalidation Support Team will support this process by providing relevant guidance to the doctor.

The 'Appraisal Induction' will include:

- Review of previous NHS appraisals [if available]
- Development of a Personal Development Plan
- Assessment/presentation of any complaints and incidents for the period
- Completion of Health and Probity declarations.

Click here for the Appraisal Induction Forms.

The newly employed doctor will also meet with the Trust's Medical Director / Responsible Officer once their appraisal induction is complete. This will be organised by the Trust's Revalidation Support Team.

7 GP with Special Interest/Trust Contracts Appraisal

Under the principles of whole practice appraisal General Practitioners with Special Interest or Trust contracts [e.g. GP OOH, A & E] will be expected to provide documented evidence of their special interest work for inclusion in their formal national GP appraisal.

See 'Supporting the Revalidation of General Practitioners – Guidance for GP's and their Clinical Supervisors – click here.

GPs should return evidence of completion of their GP appraisal to the Medical Director on completion of the process.

8 Appraisal for Doctors in Training

All doctors in training within the Northern Ireland Deanery (NIMDTA) are required to be assessed and appraised in accordance with the principles of *Good Medical Practice*. The existing educational processes, including records of assessment, will form the basis of an appraisal portfolio for revalidation for this group of doctors.

In January 2013 the Northern Ireland Medical and Dental Training Agency [NIMDTA] requested Trusts to submit a 'Collective Exit and Exception Exit Report' for trainees allocated to the Trust in the preceding 6 months as part of revalidation process.

The Deanery have requested that the Trust provides information on any trainee who has been involved in: conduct, capability or formal serious untoward incidents/significant event investigations or are named in complaints, See 'Guideline for the Sharing of Information with NIMDTA for Trainee Revalidation – click here

9 Whole Practice Appraisal

Revalidation will be based on all areas of a doctor's practice therefore the appraisal discussion should reflect this. Doctors are expected to bring supporting information in relation to all practice they undertake, including that in the independent sector. For further information and templates see 'Whole Practice Appraisal – Guidance for Doctors Employed in SHSCT' – click here. ***NB For those who are a joint appointee with another NHS employer, the Southern Trust will provide a Statement of No Concerns (Appendix 1).***

10 Appraisal Process

10.1 Timing

The appraisal process must be carried out annually. The Trust operates an annual appraisal cycle from January to December. With the introduction of revalidation all doctors MUST ensure that their appraisal adheres to this cycle.

Between January and March, Medical Managers and doctors should complete the process of reviewing their job plan for the appraisal year and engaging in the appraisal meeting.

10.2 Duration & Time Allocation

Good quality appraisal meetings would normally be expected to last for approximately two hours. For appraisers, it is expected that, ordinarily, four hours of SPA time will cover preparation for and the conduct of each appraisal. Appraisees will be allocated eight hours of SPA time, annually.

Arrangements should be made to ensure that the meeting is not disturbed except for extreme emergencies. Telephones and bleeps should be diverted and colleagues should be asked to provide emergency cover for the consultants' patients. Appraisers should carefully consider seating arrangements etc. to create an environment conducive to constructive dialogue.

10.3 Organisation

The appraisee is responsible for agreeing a time and venue for the appraisal that guarantees privacy and confidentiality. Where, for whatever reason, a third party is required to contribute to an appraisal (or, indeed, where a special appraiser has to be involved), this should be discussed and agreed well in advance.

10.4 Appraisal and Job Planning

In advance of the appraisal meeting each doctor should have the job plan of their appraisal year in their folder for discussion with his/her Medical Manager. Based on this, the doctor should identify those issues that he/she wishes to raise with the appraiser and prepare a workload summary to facilitate departmental planning and development. This should highlight any significant changes which might have arisen over the previous 12 months and which require discussion, which, in turn, will inform their new job plan.

10.5 What Preparation Needs to Happen Before the Appraisal Meeting?

10.5.1 Preparation by the Appraisee

Preparation is the key to a successful appraisal. Doctors must prepare using the Standardised DHSSPS Forms HSCNI Career Grade Medical Staff Appraisal Appendix 2] see Section 10 for detailed guidance on the completion of this documentation. The appraisee will be required to send documentation to the appraiser at least 10 days before the appraisal to allow for time for preparation by the appraiser.

10.5.2 Preparation by the appraiser

The role of the appraiser is to assist the appraisee in reflecting on past performance and formulating objectives to achieve future performance.

On receipt of the pre-appraisal documentation, the appraiser will contact the appraisee to agree any specific agenda items that may form the focus of the appraisal meeting. Appraisers must make themselves aware of any planned service developments and other