Southern Health and Social Care Trust

Quality Care - for you, with you

HSC Value	What does this mean?	What does this look like in practice? - Behaviours
W **Working Together**	We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.	• I work with others and value everyone's contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible
Compassion	We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.	• I am sensitive to the different needs and feelings of others and treat people with kindness • I learn from others by listening carefully to them • I look after my own health and well-being so that I can care for and support others
Excellence	We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high-quality, compassionate care and support.	• I put the people I care for and support at the centre of all I do to make a difference • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking 'could we do this better?'
Openness & I	We are open and honest with each other and act with integrity and candour.	• I am open and honest in order to develop trusting relationships • I ask someone for help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice

All staff are expected to display the HSC Values at all times

HSC Southern Health and Social Care Trust

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#bettertogether

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WORKING TOGETHER · EXCELLENCE · COMPASSION · OPENNESS & HONESTY

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2022 . 06 . 10

Q6 . b5B

Head of Service Stroke Service, Frail Elderly Haematology, & Medical Ward

Working together Excellence Openness & Honesty Compassion

Southern Health and Social Care Trust

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As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.
Successful applicants may be required to attend for a Health Assessment

THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER

JOB TITLE:	Head of Service – Stroke Service, Frail Elderly Haematology, & Medical ward.
BAND:	8B
DIRECTORATE:	Acute Services
LOCATION:	Craigavon Hospital and Daisy Hill Hospital
REPORTS TO:	Assistant Director of Acute Services – Acute Medicine & Unscheduled Care
ACCOUNTABLE TO:	Director of Acute Services

JOB SUMMARY

The Head of Service is accountable to the Assistant Director for Acute Services in Medicine
for the leadership and direction of staff within the relevant specialities.

Areas of responsibilities will include:

- Stroke Wards CAH & DHH
- Frailty Elderly ward & Medical ward CAH
- Haematology ward

The post holder has overall responsibility for the operational management of the services, to ensure that programmes are identified and managed to improve the service provided to patients through improved performance, improved quality and an improved patient experience.

The post holder will be responsible for budget and for delivering financial balance within their area of responsibility and the management of cost improvement programmes to support the achievement of balanced budget. The post holder will also be responsible for identifying and implementing service improvement initiatives within their area of responsibility.

The post holder will ensure that staff are fully engaged in the process of change management and in particular, that clinicians and multi-disciplinary professionals are fully involved at the forefront of service improvement initiatives.

The post holder will provide managerial leadership for the staff within the relevant speciality(s) in order to support the delivery of high quality clinical services for patients.

The post holder will work in collaboration with Clinical Directors/Lead Clinician(s) to develop a team approach to the clinical services for which they are accountable.

The post holder will work in collaboration with other Head of Services to ensure a consistent management approach across sites for efficient management of safe, high quality, Unscheduled and Elective Services to ensure delivery of all access standards.

KEY RESULT AREAS

Service Delivery

1. Provide leadership and direction to staff so that agreed objectives and policies set are achieved.
2. Be accountable for the effective and efficient operation of clinical services.
3. Ensure that management is provided with advice and information required to formulate policies, decide priorities, set and achieve objectives and monitor progress in collaboration with the Clinical Directors/Lead Clinician(s).
4. Review service provisions defining priorities and objectives in order to maintain and further develop the services.
5. Undertake mapping of existing strategy services and policies and outline appropriate action plans for improvement in collaboration with the Clinical Directors/Lead Clinician(s).
6. Lead service change working with key stakeholders to redesign plan and deliver improvements to patient care pathways in collaboration with the Lead Clinician(s).
7. Empower and engage all staff and ensure involvement at all levels to achieve new ways of working and implement alternative models of service delivery.

8. Responsible for management of all staff including medical staff, ensuring good systems are in place for annual leave, sick leave and appropriate plans in place for replacing staff including short notice absences.

9. In line with regional guidance review access and waiting times, agree key target priorities and ensure targets are met both locally and regionally.

10. Be responsible for the development, implementation and ownership of effective information and communication systems and co-ordinate working practices between staff within the clinical service(s).

11. Contribute to the continuing success of the Acute Services Directorate, assisting in the delivery of the Corporate agenda by way of specific objectives, projects and initiatives.

12. Work in collaboration with key stakeholders to enhance and improve services.

13. Respond to patient complaints, learn lessons and implement improvements as a result of such complaints

14. Monitor and regularly review the flow of patients and staffing levels/mix to improve productivity and efficiency. Lead the implementation of necessary actions to develop, implement and maintain a flow system which "pulls" patients through

Quality

1. Ensure that the needs of the patients and their carers are at the core of the way services are delivered.

2. Ensure that practice and service developments are underpinned by the most up to date evidence based research.

3. Work in partnership with the Clinical Directors/Lead Clinician(s). to ensure that services comply with all professional regulatory and requisite standards and the discharge of statutory functions.

4. Work in partnership with the Clinical Directors/Lead Clinician(s) and working with the full range of staff groups, lead innovation and change to underpin the modernisation of services.

5. Establish and maintain clear systems and processes for accountability and performance management.

6. Monitor and support the use of clinical guidelines and protocols for staff within the Division.

7. Ensure public involvement of users and carers in the planning of services within the Division.

8. Actively seek and encourage feedback from users to enable continuous improvement plan for implementation with the support of the Clinical Directors/Lead Clinician(s).

9. Work in partnership with the Clinical Directors/Lead Clinician(s) to ensure robust clinical governance and risk management systems are in place within the Division ensuring corrective action plans are developed and implemented.

10. Work in partnership with the Trust Governance management to support the quality and clinical & social care governance agenda.

Strategic Planning and Development

1. Support to Assistant Director, Medicine & Unscheduled Care with the development of the strategic plan for the delivery of Medicine & Unscheduled Care services in line with regional, Ministerial and HSC priorities.

2. Assist with corporate initiatives aimed at cost effectiveness and improving patient flow

Financial and Resource Management

1. Manage the service budgets and ensure the meeting of all financial targets

2. Develop and promote staff understanding of the financial requirements in order to ensure opportunity to maximise income generation potential in the delivery of services

3. With the support of the Lead Clinician(s) to review demand and capacity within Acute Medicine & Unscheduled Care utilising the Real Capacity Model and implement a programme of service changes to improve the matching of demand, capacity and target performance.

4. Ensure the effective deployment of staff and skills to ensure all standards and targets are achieved to maximise staff performance and retention through training and development and modern employment practices.

5. Ensure the effective use of equipment and facilities within Acute Medicine & Unscheduled Care to optimise patient care and service delivery.

6. Lead on all relevant capital investment and service development proposals, liaising with multi-disciplinary colleagues as and when required.

People Management

1. Provide clear leadership to Acute Medicine & Unscheduled Care staff and ensure that highly skilled and motivated staff support the Division where/when requested.

2. Lead the development and implementation of workforce reform and modernisation initiatives within Acute Medicine & Unscheduled Care as and when required.

3. Ensure compliance with employment legislation, HPSS directions and Trust standard orders, policies, procedures and regulations by introducing appropriate systems, management and control processes within Acute Medicine & Unscheduled Care.

Corporate Management

1. Assist with the Trust's corporate planning by supporting the Assistant Director, Medicine & Unscheduled Care.

2. Develop and maintain working relationships with other Manager colleagues and ensure achievement of objectives and the effective functioning of all relevant services.

3. Establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Division effectively discharges its functions

4. Lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers

Leadership

1. Lead the operational management within Acute Medicine and Unscheduled Care, ensuring priorities meet objectives

2. Provide leadership to staff within Acute Medicine and Unscheduled Care to ensure the delivery of safe, effective patient care and to enable effective sharing of knowledge, ideas and skills through the development of a culture of continuous improvement

3. Ensure all policies are operationalised appropriately and proportionately.

4. Promote positive working relationships within all relevant specialties and be empathetic to the implications of service developments or changes for other parts of the Acute Hospital services.

5. Ensure strong professional leadership across the Division.

6. Ensure the development of robust mechanisms for consistent communication with Acute Medicine and Unscheduled Care staff to enable them to influence the health agenda.

7. Establish, implement and maintain standards of practice within all relevant specialties consistent with the standards of the relevant professional bodies.

Monitoring and Reviewing Performance

1. Responsible for developing robust performance indicators within Acute Medicine and Unscheduled Care translating regional indicators/targets into speciality targets, ensuring monitoring control and remedial action systems are in place.

2. Responsible for the performance against the plan for Acute Medicine and Unscheduled Care, ensuring financial balance is achieved.

3. Manage inpatient and day case and outpatients access targets and ensure the required level of performance is achieved and that safe care is delivered at all times.

4. Lead on activities to review the effective use of resources and facilities within all relevant specialties and improvements that may be made in the achievement of the Acute Medicine and Unscheduled Care strategy or objectives

5. Ensure the Acute Medicine and Unscheduled Care plans are in place to monitor achievement against corporate objectives, e.g.: Junior Doctor compliance, waiting time targets for access and governance etc. Assess level of risk to delivery of required performance and address all relevant issues by expedient management action.

6. Ensure adherence across Acute Medicine and Unscheduled Care to all Trust policies and procedures and contribute to their formulation as appropriate.

7. Ensure that robust performance arrangements are development and implemented within Acute Medicine and Unscheduled Care.

HUMAN RESOURCE MANAGEMENT RESPONSIBILTIES

1. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.

2. Maintain staff relationships and morale amongst the staff reporting to him/her.

3. Review the organisation plan and establishment level of the service for which he/she

is responsible to ensure that each is consistent with achieving objectives, and recommend change where appropriate.

4. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

5. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

6. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

3. Adhere at all times to all Trust policies/codes of conduct, including for example:
   - Smoke Free policy
   - IT Security Policy and Code of Conduct
   - standards of attendance, appearance and behaviour

4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

5. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

4. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

5. Take responsibility for his/her own ongoing learning and development, including full

participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

6. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

7. Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

Southern Health and Social Care Trust

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PERSONNEL SPECIFICATION

JOB TITLE AND BAND Head of Service – Stroke, Frail Elderly, Haematology and Dermatology 8B

DEPARTMENT / DIRECTORATE: Acute Services

SALARY

HOURS: 37.5 per week

Ref No:

Notes to applicants:

1. *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted.*
2. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA		
SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.		
Factor	**Criteria**	**Method of Assessment**
Experience	1. Hold a relevant[1], University Degree or recognised Professional Qualification or equivalent qualification **AND** 2 years' experience in a Senior Role[2] **OR** have at least 5 years' experience in a Senior Role[3].	Shortlisting by Application Form

[1] *This will be defined as one of the following organisations in Northern Ireland - The Regional HSC Board; The Regional Agency for Public Health & Social Well being; the Regional Business Services Organisation; HSC Trusts, Special Agencies, the Patient Client Council, the RQIA, the NI Practice & Education Council and the NI Social Care Council*

[1] *'relevant qualification' will be defined as any business, administrative, corporate function or health related qualification*

[2] *'Senior Role' is defined as Band 7 or equivalent or above.*

	2. Have a minimum of 1 years' experience in a lead role delivering objectives which have led to a significant[3] Improvement in Service. 3. Have a minimum of 1 years' experience working with a diverse range of internal and external stakeholders in a role which has contributed to the successful implementation of a significant[4] change in initiative. 4. Have a minimum of 2 years' experience in staff management 5. Hold a full current license valid for use in the UK and have access to a car on appointment[4].	
Qualifications/ Registration	1. Hold a relevant[5], University Degree or recognised Professional Qualification or equivalent qualification **AND** 2 years' experience in a Senior Role[6] **OR** have at least 5 years' experience in a Senior Role[3].	Shortlisting by Application Form
Knowledge & Skills	1. Have an ability to effectively manage a delegated budget to maximize utilization of available resources. 2. Have an ability to provide effective leadership.	

[3] *'Significant' is defined as contributing directly to key Directorate objectives*
[4] *This criterion will be waived in the case of a suitable applicant who has a disability which prohibits from driving but who is able to organize suitable alternative arrangements in order to meet the requirements of the post in full.*
[1] *This will be defined as one of the following organisations in Northern Ireland - The Regional HSC Board; The Regional Agency for Public Health & Social Well being; the Regional Business Services Organisation; HSC Trusts, Special Agencies, the Patient Client Council, the RQIA, the NI Practice & Education Council and the NI Social Care Council*
[5] *"relevant qualification' will be defined as any business, administrative, corporate function or health related qualification*
[6] *'Senior Role' is defined as Band 7 or equivalent or above.*

	3. Demonstrate evidence of highly effective planning and organisational skills 4. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.	

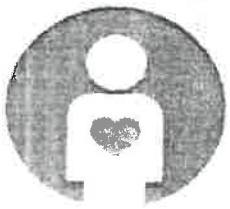
WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trusts Smoke Free Policy

Southern Health and Social Care Trust

Quality Care - for you, with you

	HSC Value	What does this mean?	What does this look like in practice? - Behaviours
	Working Together	We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.	• I work with others and value everyone's contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible
	Compassion	We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.	• I am sensitive to the different needs and feelings of others and treat people with kindness • I learn from others by listening carefully to them • I look after my own health and well-being so that I can care for and support others
	Excellence	We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high-quality, compassionate care and support.	• I put the people I care for and support at the centre of all I do to make a difference • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking 'could we do this better?'
	Openness & Honesty	We are open and honest with each other and act with integrity and candour.	• I am open and honest in order to develop trusting relationships • I ask someone for help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice

All staff are expected to display the HSC Values at all times

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2022. 25.05
Q6. 65c

Head of Service Band 8b Diabetes & Endocrine, Gastroenterology, Neurology & Rheumatology (1 South Ward & Day Clinical Centre)

Working together Excellence Openness & Honesty Compassion

Southern Health and Social Care Trust

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JOB DESCRIPTION

JOB TITLE	Head Of Service Diabetes & Endocrine, Gastroenterology, Neurology, Rheumatology
BAND	8b
DIRECTORATE	Acute Services
INITIAL LOCATION	Craigavon Area Hospital
REPORTS TO	Assistant Director of Acute Services
ACCOUNTABLE TO	Director of Acute Services

JOB SUMMARY

The Head of Service is accountable to the Assistant Director for Acute Services in Medicine for the leadership and direction of staff within the relevant specialities.

Areas of responsibilities will include:

- Ward 1 South Craigavon Area Hospital
- Day Clinical Centre, South Tyrone Hospital

The post holder has overall responsibility for the operational management of the services, to ensure that programmes are identified and managed to improve the service provided to patients through improved performance, improved quality and an improved patient experience.

The post holder will be responsible for budget and for delivering financial balance within their area of responsibility and the management of cost improvement programmes to support the achievement of balanced budget. The post holder will also be responsible for identifying and implementing service improvement initiatives within their area of responsibility.

The post holder will ensure that staff are fully engaged in the process of change management and in particular, that clinicians and multi-disciplinary professionals are fully involved at the forefront of service improvement initiatives.

The post holder will provide managerial leadership for the staff within the relevant speciality(s) in order to support the delivery of high quality clinical services for patients.

The post holder will work in collaboration with Clinical Directors/Lead Clinician(s) to develop a team approach to the clinical services for which they are accountable.

The post holder will work in collaboration with other Head of Services to ensure a consistent management approach across sites for efficient management of safe, high quality, Unscheduled and Elective Services to ensure delivery of all access standards.

KEY DUTIES / RESPONSIBILITIES

Service Delivery

1. Provide leadership and direction to staff so that agreed objectives and policies set are achieved.
2. Be accountable for the effective and efficient operation of clinical services.
3. Ensure that management is provided with advice and information required to formulate policies, decide priorities, set and achieve objectives and monitor progress in collaboration with the Clinical Directors/Lead Clinician(s).
4. Review service provisions defining priorities and objectives in order to maintain and further develop the services.
5. Undertake mapping of existing strategy services and policies and outline appropriate action plans for improvement in collaboration with the Clinical Directors/Lead Clinician(s).
6. Lead service change working with key stakeholders to redesign plan and deliver improvements to patient care pathways in collaboration with the Lead Clinician(s).
7. Empower and engage all staff and ensure involvement at all levels to achieve new ways of working and implement alternative models of service delivery.
8. Responsible for management of all staff including medical staff, ensuring good systems are in place for annual leave, sick leave and appropriate plans in place for replacing staff including short notice absences.
9. In line with regional guidance review access and waiting times, agree key target priorities and ensure targets are met both locally and regionally.

10. Be responsible for the development, implementation and ownership of effective information and communication systems and co-ordinate working practices between staff within the clinical service(s)

11. Contribute to the continuing success of the Acute Services Directorate, assisting in the delivery of the Corporate agenda by way of specific objectives, projects and initiatives.

12. Work in collaboration with key stakeholders to enhance and improve services.

13. Respond to patient complaints, learn lessons and implement improvements as a result of such complaints

14. Monitor and regularly review the flow of patients and staffing levels/mix to improve productivity and efficiency. Lead the implementation of necessary actions to develop, implement and maintain a flow system which "pulls" patients through

Quality

1. Ensure that the needs of the patients and their carers are at the core of the way services are delivered.

2. Ensure that practice and service developments are underpinned by the most up to date evidence based research.

3. Work in partnership with the Clinical Directors/Lead Clinician(s). to ensure that services comply with all professional regulatory and requisite standards and the discharge of statutory functions.

4. Work in partnership with the Clinical Directors/Lead Clinician(s) and working with the full range of staff groups, lead innovation and change to underpin the modernisation of services.

5. Establish and maintain clear systems and processes for accountability and performance management.

6. Monitor and support the use of clinical guidelines and protocols for staff within the Division.

7. Ensure public involvement of users and carers in the planning of services within the Division.

8. Actively seek and encourage feedback from users to enable continuous improvement plan for implementation with the support of the Clinical Directors/Lead Clinician(s).

9. Work in partnership with the Clinical Directors/Lead Clinician(s) to ensure robust clinical governance and risk management systems are in place within the Division ensuring corrective action plans are developed and implemented.

10. Work in partnership with the Trust Governance management to support the quality and clinical & social care governance agenda.

11. Ensure public involvement of users and carers in the planning of services within the Division.

12. Actively seek and encourage feedback from users to enable continuous improvement plan for implementation with the support of the Clinical Directors/Lead Clinician(s).

13. Work in partnership with the Clinical Directors/Lead Clinician(s) to ensure robust clinical governance and risk management systems are in place within the Division ensuring corrective action plans are developed and implemented.

14. Work in partnership with the Trust Governance management to support the quality and clinical & social care governance agenda.

Strategic Planning and Development

1. Support to Assistant Director, Medicine & Unscheduled Care with the development of the strategic plan for the delivery of services in the Medicine Division in line with regional, Ministerial and HSC priorities.

2. Assist with corporate initiatives aimed at cost effectiveness and improving patient flow

Financial and Resource Management

1. Manage the service budgets and ensure the meeting of all financial targets

2. Develop and promote staff understanding of the financial requirements in order to ensure opportunity to maximise income generation potential in the delivery of services

3. With the support of the Lead Clinician(s) to review demand and capacity within Acute Medicine & Unscheduled Care utilising the Real Capacity Model and implement a programme of service changes to improve the matching of demand, capacity and target performance.

4. Ensure the effective deployment of staff and skills to ensure all standards and targets are achieved to maximise staff performance and retention through training and development and modern employment practices.

5. Ensure the effective use of equipment and facilities within Acute Medicine & Unscheduled Care to optimise patient care and service delivery.

3. Lead on all relevant capital investment and service development proposals, liaising with multi-disciplinary colleagues as and when required.

People Management

1. Provide clear leadership to Acute Medicine & Unscheduled Care staff and ensure that highly skilled and motivated staff support the Division where/when requested.

2. Lead the development and implementation of workforce reform and modernisation initiatives within Acute Medicine & Unscheduled Care as and when required.

3. Ensure compliance with employment legislation, HPSS directions and Trust standard orders, policies, procedures and regulations by introducing appropriate systems, management and control processes within Acute Medicine & Unscheduled Care.

Corporate Management

1. Assist with the Trust's corporate planning by supporting the Assistant Director, Medicine & Unscheduled Care.

2. Develop and maintain working relationships with other Manager colleagues and ensure achievement of objectives and the effective functioning of all relevant services.

3. Establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Division effectively discharges its functions

4. Lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers

Leadership

1. Lead the operational management within Acute Medicine and Unscheduled Care, ensuring priorities meet objectives

2. Provide leadership to staff within Acute Medicine and Unscheduled Care to ensure the delivery of safe, effective patient care and to enable effective sharing of knowledge, ideas and skills through the development of a culture of continuous improvement

3. Ensure all policies are operationalised appropriately and proportionately.

4. Promote positive working relationships within all relevant specialties and be empathetic to the implications of service developments or changes for other parts of the Acute Hospital services.

5. Ensure strong professional leadership across the Division.

6. Ensure the development of robust mechanisms for consistent communication with Acute Medicine and Unscheduled Care staff to enable them to influence the health agenda

7. Establish, implement and maintain standards of practice within all relevant specialties consistent with the standards of the relevant professional bodies.

Monitoring and Reviewing Performance

1. Responsible for developing robust performance indicators within Acute Medicine and Unscheduled Care translating regional indicators/targets into specialty targets, ensuring monitoring control and remedial action systems are in place.

2. Responsible for the performance against the plan for Acute Medicine and Unscheduled Care, ensuring financial balance is achieved.

3. Manage inpatient and day case and outpatients access targets and ensure the required level of performance is achieved and that safe care is delivered at all times.

4. Lead on activities to review the effective use of resources and facilities within all relevant specialties and improvements that may be made in the achievement of the Acute Medicine and Unscheduled Care strategy or objectives

5. Ensure the Acute Medicine and Unscheduled Care plans are in place to monitor achievement against corporate objectives, e.g.: Junior Doctor compliance, waiting time targets for access and governance etc. Assess level of risk to delivery of required performance and address all relevant issues by expedient management action.

6. Ensure adherence across Acute Medicine and Unscheduled Care to all Trust policies and procedures and contribute to their formulation as appropriate.

7. Ensure that robust performance arrangements are development and implemented within Acute Medicine and Unscheduled Care.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

1. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.

2. Maintain staff relationships and morale amongst the staff reporting to him/her.

3. Review the organisation plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives, and recommend change where appropriate.

4. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

5. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

6. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

GENERAL MANAGEMENT RESPONSIBILITIES

1. The post holder will, in the event of a concern being raised with them, ensure that feedback/learning is communicated at individual, team and organisational level (as per HSC Trust policy) regarding concerns and how they were resolved.

2. To work proactively with the Trust's Emergency planner and other internal and external stakeholders to develop appropriate emergency response and business continuity plans to ensure the service can maintain a state of emergency preparedness to respond safely and effectively to a range of threats, hazards and disruption.

PERSONAL AND PUBLIC INVOLVEMENT RESPONSIBILITIES (PPI)

Lead on and be responsible for the co-ordination of the Trust's PPI Strategy within the Division or other sphere of responsibility. This will include supporting active engagement

with user groups and the voluntary and independent sectors in the design and delivery of services.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

3. Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour

4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

5. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

6. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004, the General Data Protection Regulations (GDPR) and the Data Protection Act 2018. Employees are required to be conversant with the [org name] policy and procedures on records management and to seek advice if in doubt.

7. Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.

8. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

June 2022

Southern Health and Social Care Trust

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PERSONNEL SPECIFICATION

JOB TITLE AND BAND Head of Service Diabetes, Endocrine, Gastroenterology, Neurology & Rheumatology Band 8b

DEPARTMENT / DIRECTORATE Acute

HOURS 37.5

Ref No: <to be inserted by HR>

June 2022

Notes to applicants:

1. *You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Shortlisting will be carried out on the basis of the essential criteria set out in Section 1 below, using the information provided by you on your application form. Please note the Trust reserves the right to use any desirable criteria outlined in Section 3 at shortlisting. You must clearly demonstrate on your application form how you meet the desirable criteria.*
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA

SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.

Factor	Criteria	Method of Assessment
Qualifications/ Registration/Experience	1. Hold a relevant', University Degree or recognised Professional Qualification or equivalent qualification AND 2 years' experience in a Senior Role[2] **OR** Have at least 5 years' experience in a Senior Role[3]	Shortlisting by Application Form

	2. Have a minimum of 1 years' experience in a lead role delivering objectives which have led to a significant[3] Improvement in Service. 3 Have a minimum of 1 years' experience working with a diverse range of internal and external stakeholders in a role that has contributed to the successful implementation of a significant[4] change in initiative. 4 Have a minimum of 2 years' experience in staff management	
Other	5 Hold a current full driving licence, which is valid for use in the UK, and have access to a car on appointment. *These criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post.*	Shortlisting by Application Form
SECTION 2: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage:		
Skills / Abilities	6 Have an ability to effectively manage a delegated budget to maximize utilization of available resources 6 Have an ability to provide effective leadership. 7 Demonstrate evidence of highly effective planning and organizational skills 8 Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement	Interview / Test

[3] 'Significant' is defined as contributing directly to key Directorate objectives
[4] This criterion will be waived in the case of a suitable applicant who has a disability which prohibits from driving but who is able to organize suitable alternative arrangements in order to meet the requirements of the post in full.
[1] This will be defined as one of the following organisations in Northern Ireland - The Regional HSC Board; The Regional Agency for Public Health & Social Well being; the Regional Business Services Organisation; HSC Trusts, Special Agencies, the Patient Client Council, the RQIA, the NI Practice & Education Council and the N! Social Care Council
[5] 'relevant qualification' will be defined as any business, administrative, corporate function or health related qualification
[6] 'Senior Role' is defined as Band 7 or equivalent or above

Candidates who are shortlisted for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. The competencies concerned are set out in the NHS Healthcare Leadership Model, details of which can be found at http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model. Particular attention will be given to the following dimensions:

- Inspiring shared purpose
- Leading with care
- Evaluating information
- Connecting our service
- Sharing the vision
- Engaging the team
- Holding to account
- Developing capability
- Influencing for results.

If this post is being sought on secondment then the individual MUST have the permission of their line manager IN ADVANCE of making application.

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.
Successful applicants may be required to attend for a Health Assessment

THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER

Southern Health and Social Care Trust

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HSC Value	What does this mean?	What does this look like in practice? - Behaviours
W **Working Together**	We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.	• I work with others and value everyone's contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible
Compassion	We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.	• I am sensitive to the different needs and feelings of others and treat people with kindness • I learn from others by listening carefully to them • I look after my own health and well-being so that I can care for and support others
Excellence	We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high-quality, compassionate care and support.	• I put the people I care for and support at the centre of all I do to make a difference • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking 'could we do this better?'
Openness & Honesty	We are open and honest with each other and act with integrity and candour.	• I am open and honest in order to develop trusting relationships • I ask someone for help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice

All staff are expected to display the HSC Values at all times

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#bettertogether

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Received Anne McVey on 20/06/2022. Annotated by the Urology Services Inquiry.

Southern Health and Social Care Trust

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2022.06.10
@6.65F

Lead Nurse 8a

Medical Directorate
Acute

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JOB DESCRIPTION

JOB TITLE	Lead Nurse Cardiology and Respiratory Services also Haematology ward and Dermatology Services these two areas are subject to change.
BAND	8A
DIRECTORATE	Medical Directorate
INITIAL LOCATION	Craigavon Area Hospital
REPORTS TO	Head of Service
ACCOUNTABLE TO	Assistant Director

JOB SUMMARY

The Lead Nurse will be responsible to the Head of Service for the operational and professional nursing management and leadership within the Division. The Post holder is expected to function at a senior level providing visible, professional nursing leadership, support and direction to ensure safe patient cantered care and will proactively manage, lead and provide solutions to resolve complex operational issues working with Ward Sisters/Charge Nurses, Patient Flow team & Heads of Service including the lead for nursing workforce, education, training and development and governance.

He / She will be responsible for ensuring the standards of nursing practice throughout all relevant specialities are at the required professional standard ensuring that safe, high quality clinical services are delivered and will lead on programmes of improvement related to implementing and sustaining Regional Nursing Quality Indicators (NQIs).

As the Lead Nurse they will work with the entire Multi- disciplinary team (MDT) to optimize patient experience and outcomes of care through service and workforce efficiency, productivity and effectiveness. The Post holder will be expected to contribute to strategic direction and policy setting for the nursing within their Division.

KEY DUTIES / RESPONSIBILITIES

Service Delivery

1. Assure the highest standards of clinical care by the provision of management & leadership for nursing staff, patients, relatives, carers and visitors.

2. Lead and develop excellent patient care through continuous review of evidence based clinical standards, policies & standard operating procedures.

3. Create a strong patient focused team, embedding the regional patient/client experience standards (Respect, Attitude, Behaviour Communication, Privacy and Dignity), that challenges organisational and professional barriers and boundaries.

4. Develop a culture that is flexible and positive to change, where staff feel valued and where opportunities are actively created for individuals to maximise their potential and excel.

5. Promote a learning environment for staff, ensuring that the education, training and developmental needs of staff are reflected in the annual Education Commissioning, appraisal and PDP processes.

6. Promote a culture, which is underpinned by honest, open communication and team working across disciplines

7. Participate in clinical and professional networks across acute hospital sites within the Trust.

8. Contribute to the development and implementation of the nursing strategy as agreed by the Executive Director of Nursing.

9. Lead the effective implementation and ongoing monitoring of regional quality and operational initiatives

10. Provide advice, guidance, support and professional leadership to Ward/Department Sisters/Charge Nurses, Nurses, Specialist Nurses, the Patient Flow Team and Support Workers, demonstrating a responsible attitude in order to promote confidence in the service.

11. Ensure close collaborative working with the patient flow team to deliver on the regional performance standards for unscheduled and elective care

12. Responsible for the monitoring of clinical standards including observations of care provision e.g. all NQI's thus providing an assurance to senior management.

13. Support the effective implementation of environmental cleanliness standards. Ensure staffs have a clear understanding of the care and environmental standards they are expected to maintain taking prompt action to rectify any non-compliance.

14. Support the process for monitoring patient experience and assist to implement actions in the light of patient feedback, thus achieving a high level of patient satisfaction.

15. Act as mentor/coach to enhance the performance and capability of staff through formal and informal interactions, provide constructive feedback to staff, supporting them to develop enhanced skills and ability.

16. Ensure that all decontamination requirements are met and adhered to in all Trust services under your span of control.

17. Develop appropriate mechanisms for accessing the views and facilitating the involvement of service users and carers in the development and delivery of services

Quality/Governance

1. Take personal responsibility for individual professional growth, development & revalidation. Maintaining clinical competence and credibility within nursing practice

2. Support the Head of Service in the effective and efficient management of clinical services.

3. Work to foster and develop an environment where nurses are valued and in adherence with the NMC Code of Professional Conduct: Standards for Conduct, Performance and Ethics. Ensure effective record keeping and documentation in line with NMC Guidelines.

4. Ensure systems are in place that ensures that staff keeps up to date with current developments regarding patient care.

5. Ensure staff maintain confidentiality at all times, including the storage of records and the transfer of verbal and written information.

6. Ensure effective communication systems are in place to support programmes of care and, or care pathways.

7. Assist the Head of Service in the effective implementation of ;
   (I) robust induction and development review/ appraisal programmes
   (II) clinical supervision framework
   (III) preceptorship programmes for newly appointed nursing staff.

8. Establish and maintain clear systems and processes for accountability for staff.

9. Monitor and support the use of appropriate clinical governance policies, guidelines, and protocols for staff, reviewing and monitoring compliance, specifically to support the Trust's policy and procedures for dealing with complaints, clinical incidents and serious adverse incidents

10. Assist the Head of Service with co-ordinating the response to complaints prior to submission through line management structures.

11. Review nursing issues arising from complaints about services provided ensuring that appropriate action is taken; lessons are learnt and reflected in practice.

12. Work with the infection control team and clinical colleagues, monitor infection control rates and take forward those actions and changes necessary to prevent and minimise hospital acquired infections

13. Ensure systems are in place for the procurement, safe use. Storage, maintenance, decontamination and disposal of medical devices and other equipment.

14. Support the Head of Service to ensure that the service complies with the requisite controls assurance standards with particular reference to decontamination, medicines management, environmental cleanliness, infection control and management of medical devices.

15. Ensure control robust systems are in place to assure the Executive Director of Nursing that all nurses have current registration with NMC

16. Ensure that all recommendations arising from RQIA inspections are acted upon and implemented in a timely manner.

Leadership & Setting Direction

1. Provide highly accessible, approachable and visible professional nursing leadership and operational management support to Ward Sisters/Charge Nurses, ensuring clinical services develop in line with evidence based practice.

2. Act as a role model inspiring and empowering nurses to implement new ways of working

3. Ensure efficient and appropriate professional development and succession planning are in place for nursing staff.

4. Support the Head of Service in the development of the directorate policies and to contribute to the development of Trust policies where appropriate.

5. Support the Head of Service in the review, development, implementation and delivery of services, ensuring integration with corporate and service group strategies and service delivery priorities.

6. Support the Head of Service in the development of strategic and operational plans for the delivery of services, in line with regional strategies, Ministerial and HSSA priorities.

7. Assist the Head of Service with service development proposals and business cases as related to nursing.

8. Deputise for the Head of Service

Development and Innovation

1. Promote and facilitate the implementation of the Trusts Personal Performance and Development Review.

2. Support the management structures and practices to ensure a culture of effective team working, continuous improvement and innovation

3. Lead the annual training needs analysis for nurses in all relevant Specialities.

4. Participate in the recruitment and appointment of staff in accordance with Trust policy.

5. Actively promote new ways of working and models of service delivery to improve services for patients.

   In conjunction with the Head of Service, promote innovation and change to underpin the modernisation of services with a view to re-profiling across the Trust where necessary

Strategic Planning and Development

1. Support the Service with the development of the strategic plan for the delivery of facilities within the Acute Services Directorate on behalf of Director of Acute Services, in line with regional strategies, Ministerial and HSCA priorities.

2. Contribute to the strategic direction of the Trust and to the achievement of corporate objectives as appropriate.

3. Work with members of relevant teams on the innovative development of new and existing services.

4. Challenge the status quo in the planning and delivery of all relevant clinical services.

Financial and Resource Management

1. Deliver all services within remit of responsibility within financial balance and identify to the Head of Service where conflicts arise

2. In conjunction with the Head of Service critically assess workforce, skill mix and explore options to create new roles within financial constraints.

3. In conjunction with the Head of Service monitor the use of bank and agency staff and ensure that the Trust policies for bank and agency use are implemented

4. Assist the Head of Service to ensure systems are in place for procurement, maintenance and replacement of all medical devices
   a. .
5. Assist in the management of services and budget and ensure financial targets are met.
6. .
7. Assist with identification of cash releasing schemes and meet financial savings as outlined by Director of Acute Services.

People Management

1. Provide clear and strategic leadership to staff and ensure a highly skilled, flexible and motivated workforce to provide high quality patient care.

2. Support the Head of Service in the development and implementation of workforce modernisation initiatives within clinical services.

3. Ensure compliance with employment legislation, HSS directives and Trust standing orders, policies, procedures and regulations by introducing appropriate systems when required.

4. Encourage a culture that allows staff to maximise their potential, ensuring that they are able to contribute to the Trust Corporate strategy.

5. Ensure full engagement of all professional staff working in areas of responsibility.

6. Ensure staff are led and managed within agreed Policies and procedures.

7. Manage staff performance and action accordingly.

8. Ensure the Trust's sickness absence policy is implemented within the services and establish an effective mechanism for regularly monitoring levels of sickness and absence, taking corrective action where necessary.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

1. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.

2. Maintain staff relationships and morale amongst the staff reporting to him/her.

3. Review the organisation plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives, and recommend change where appropriate.

4. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

5. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

6. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

Corporate Management

1. Contribute to the Trust's corporate planning, policy and decision making processes and ensure the Acute Services Directorate objectives and decisions are effectively communicated.

2. Establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Directorate effectively discharges its functions.

3. Contribute to the Trust's overall corporate governance processes to ensure the development of an integrated governance framework for the Trust that assures safe and effective care for patients and clients and complies with public sector values, codes of conduct, operations and accountability.

4. Lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

3. Adhere at all times to all Trust policies/codes of conduct, including for example:
   - Smoke Free policy
   - IT Security Policy and Code of Conduct
   - standards of attendance, appearance and behaviour

4. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

5. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

6. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

7. Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the Band may be assigned from time to time.
It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

Southern Health and Social Care Trust

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PERSONNEL SPECIFICATION

JOB TITLE AND BAND Lead Nurse for Medicine & Unscheduled Care for & Renal Service DHH

DEPARTMENT / DIRECTORATE **ACUTE**

HOURS 37.5 per week

Ref No: <to be inserted by HR> **<Month & Year>**

Notes to applicants:

1. *You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *Shortlisting will be carried out on the basis of the essential criteria set out in Section 1 below, using the information provided by you on your application form. Please note the Trust reserves the right to use any desirable criteria outlined in Section 3 at shortlisting. You must clearly demonstrate on your application form how you meet the desirable criteria.*
3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.*

ESSENTIAL CRITERIA

SECTION 1: The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.

Factor	Criteria	Method of Assessment
Experience	1. Have a minimum of 2 years' experience in staff management 2. Have a minimum of 1 years' experience in a lead role delivering objectives that have led to a significant[2] Improvement	Shortlisting by Application Form

	in Service. 3. Have a minimum of 1 years' experience working with a diverse range of internal and external stakeholders in a role which has contributed to the successful implementation of a significant change in initiative.	
Qualifications/ Registration	1. Currently a Registered Nurse Level 1, (Adult) on the Live NMC Register 2. Hold a university degree or equivalent and worked for at least 2 years in a Senior role[1] **OR** Have worked for at least 5 years in a senior role[1]	Shortlisting by Application Form
Other	Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. *This criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post.*	Shortlisting by Application Form
SECTION 2: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage:		
Skills / Abilities	1. Have an ability to effectively manage a delegated budget to maximise utilisation of available resources. 2. Have an ability to provide effective leadership 3. Demonstrate evidence of highly effective planning and organisational skills 4. Demonstrate a commitment to the provision of high quality and sage services with an ability to drive a culture of continuous improvement 5. Demonstrate a commitment to the provision of high quality safe services with an ability to drive a culture of continuous improvement.	Interview / Test

[1] "senior role" is defined as experience gained at Band 7 or above
[2] Significant' is defined as contributing directly to key Directorate objectives
[3] This criterion will be waived in the case of a suitable applicant who has a disability which prohibits from driving but who is able to organize suitable alternative arrangements in order to meet the requirements of the post in full.

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified.

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this leadership role. The competencies concerned are given in the NHS Leadership Qualities Framework, details of which can be accessed at nhsleadershipqualities.nhs.uk.

Particular attention will be given to the following:

- Self Belief
- Self Management
- Drive for results
- Leading change through people
- Holding to account
- Effective and Strategic Influencing
- Collaborative working

As part of the Recruitment & Selection process it may be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.
Successful applicants may be required to attend for a Health Assessment

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HSC Value	What does this mean?	What does this look like in practice? - Behaviours
Working Together	We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.	• I work with others and value everyone's contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible
Compassion	We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.	• I am sensitive to the different needs and feelings of others and treat people with kindness • I learn from others by listening carefully to them • I look after my own health and well-being so that I can care for and support others
Excellence	We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high-quality, compassionate care and support.	• I put the people I care for and support at the centre of all I do to make a difference • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking 'could we do this better?'
Openness & Honesty	We are open and honest with each other and act with integrity and candour.	• I am open and honest in order to develop trusting relationships • I ask someone for help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice

All staff are expected to display the HSC Values at all times

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Appendix Question 7

McVey, Anne

From: Hynds, Siobhan [redacted]
Sent: 02 February 2017 16:24
To: Gibson, Simon
Cc: McVey, Anne; Toal, Vivienne; Gishkori, Esther; Wright, Richard; Weir, Colin; Khan, Ahmed
Subject: Action note 26th January AOB draft SH comments
Attachments: Action note 26th January AOB draft.docx

Simon,

I have tracked some minor changes to the notes for your consideration. I have changed the terminology to reflect the MHPS framework.

Regards,

Siobhan

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources & Organisational Development Directorate
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ

Tel: [redacted] Direct Line: [redacted]
Mobile: [redacted] Fax: [redacted]

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Southern Health & Social Care Trust

~~Oversight Committee~~Case Conference
26th January 2017

Present:
~~Dr Richard Wright, Medical Director~~ Vivienne Toal, Director of HROD,
(Chair)
Dr Richard Wright, Medical Director
~~Vivienne Toal, Director of HROD~~
Anne McVey, Assistant Director of Acute Services (on behalf of Esther Gishkori)

2017.02.02
Q7.78.2

Apologies
Esther Gishkori, Director of Acute Services

In attendance:
Dr Ahmed Khan, Case Manager
Simon Gibson, Assistant Director, Medical Director's Office
Colin Weir, Case Investigator
Siobhan Hynds, ~~Employee Relations Manager~~Head of Employee Relations

Dr A O'Brien

Context
Vivienne Toal outlined the purpose of the meeting, which was to consider the preliminary investigation into issues identified with Mr O'Brien and obtain agreement on next steps following his period of immediate exclusion, which concludes on 27th January.

Preliminary investigation
As Case Investigator, Colin Weir summarised the investigation to date, including updating the Case Manager and Oversight Committee on the meeting held with Mr O'Brien on 24th January, and comments made by Mr O'Brien in relation to issues raised.

Firstly, it was noted that 783 GP referrals had not been triaged by Mr O'Brien in line with the agreed / known process for such referrals. This backlog was currently being triaged by the Urology team, and was anticipated to be completed by the end of January. There would appear to be a number of patients who have had their referral upgraded. Mr Weir reported that a~~A~~t the meeting on 24th January, Mr O'Brien stated that as Urologist of the Week he didn't have the time to undertake triage as the workload was too heavy to undertake this duty in combination with other duties.

Secondly, it was noted that there were 668 patients who have no outcomes formally dictated from Mr O'Brien's outpatient clinics over a period of at least 18 months. A review of this backlog is still on-going. Mr Weir reported that ~~In relation to the lack of dictated letters following outpatient consultations, it was not felt there was not a satisfactory explanation provided.~~ Mr O'Brien indicated that he often waited until the full outcome of the patient's whole outpatient journey to communicate to GPs. ~~In relation to the lack of dictated letters following outpatient consultations,~~ Mr Weir noted this was not ~~it was not felt there was not~~ a satisfactory explanation. ~~provided.~~ Members of the Case Conference agreed, ~~It was agreed~~ that this would not be in line with GMCs guidance on Good Medical Practice, which highlighted the need for timely communication and contemporaneous note keeping.

Thirdly, there were 307 sets of patients notes returned from Mr O'Briens home, and 13 sets of notes tracked out to Mr O'Brien were still missing. Mr Weir reported that the 13 sets of notes have been documented to Mr O'Brien for comment on the whereabouts of the notes. Mr Weir reported that Mr O'Brien was sure that he no longer had these notes; all patients had been discharged from his care, therefore he felt he had no reason to keep these notes. Mr Weir felt that there was a potential of failure to record when notes were being tracked back into health records, although it was noted that an extensive search of the health records library had failed to locate these 13 charts. Members of the Case Conference agreed further searches were required taking into consideration Mr O'Brien's comments.

Historical attempts to address issues of concern.

It was noted that Mr O'Brien had been written to on 23rd March 2016 in relation to these issues, but that no written response had been received. There had been a subsequent meeting with the AMD for Surgery and Head of Service for Urology to address this issue. Mr Weir noted that Mr O'Brien had advised that a~~A~~t this meeting, Mr O'Brien asked Mr Mackle what actions he wanted him to undertake. Mr O'Brien stated Mr Mackle made no comment and rolled his eyes, and no action was proposed.

It was noted that Mr O'Brien had successfully revalidated in May 2014, and that he had also completed satisfactory annual appraisals. Dr Khan reflected a concern that the appraisal process did not address concerns which were clearly known to the organisation. It was agreed that there may be merit in considering his last appraisal.

Discussion

In terms of advocacy, in his role as Clinical Director, Mr Weir reflected that he felt that Mr O'Brien was a good, precise and caring surgeon.

At the meeting on 24th January, Mr O'Brien expressed a strong desire to return to work. Mr O'Brien accepted that he had let a number of his administrative processes drift, but gave an assurance that this would not happen again if he returned to work. Mr O'Brien gave an assurance to the Investigating Team that he would be open to monitoring of his activities, he would not impede or hinder any investigation and he would willingly work within any framework established by the Trust.
Dr Khan asked whether there was any historical health issues in relation to Mr O'Brien, or any significant changes in his job role that made him unable to perform the full duties of Urologist of the Week. There was none identified, but it was felt that it would be useful to consider this.

Decision
As Case Manager, Dr Khan considered whether there was a case to answer following the preliminary investigation. It was felt that based upon the evidence presented, there was a case to answer, as there was significant deviation from GMC Good Medical Practice, the agreed processes within the Trust and the working practices of his peers.

This decision was agreed by the ~~3~~ members of the ~~Oversight~~ Case Conference~~Committee~~, and therefore a formal investigation would now commence, with formal Terms of Reference now required.
Action: Mr Weir

Formal investigation
There was a discussion in relation to whether formal exclusion was appropriate during the formal investigation, in the context of:

- Protecting patients
- Protecting the integrity of the investigation
- Protecting Mr O'Brien

Mr Weir reflected that there had been no concerns identified in relation to the clinical practice of Mr O'Brien.

The ~~Oversight Committee~~members discussed whether Mr O'Brien could be brought back with either restrictive duties or robust monitoring arrangements which could provide satisfactory safeguards. Mr Weir outlined ~~s view was~~ that he was of the view that Mr O'Brien could come back and be closely monitored, with supporting mechanisms, doing the

full range of duties. The members ~~Oversight Committee~~ considered what would this monitoring would look like, to ensure the protection of the patient.

The case conference members ~~Oversight Committee~~ noted the detail of what this monitoring would look like was not available for the meeting, but this would be needed. It was agreed that the operational team would provide this detail to the case investigator, case manager and members of the Oversight Committee.

Action: Esther Gishkori / Ronan Carroll

It was agreed that, should the monitoring processes identify any further concerns, then an ~~the~~ Oversight Committee would be ~~re~~convened to consider formal exclusion.
It was noted that Mr O'Brien had identified workload pressures as one of the reasons he had not completed all administrative duties - there was consideration about whether there was a process for him highlighting unsustainable workload. It was agreed that an urgent review of Mr O'Brien's job plan was required.
Action: Mr Weir

It was agreed by the ~~Oversight Committee~~case conference members that any review would need to ensure that there was comparable workload activity within job plan sessions between Mr O'Brien and his peers.
Action: Esther Gishkori/Ronan Carroll

Following consideration of the discussions summarised above, as Case Manager Dr Khan decided that Mr O'Brien should be allowed to return to work.

This decision was agreed by ~~the 3 members of the Oversight Committee~~the Medical Director, Director of HR and deputy for Director of Acute Services.

It was agreed that Dr Khan would inform Mr O'Brien of this decision by telephone, and follow this up with a meeting next week to discuss the conditions of his return to work, which would be:

- Strict compliance with Trust procedures and policies in relation to:
    - Triaging of referrals
    - Contemporaneous note keeping
    - Storage of medical records
    - Private practice
- Agreement to read and comply with GMCs "Good Medical Practice" (April 2013)
- Agreement to an urgent job plan review
- Agreement to comply with any monitoring mechanisms put in place to assess his administrative processes

Action: Dr Khan

It was noted that Mr O'Brien was still off Personal Information redacted, and that an Occupational Health appointment was scheduled for 9th February, following which an occupational health report would be provided. This may affect the timetable of Dr O'Brien's return to work.

It was agreed to update NCAS in relation to this case.
Action: Dr Wright

Appendix Question 11

Department of
Health, Social Services
and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

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INTEGRATED ELECTIVE ACCESS PROTOCOL
30th April 2008

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CONTENTS

ABBREVIATIONS

AHP	Allied Health Professional
BCC	Booking and Contact Centre (ICATS)
CNA	Could Not Attend (Admission or Appointment)
DHSSPSNI	Department of Health, Social Services and Public Safety
DNA	Did Not Attend (Admission or Appointment)
DTLs	Diagnostic Targeting Lists
ERMS	Electronic Referrals Management System
GP	General Practitioner
HIC	High Impact Changes
HROs	Hospital Registration Offices
ICATS	Integrated Clinical Assessment and Treatment Services
ICU	Intensive Care Unit
LOS	Length of Stay
PAS	Patient Administration System
PTLs	Primary Targeting Lists
SDU	Service Delivery Unit
TCI	To Come In (date for patients)

SECTION 1

CONTEXT

1.1 INTRODUCTION

1.1.1 This protocol has been developed to encompass the elective pathway within a hospital environment. The principles can be applied to primary and community settings, however it is recommended that guidance is developed which recognises the specific needs of the care pathway provided in these settings.

1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations and elective inpatient or day case treatment is the responsibility of a number of key individuals within the organisation. General Practitioners, commissioners, hospital medical staff, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time guarantees, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communications with patients is a core responsibility of the hospital and the wider local health community.

1.1.3 The purpose of this protocol is to define those roles and responsibilities, to document how data should be collected, recorded and reported, and to establish a number of good practice guidelines to assist staff with the effective management of outpatient, diagnostic and inpatient waiting lists. It will be a step-by-step guide to staff, and act as a reference work, for the successful management of patients waiting for hospital treatment.

1.1.4 This protocol will be updated, as a minimum, on an annual basis to ensure that Trusts' polices and procedures remain up to date, and reflect best practice locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.

1.1.5 This protocol will be available to all staff via Trusts' Intranet.

1.1.6 The DHSSPSNI has set out a series of challenging targets for Trusts in Northern Ireland in the field of elective treatment management. Trusts will recognise the need to move the treatment agenda forward in the context of its shared responsibility for the delivery of these goals.

1.1.7 There is an imperative to identify capacity constraints that could threaten the delivery of these key access targets and speed up the planning and delivery of extra capacity, where it is needed, to address these constraints. The health community will need to develop a co-ordinated approach to capacity planning taking into account local capacity on a cross Trust basis and independent sector capacity on an on-going partnership basis.

1.1.8 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.

1.1.9 The intention is that this protocol will be further developed to consider all aspects of access to a range of quality healthcare at a date and time of the patients' choice.

1.1.10 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.

1.1.11 Delivery of this protocol will require a step change in the way Trusts function. Trusts will need to transform themselves and this can only be achieved through a change in the way its staff approach their work on a day-to-day basis. Through this protocol, Trusts will aspire to work with patients and staff to raise expectations basing them not on where we are but on where we need to be.

1.1.12 For the purposes of this protocol, the term inpatient refers to inpatient and day case elective treatment. The term 'PAS' refers to all patient

administration systems, whether in a hospital or community setting, or an electronic or manual system.

1.1.13 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on PAS and the waiting times for treatment. All staff involved in the implementation of this protocol, clinical and clerical, will undertake initial training and regular annual updating. Trusts will provide appropriate information to staff so they can make informed decisions when implementing and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.

1.2 UNDERPINNING PRINCIPLES

1.2.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined specifically by specialty / procedure / service.

1.2.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.

1.2.3 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient - they are fit, ready, and able to come in.

1.2.4 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures, not the norm. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving day case surgery to outpatient care, and outpatient care to primary care or alternative clinical models where appropriate.

1.2.5 Change No 1 within the publication "10 High Impact Changes for Service Improvement and Delivery"[1] focuses on day surgery and the document provides Trusts with tools and resources to help implement this high impact change.

1.2.6 Trusts will introduce booking systems aimed at making hospital appointments more convenient for patients. Booking systems are chronologically based and will move Trusts onto a system of management and monitoring that is chronologically as opposed to statistically based.

1.2.7 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority with immediate effect. The intention is to provide patients with certainty and choice enabling them to access services that are sensitive to their needs.

1.2.8 This will require changes in working practices. It will also require technological change to information systems to enable provision of quality information to support the booking process.

1.2.9 There is a need to balance the flow of patients from primary care through outpatients and on to booking schedules should they need elective admission. It follows that the level of activity in the Service and Budget Agreements and the level of provision of outpatient and inpatient capacity must be linked. If one changes, all should change.

1.2.10 This "bottom up" approach is based on the belief that services need to be built on firm clinical foundations. Trusts need a clinical vision built up specialty by specialty and department by department through debate and agreement between clinicians across the health community as to the best way to meet patient needs locally.

1.2.11 It is essential that patients who are considered vulnerable for whatever reason have their needs identified at the point of referral.

[1] "10 High Impact Changes for Service Improvement and Delivery" – September 2004, NHS Modernisation Agency, www.modern.nhs.uk/highimpactchanges

1.2.12 All relevant information must be recorded to ensure that when selecting a vulnerable patient for admission, their needs are identified early and appropriate arrangements made. This information should be recorded in detail in the episodic comment field of PAS relating to the listing. The patient master index comment field should not be used due to confidentiality issues.

1.2.13 Communication with this patient group will recognise their needs and, where appropriate, involve other agencies.

1.2.14 An operational process should be developed by Trusts to ensure that children and vulnerable adults who DNA or CNA their outpatient appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

1.2.15 In implementing this protocol the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.3 OWNERSHIP

1.3.1 Ownership is key to delivering quality of care. Trusts must ensure that all staff are conversant with the Departmental targets and standards and are comfortable with the local health communities' approach to their delivery.

1.3.2 These targets and standards must be seen to be core to the delivery of all aspects of care provision by all levels of staff within the Trust.

1.3.3 This is a major change agenda requiring significant commitment and investment at corporate and individual level. An Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to.

1.3.4 Trusts must be committed to training and developing staff and providing the supporting systems to ensure that together we can bring about the improvement in patient care.

1.4 REGIONAL TARGETS

1.4.1 The targets in respect of elective treatments are:

- A maximum waiting time of 13 weeks for inpatient and daycase admissions by March 2009
- A maximum waiting time of 9 weeks for a 1st outpatient appointment by March 2009
- A maximum waiting time of 9 weeks for a diagnostic test by March 2009
- A maximum waiting time of 13 weeks from referral to treatment by an Allied Health Professional (AHP) by March 2009
- By March 2009, sustain the target where 98% of patients diagnosed with cancer should begin treatment within a maximum of 31 days of the diagnosis
- By March 2009, 95% of patients with suspected cancer who have been referred urgently should begin their first definitive treatment within a maximum of 62 days

1.5 DELIVERY OF TARGETS

1.5.1 The waiting time targets are based on the "worst case" i.e. they reflect the minimum standards with which every Trust must comply.

1.5.2 The expectation is that these targets are factored into plans at Trust Board, divisional, specialty and departmental levels as part of the normal business

and strategic planning processes. Divisional, specialty and departmental managers will be expected to have produced implementation plans setting out the key steps they need to take to ensure the delivery of the Trust and Departmental protocol objectives within the area(s) of their responsibility. Trusts will manage implementation through a regular review of "local" divisional, specialty and departmental plans for the implementation of waiting and booking targets.

1.5.3 It is expected that Trusts will develop robust information systems to support the delivery of these targets. Daily management information should be available at both managerial and operational level so that staff responsible for selecting patients are working from up to date and accurate information. Future developments should also look towards a clinic management system which will highlight the inefficiencies within the outpatient setting.

1.6 CAPACITY

1.6.1 It is important for Trusts to understand their baseline capacity, the make-up of the current cohort of patients waiting and the likely changes in demand that will impact on their ability to treat patients and meet the Departmental Targets.

1.6.2 To manage at specialty and departmental level it is anticipated that managers will have, as a minimum, an overview of their core capacity including:

- Number of clinic and theatre sessions
- Session length
- Average procedure / slot time
- Average length of stay

1.6.3 It is expected that similar information will be available at consultant level. For inpatients this is at procedure level, and for outpatients and diagnostics at service level.

1.6.4 This information will enable Trusts to evaluate its waiting/booked lists in terms of theatre sessions (time in hours) and length of stay (time in bed days).

1.6.5 Each specialty should understand its elective bed requirements in terms of both inpatients and daycases, setting challenging daycase and LOS targets and agreeing plans to deliver them. In addition, systems must be developed to ensure assessment can be made of available capacity and flexible working arrangements developed accordingly.

1.6.6 Theatre sessions should be seen as corporate resources and used flexibly to ensure the delivery of waiting list and waiting time targets across consultants within the same specialty and specialties within the same Trust. This ties in with the Real Capacity Paper which also requires commissioners to demonstrate that they have used capacity flexibly across Trusts. The expectation is that divisions and/ or specialties will be able to demonstrate that they have optimised the use of existing capacity to maximise the treatment of patients within existing resources.

1.6.7 Trusts will treat patients on an equitable basis across specialties and managers will work together to ensure consistent waiting times for patients of the same clinical priority.

1.6.8 Trusts will set out to resource enough capacity to treat the number and anticipated casemix of patients agreed with commissioners. The Real Capacity Planning exercise will support this process locally.

1.6.9 Divisions/specialties will monitor referrals and additions to lists in terms of their impact on clinic, theatre time, bed requirements and other key resources e.g. ICU facilities, to ensure a balance of patients in the system and a balance between patients and resources.

1.6.10 When the balance in the system is disturbed to the extent that capacity is a constraint, divisional/specialty managers will be expected to produce plans

to expedite solutions and agree these through the accountability review process.

1.6.11 It is important for all services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.

1.6.12 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.

1.6.13 In summary, the intention is to link capacity to the Service and Budget Agreement i.e. to agree the plan, put in place the resources to achieve the plan, monitor the delivery of the plan and take corrective action in the event of divergence from the plan proactively. The existing arrangements whereby patients are added to waiting lists irrespective of whether Trusts have the capacity to treat them must change.

1.7 BOOKING PRINCIPLES

1.7.1 These booking principles have been developed to support all areas across the elective pathway where appointment systems are used.

1.7.2 Offering the patient choice of date and time is essential in agreeing and booking appointments with patients. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them. This takes away the uncertainty of not knowing how long the wait will be as patients are advised of their expected wait. Advanced booking in this way also gives patients notice of the date so that they can make any necessary arrangements, such as child care or work arrangements.

1.7.3 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place.

1.7.4 Booking development work within Trusts should be consistent with regional and local targets, which provide a framework for progress towards ensuring successful and consistent booking processes across the health community in Northern Ireland.

1.7.5 All booking processes should be underpinned with the relevant local policies and procedures to provide clarity to operational staff of the day to day requirements and escalation route, for example: management of patients who cancel / DNA their appointment, process for re-booking patients, and monitoring of clinical leave and absence.

1.7.6 Trusts should ensure booking processes are continually reviewed and updated as required to reflect local and regional requirements at an operational level.

1.7.7 The definition of a booked appointment is:

a) The patient is given the choice of when to attend.
b) The patient is advised of the total waiting time during the consultation between themselves and the healthcare provider / practitioner or in correspondence from them.
c) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment
d) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within 2 weeks if cancer is suspected.
e) The patient may choose to agree a date outside the range of dates offered or defer their decision until later

1.7.8 Booking Process

1.7.9 There are 3 main patient appointment types to be booked. Booking systems for these appointments should be designed around an agreed patient pathway and accepted clinical practice. They are:

a) New Urgent patients (including suspected cancer)
b) New Routine patients
c) Review patients

1.7.10 Clinic templates should be constructed to ensure that sufficient capacity is carved out to meet the local and maximum waiting time guarantees for new patients, and the clinical requirements of follow-up patients.

1.7.11 Principles for booking Cancer Pathway patients

a) All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral
b) Dedicated registration functions for red flag and suspected cancer referrals should be in place within centralised HROs
c) Clinical teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients
d) Patients will be contacted by telephone twice (morning and afternoon)
e) If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum of 3 days of receipt of referral
f) Systems should be established to ensure the Patient Tracker / MDT Co-ordinator is notified of the suspected cancer patient referral, to allow them to commence prospective tracking of the patient

1.7.12 Principles for booking Urgent Pathway patients

a) Local agreements should be in place with consultants to determine the timeframe within which urgent patients should be booked, and made explicit to booking teams

b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation
c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP's classification of urgency
d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.
e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.7.13 Principles for booking Routine Pathway patients

a) Patients should be booked to ensure appointment within the maximum waiting time guarantees for routine appointments
b) Referrals will be received, registered within one working day at HRO's and forwarded to consultants for prioritisation
c) Patients will receive an acknowledgement from the Trust indicating their expected length of wait and information on the booking process they will follow
d) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified
e) Patients should be selected for booking in chronological order from the PTL
f) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment

1.7.14 Principles for Booking Review Patients

a) Patients who need to be reviewed within 6 weeks will agree their appointment before they leave the clinic

b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list
c) Patients will be added to the review waiting list with an indicative date of treatment and selected for booking according to this date
d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment

1.7.15 It is recognised that some groups of patients may require booking processes that have additional steps in the pathway. These should be designed around the principles outlined to ensure choice and certainty as well as reflecting the individual requirements necessary to support their particular patient journey. Examples of this include:

a) midwives contacting patients directly by telephone to arrange their appointment
b) clinical genetics services where family appointments are required
c) mental health or vulnerable children's services where patients may need additional reminders or more than one professional contacted if patients fail to make an appointment.

SECTION 2

GUIDANCE FOR MANAGEMENT OF ICATS SERVICES

2.1 INTRODUCTION

2.1.1 The administration and management of ICATS referrals and ICATS requests for diagnostics must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

2.1.2 ICATS services are managed in accordance with the Data Definitions and Guidance Document for Monitoring of ICATS Services Sept 2007 (**Appendix 1**).

2.1.3 The level of functionality available on the Electronic Referral Management System to support the administration of patients in an ICATS setting is developmental. Achievement of the standards outlined will be where functionality permits.

2.1.4 Referrals will be managed through a centralised registration process in the nominated Hospital Registration Offices (HRO's) within Trusts to receive, register and process all ICATS referrals. The Trust should ensure that a robust process is in place to ensure that referrals received outside the HRO are date stamped, forwarded to the HRO and registered onto ERMS according to the date received by the Trust.

2.1.5 All new patients should be able to book their appointment in line with the guidance outlined in Booking Principles Section 1.7 The expectation is that follow up patients should also be offered an opportunity to choose the date and time of their appointment.

2.2 KEY PRINCIPLES

2.2.1 Where ICATS is in place for a specialty, all referrals should be registered and scanned onto Electronic Referral Management System (ERMS) within 24 hours of receipt.

2.2.2 Each ICATS must have a triage rota to ensure that every referral is triaged and the appropriate next step is confirmed, according to the clinically agreed

rules, within three working days of receipt in any Hospital Registration Office (HRO). Triage rotas must take multi-site working into account. A designated officer in ICATS should oversee the triage arrangements.

2.2.3 The outcome of the triage will be confirmed by letters to the GP and patient within a further two working days of triage (five working days in total from receipt).

2.2.4 ICATS clinical staff will be aware of all exclusions that prevent patients from being assessed or treated within the ICATS setting.

2.2.5 Patients of equal clinical priority will be selected for booking in chronological order in order to meet the maximum waiting time guarantee for patients and local access standards.

2.2.6 All patients deemed appropriate will be offered an ICATS appointment within six weeks from the triage date.

2.2.7 Data collection should be accurate, timely, complete and subject to regular audit and validation.

2.2.8 Staff should be supported by appropriate training programmes.

2.3 CALCULATION OF THE WAITING TIME

2.3.1 The waiting time clock for ICATS starts after the triage decision has been taken that an appointment in ICATS clinic is the appropriate next step.

2.3.2 The ICATS clock stops when the patient attends for first appointment or when the patient has been discharged from ICATS.

2.3.3 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the

verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

2.3.4 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

2.3.4 No patient should have his or her appointment cancelled. If the ICATS service cancels a patient's appointment, the patient's waiting time clock will not be reset and the patient should be offered another appointment, ideally at the time of the cancellation, and which is within six weeks of the original appointment date.

2.4 NEW REFERRALS

2.4.1 All ICATS referrals will be registered and scanned onto ERMS within 24 hours of receipt. All referrals forwarded for ICATS triage must be triaged or assessed to make a clear decision on the next step of a referral within three working days of the referral being logged by the HRO onto ERMS.

2.4.2 Within five working days of the referral being recorded onto ERMS, the GP and patient must be issued with written confirmation of the next stage of the patient's treatment.

2.4.3 Where there is insufficient information for the professional to make a decision, they have the option to either return the referral to the referrer requesting the necessary information or contact the referrer in the first instance to access the necessary information. If this cannot be gained, the referral should be returned to the referrer requesting the necessary information and a new referral may be initiated.

2.4.4 Those patients identified for outpatients and diagnostic services following triage will be managed in line with the relevant sections of this IEAP.

Flowcharts illustrating the Triage Outcomes Process can be found in **Appendix 2.**

2.5 BOOKING

2.5.1 All patients requiring an appointment in an ICATS will have the opportunity to agree the date and time of their appointment, in line with the booking principles outlined in Section 1.7.

2.5.2 If a patient requests an appointment beyond the six week ICATS standard the patient will be discharged and told to revisit their GP when they are ready to be seen at the ICATS clinic. This will ensure that all patients waiting for an ICATS appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate recalculation of the patient's waiting time and to facilitate booking the patient into the date they requested.

2.5.3 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

2.6 REASONABLE OFFERS

2.6.1 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the second appointment date declined.

2.6.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

2.6.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date the service was notified of the cancellation, as the patient has entered into an agreement with the Trust.

2.6.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3.**

2.7 MANAGEMENT OF PATIENTS WHO CANCELLED OR DID NOT ATTEND (DNA) THEIR APPOINTMENT

2.7.1 If a patient DNAs their first ICATS appointment the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

2.7.2 If a patient cancels their outpatient appointment the following process must be implemented:

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.

- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

2.7.3 If a patient has been referred back to their referring clinician and the referrer still wishes a patient to be seen in ICATS, a new referral is required.

2.7.4 The Implementation Procedure for the Management of Patients who DNA or Cancel can be found in **Appendix 4.**

2.8 MAXIMUM WAITING TIME GUARANTEE

2.8.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their GP when they are ready to be seen. This will ensure that all patients waiting for an appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

2.9 COMPLIANCE WITH TRUST LEAVE PROTOCOL

2.9.1 It is essential that leave/absence of ICATS practitioners is organised in line with Trusts' notification of leave protocol. It is also necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of ICATS clinics.

2.9.2 The protocol should require a minimum of six weeks' notification of intended leave. A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

2.10 CLINIC OUTCOME MANAGEMENT

2.10.1 There are a number of locations within Trusts where patients present for their ICATS consultation. This protocol applies to all ICATS locations. It is the responsibility of the ERMS user managing the attendance to maintain data quality.

2.10.2 Changes in the patient's details must be updated on ERMS and the medical records on the date of clinic.

2.10.3 When the assessment has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on ERMS.

2.11 REVIEW APPOINTMENTS

2.11.1 All review appointments must be made within the time frame specified by the ICATS practitioner. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the ICATS practitioner.

2.11.2 As previously stated, the Booking Centres will be responsible for partially booking all new appointments. Booking Centres will also book review appointments that are required to be more than 6 weeks in the future. ICATS administration staff will make bookings directly with the patient at the clinic for any further appointments needing to occur within 6 weeks.

2.12 TEMPLATE CHANGES

2.12.1 Templates should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

2.12.2 Templates will identify the number of slots available for new and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated to each appointment slot.

2.12.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for clinic template changes.

2.12.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for management of Clinic Template Changes can be found in **Appendix 5.**

2.13 VALIDATION

2.13.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. Trusts should ensure that all relevant data fields are completed in ERMS. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce.

2.13.2 The data validation process will apply to both new and follow up appointments. The Implementation Procedure for data validation can be found in **Appendix 6.**

SECTION 3

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

3.1 INTRODUCTION

3.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of outpatient services.

3.1.2 The administration and management of the outpatient pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

3.1.3 There will be dedicated Hospital Registration Offices (HROs) within Trusts to receive, register and process all outpatient referrals. The HROs will be required to register and scan referrals (where appropriate) onto the Electronic Referrals Management System (ERMS) and PAS.

3.1.4 There will be dedicated booking functions within Trusts and all new and review outpatients should have the opportunity to book their appointment. The booking process for non-routine groups of outpatients or those with additional service needs should be designed to identify and incorporate the specific pathway requirements of these patients.

3.2 CALCULATION OF THE WAITING TIME

3.2.1 The starting point for the waiting time of an outpatient new referral is the date the clinician's referral letter is received by Trusts. All referral letters, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received into the organisation.

3.2.2 In cases where referrals bypass the dedicated HRO's, (e.g. sent directly to a consultant), the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the HRO and registered at the date on the date stamp.

3.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who

refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

3.2.3 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

3.3 KEY PRINCIPLES

3.3.1 Referrals into Trusts should be pooled where possible within specialties. Referrals to a specific consultant by a GP should only be accepted where there are specific clinical requirements or stated patient preference. As a minimum, all un-named referrals should be pooled.

3.3.2 All referrals, appointments and waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list, allocated according to urgency of the treatment. Trusts will manage patients in 2 streams, i.e. urgent and routine. Templates should be constructed to ensure enough capacity is available to treat each stream within agreed maximum waiting time guarantees. The Implementation Procedure for Template Redesign can be found in **Appendix 7.**

3.3.3 The regional target for a maximum OP waiting time is outlined in Section 1.4. Maximum waiting times for urgent patients should be agreed locally with clinicians.

3.3.4 Maximum waiting times for urgent patients should be agreed locally with clinicians, and made explicit to staff booking these patients to ensure that they are appointed within the clinical timeframe indicated by the consultant and capacity issues quickly identified and escalated.

3.3.5 Patients of equal clinical priority will be selected for booking in strict chronological order. Trusts must ensure that Department waiting and booking targets and standards are met.

3.3.6 Data collection should be accurate, timely, complete and subject to regular audit and validation.

3.3.7 Trusts should provide training programmes for staff which include all aspects of this IEAP and its Implementation Procedures. It is expected that training will be cascaded at and by each clinical, managerial or administrative tier within Trusts, providing the opportunity where required, for staff to work through operational scenarios.

3.3.8 Trusts will work towards providing a single point of contact for all patients with respect to outpatient appointment services. It is recognised that there may be services which require alternative processes.

3.4 NEW REFERRALS

3.4.1 All outpatient referrals sent to Trusts will be received at the dedicated HRO's and registered within one working day of receipt. GP priority status must be recorded at registration.

3.4.2 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and which are not returned can be identified.

3.4.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for referrals to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.

3.4.5 All outpatient referrals letters will be prioritised and returned to the HRO within 3 working days. It will be the responsibility of the health records

manager or departmental manager to monitor this performance indicator. Monitoring will take place by consultant on a monthly basis. Following prioritisation, referrals must be actioned on PAS and appropriate correspondence issued to patients within 1 working day.

3.4.6 Where clinics take place, or referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby GP prioritisation is accepted in order to proceed with booking urgent patients.

3.4.7 Inappropriate and inadequate referrals should be returned to the referral source. A minimum referral criteria dataset has been agreed and is outlined in **Appendix 8**

3.4.8 An Effective Use of Resources Policy is in place for some services and Trusts should ensure that this is adhered to. The policy is included for reference in **Appendix 9.**

3.5 URGENT AND ROUTINE APPOINTMENTS

3.5.1 All consultant led outpatient appointments where the patient attends the Trust should be booked. The key requirements are that the patient is directly involved in negotiating the appointment date and time, and that no appointment is made more than six weeks into the future.

3.5.2 All routine patients must be booked within the maximum waiting time guarantee. Urgent patients must be booked within the maximum wait agreed locally with clinicians, from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.

3.5.3 Acknowledgment letters will be sent to routine patients within five days of receipt of the referral. The estimated length of wait, along with information on

how the patient will be booked, should be included on the acknowledgement letter.

3.5.4 A minimum of three weeks' notice should be provided for all routine patients. This does not prevent patients being offered earlier appointment dates. Patients refusing short notice appointments (i.e. less than three weeks' notice) will not have their waiting time reset, in line with guidance on reasonable offers.

3.5.5 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

3.6 BOOKING

3.6.1 All new and review consultant led outpatient clinics should be able to book their appointment. This will entail patients having an opportunity to contact the hospital and agree a convenient date and time for their appointment. The use of the Patient Choice field on PAS is mandatory. The only fields that should be used are 'Y' to indicate that the appointment has been booked or 'N' to indicate that an appointment has not been booked. No other available field should be used as compliance with booking requirements will be monitored via the use of the Patient Choice field. For non-ISOFT and manual administration systems, Trusts should ensure that they are able to record and report patients who have been booked.

3.7 REASONABLE OFFERS

3.7.1 For patients who have been able to book their appointment, a reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

3.7.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

3.7.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the Trust.

3.7.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3.**

3.8 MANAGEMENT OF PATIENTS WHO CANCELLED (CNA) OR DID NOT ATTEND (DNA) THEIR APPOINTMENT

3.8.1 If a patient DNAs their outpatient appointment, the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

3.8.2 There may be instances for review patients where the clinician may wish to review notes prior to any action to remove a patient because of DNA or failure to respond to partial booking invitation letters. Trusts should ensure that robust and locally agreed rules and processes are in place so that booking clerks are clear about how to administer these patients.

3.8.3 In a transition period where fixed appointments are still being issued, patients should have two opportunities to attend.

3.8.4 If a patient cancels their outpatient appointment the following process must be implemented:

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.

- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

3.8.5 Following discharge, patients will be added to the waiting list at the written request of the referring GP and within a four week period from the date of discharge. Patients should be added to the waiting list at the date the written request is received.

3.8.6 The Implementation Procedure on DNAs and Cancellations can be found in **Appendix 4.**

3.9 MAXIMUM WAITING TIME GUARANTEE

3.9.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their GP when they are ready to be seen in the Outpatient Clinic. This will ensure that all patients waiting for an outpatient appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

3.10 COMPLIANCE WITH LEAVE PROTOCOL

3.10.1 Capacity lost due to cancelled or reduced clinics at short notice has negative consequences for patients and on the Trust's ability to successfully

implement booking processes. Clinic cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

3.10.2 It is essential that planned medical and other clinical leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments. There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.

3.10.3 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed HR policies.

3.10.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit. The Implementation Procedure for Compliance with Leave Protocol can be found in **Appendix 10.**

3.11 CLINIC OUTCOME MANAGEMENT

3.11.1 There are a number of locations within Trusts where patients present for their outpatient consultation. This protocol applies to all outpatient areas. It is the responsibility of the PAS user managing the attendance to maintain data quality.

3.11.2 All patients will have their attendance registered on PAS upon arrival in the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS and the medical records.

3.11.3 Changes in the patient's details must be updated on PAS and the medical records on the date of clinic.

3.11.4 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic. The implementation procedure for the Management of Clinic Outcomes can be found in **Appendix 11.**

3.12 REVIEW APPOINTMENTS

3.12.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the consultant. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative month of treatment and take the necessary action to ensure capacity is available for this cohort.

3.12.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the department and PAS updated. Patients requiring an appointment outside six weeks will be placed on a review waiting list, with the indicative appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

3.13 CLINIC TEMPLATE CHANGES

3.13.1 Clinic templates should be agreed between the consultant and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement and ensure that there is sufficient capacity allocated to enable each appointment type to be booked in line with clinical requirements and maximum waiting time guarantees for patients.

3.13.2 Templates will identify the number of slots available for new urgent, new routine and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

3.13.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for clinic template changes.

3.13.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for the management of Clinic Template Changes can be found in **Appendix 5.**

3.14 VALIDATION

3.14.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a weekly basis and continually reviewed as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times. The Implementation Guidance for Data Validation can be found in **Appendix 6.**

3.14.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

3.14.3 For patients in specialties that are not yet booked, they will be contacted to establish whether they will still require their appointment.

3.15 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

3.15.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to Independent Sector Providers. Transfers should not be a feature of an effective scheduled system.

3.15.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly. The Implementation Procedure and Technical Guidance for Handling Outpatient Transfers can be found in **Appendix 15a**.

SECTION 4

PROTOCOL GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

4.1 INTRODUCTION

4.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of diagnostic waiting lists. Where possible, the principles of good practice outlined in the Outpatient and Elective Admissions Section of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.

4.1.2 The administration and management of requests for diagnostics, waiting lists and appointments within and across Trust should be consistent, easily understood, patient focused and responsive to clinical decision making.

4.1.3 There will be a centralised registration process within Trusts to receive, register and process all diagnostic referrals. It is expected that this will be in a single location, where possible.

4.1.4 The Trust should work towards introducing choice of the date and time of tests to all patients. The Booking Principles outlined in Section 1 of this document should be considered in the development of this strategy.

4.2 CALCULATION OF THE WAITING TIME

4.2.1 The starting point for the waiting time of a request for a diagnostic test is the date the clinician's request is received into the department, in line with the guidance on Completing Diagnostic Waiting Times Collection (Definitions Document), September 2007. This can be found in **Appendix 14.** All referral letters and requests, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received.

4.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the service was informed of the cancellation.

4.2.3 Patients who refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

4.2.4 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

4.3 KEY PRINCIPLES

4.3.1 Trusts must have in place arrangements for pooling all referrals unless there is specific clinical information which determines that the patient should be seen by a particular consultant with sub-specialty interest.

4.3.2 All diagnostic requests, appointments and waiting lists should be managed according to clinical priority. A clinical priority must be identified for each patient on a waiting list, and patients managed in 2 streams, i.e. urgent and routine. Session or clinic templates should be constructed to ensure enough capacity is available to treat each stream within the maximum waiting time guarantees outlined in Section 1.4. Maximum waiting times for urgent patients should be agreed locally with clinicians.

4.3.3 Data collection should be accurate, timely, complete and subject to regular audit and validation.

4.3.4 Staff should be supported by appropriate training programmes.

4.3.5 Trusts will work towards providing a single point of contact for all patients with respect to diagnostic appointment services. It is recognised that there may be services which require alternative processes.

4.4 NEW DIAGNOSTIC REQUESTS

4.4.1 All diagnostic requests sent to Trusts will be received at a single location within the specialty Department. Trusts should explore the setting of one centralised diagnostic registration centre.

4.4.2 All requests will be registered on PAS / relevant IT system within one working day of receipt. Only authorised staff will have the ability to add, change or remove information in the outpatient module of PAS or other diagnostic system.

4.4.3 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system and that letters sent for prioritisation and not returned can be identified. Trusts should consider the introduction of clinical tracking systems similar to that used in patient chart tracking.

4.4.4 All requests must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for requests to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.

4.4.5 All requests will be prioritised and returned to the central registration point within 3 working days. It will be the responsibility of the health records manager or departmental manager to monitor this performance indicator. Monitoring on a consultant level will take place by consultant on a monthly basis. Following prioritisation, requests must be actioned on PAS / IT system and appropriate correspondence issued to patients within 1 working day.

4.4.6 Where clinics take place, or requests can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby the GP's priority is accepted in order to proceed with booking urgent patients.

4.4.7 Inappropriate and inadequate requests should be returned to the referral source. Minimum referral criteria is being developed to ensure the referral process is robust.

4.5 URGENT AND ROUTINE APPOINTMENTS

4.5.1 All requests must be booked within the maximum waiting time guarantee. The key requirement is that the patient is directly involved in negotiating the date and time of the appointment and that no appointment is made more than six weeks in advance.

4.5.2 Urgent requests must be booked within locally agreed maximum waits from the date of receipt. It is recognised that there will be exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.

4.5.3 All routine patients must be booked within the maximum waiting time guarantee. Acknowledgement letters will be issued to routine patients within 5 working days of receipt of request. The estimated wait, along with information on how the patients will be booked should be included on the acknowledgement letter.

4.5.4 A minimum of three weeks notice should be provided for all routine patients. This does not prevent patients being offered earlier appointment dates. Patients who refuse short notice appointments (i.e. less than three weeks notice) will not have their waiting time reset in line with guidance on reasonable offers.

4.5.5 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

4.6 CHRONOLOGICAL MANAGEMENT

4.6.1 Patients of equal clinical priority will be selected for appointment in chronological order and Trusts must ensure that regional standards and targets in relation to waiting times and booking requirements are met. The process of selecting patients for diagnostic investigations is a complex activity. It entails balancing the needs and priorities of the patient and the Trust against the available resources.

4.6.2 It is expected that Trusts will use two prioritisation categories; urgent and routine.

4.7 BOOKING METHODS

4.7.1 Booking will enable patients to have an opportunity to contact the service and agree a convenient time for their appointment. As outlined in paragraph 4.1.4, booking strategies should be developed in line with these Booking Principles. In the interim period, while fixed appointments are being issued, Trusts should ensure that the regional guidance is followed in the management of patients.

4.8 REASONABLE OFFERS

4.8.1 For patients who have been able to book their appointment, a reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

4.8.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

4.8.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the Trust.

4.8.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3.**

4.9 PATIENT CANCELLATIONS (CNAS) AND DID NOT ATTENDS (DNAS)

4.9.1 If a patient DNAs their diagnostic test, the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.
- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

4.9.2 There may be instances for follow-up patients where the clinician may wish to review notes prior to any action to remove a patient because of DNA or failure to respond to booking invitation letters. Trusts should ensure that robust and locally agreed rules and processes are in place so that booking clerks are clear about how to administer these patients.

4.9.3 In a transition period where fixed appointments are still being issued, patients should have two opportunities to attend.

4.9.4 If a patient cancels their appointment, the following process must be implemented.

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.
- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

4.9.5 Following discharge, patients will be added to the waiting list at the written request of the referring GP and within a four week period from the date of discharge. Patients should be added to the waiting list at the date the written request is received.

4.10 TRANSFERS BETWEEN HOSPITALS

4.10.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals. Transfers should not be a feature of an effective scheduled system.

4.10.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly.

4.11 COMPLIANCE WITH TRUST LEAVE PROTOCOL

4.11.1 One of the major issues regarding the operation of healthcare services is the capacity lost due to cancelled or reduced clinics at short notice. This has negative consequences for patients and on the ability to successfully implement booking requirements. Clinic or session cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

4.11.2 It is therefore essential that leave/absence is organised in line with the Trust's Human Resources leave protocol. It is necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of diagnostic sessions and the work associated with the rebooking of appointments. Where cancelling and rebooking is unavoidable the procedures used must be equitable and comply with clinical governance principles.

4.11.3 The local absence/leave protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed policies.

4.11.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

4.12 SESSION OUTCOME MANAGEMENT

4.12.1 There are a number of locations within Trusts where patients present for their diagnostic tests. This protocol applies to all diagnostic services. It is the responsibility of the PAS / relevant system user administrating the clinic to maintain data quality.

4.12.2 All patients will have their attendance registered on PAS / IT system upon arrival at the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS / IT system and the medical record.

4.12.3 Changes in the patient's details must be updated on PAS / IT system and the medical record on the date of clinic.

4.12.4 When the test has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

4.13.1 DIAGNOSTIC TEST OUTCOME

4.13.1 The outcome of the diagnostic test must be available to the referrer without undue delay. A standard for the reporting turnaround time of tests will be introduced during 2008 and Trusts will be expected to monitor and report compliance to the standard.

4.14 FOLLOW UP APPOINTMENTS

4.14.1 All follow up appointments must be made within the time frame specified by the clinician. If a follow up appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.

4.14.2 Where follow up appointments are not booked, patients who require a review within six weeks will negotiate the date and time of this appointment before leaving the department and PAS / IT system updated. Patients requiring an appointment outside six weeks will have their appointment managed through a 'hold and treat' system. They will be managed on a review waiting list, with an indicative date of treatment and sent a letter confirming their appointment date six weeks in advance.

4.15 TEMPLATE CHANGES

4.15.1 Session templates should be agreed with the healthcare professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

4.15.2 Templates will identify the number of slots available for new urgent, new routine, planned and follow up appointments; specify the time each session is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

4.15.3 All requests for template and temporary session rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for session template changes.

4.15.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

4.16 VALIDATION

4.16.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times.

4.16.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

4.16.3 For patients in specialties which still issue fixed appointments, they will be contacted to establish whether they require their appointment.

4.16.4 Until follow-up and planned appointments are booked, the validation process will apply to follow up appointments.

4.17 PLANNED PATIENTS AND DIAGNOSTICS TESTS CLASSIFIED AS DAY CASES

4.17.1 Trusts should ensure that the relevant standards in the Elective Admissions section of this document are adhered to.

4.18 PLANNED PATIENTS

4.18.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria.

4.18.2 These patients are not actively waiting for treatment to be initiated, only for planned continuation of treatment. A patient's care is considered as planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.

4.18.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients must have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

4.19 HOSPITAL INITIATED CANCELLATIONS

4.19.1 No patent should have his or her admission cancelled. If Trusts cancel a patient's admission, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity, which should must be within the maximum waiting time guarantee.

4.19.2 Trusts should aim to have processes in place to have the new proposed admission date arranged before that patient is informed of the cancellation.

4.19.3 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.

4.19.4 Trusts will make best efforts to ensure that a patient's admission is not cancelled a second time for non-clinical reasons.

4.19.5 Where patients are cancelled on the day of a test as a result of not being fit, they will be suspended, pending a clinical review of their condition. The patient should be fully informed of this process.

4.19.6 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment as a result of hospital initiated reasons, i.e. equipment failure, a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

4.20 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

4.20.1 Where more than one diagnostic test is required to assist with clinical decision making, the first test should be added to the waiting list with additional tests noted.

4.20.2 Where different clinicians are working together will perform more than one test at one time the patient should be added to the waiting list of the clinician for the priority test with additional clinicians noted, subject to local protocols.

4.20.3 Where a patient requires more than one test carried out on separate occasions by different (or the same) clinician, the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.

4.20.4 Where a patient is being managed in one Trust but has to attend another for another type of diagnostic test, monitoring arrangements must be in place between the relevant Trusts to ensure that the patient pathway runs smoothly.

SECTION 5

GUIDANCE FOR MANAGEMENT OF ALLIED HEALTH PROFESSIONAL (AHP) SERVICES

5.1 INTRODUCTION

5.1.1 Allied Health Professionals work with all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors. This guidance provides an administrative framework to support the management of patients waiting for AHP services.

5.1.2 Although it is written primarily for services provided in Trusts, it is recognised that there are a number of AHPs who provide services for children with physical and learning disabilities within special schools and with special educational needs within mainstream schools. Operational practices in these settings should be in line with the principles of the IEAP and provide consistency and equity for patients. Trusts should collaborate with colleagues within the Department of Education and the relevant schools to harmonise practices and ensure that children are able to access services equitably and within the maximum waiting time guarantees. A robust monitoring process will be required.

5.1.3 For the purposes of this section of the protocol, the generic term 'clinic' will be used to reflect AHP activity undertaken in hospital, community or domiciliary settings as it is recognised that AHPs provide patient care in a variety of care locations.

5.2 KEY PRINCIPLES

5.2.1 Trusts should ensure that there is a systematic approach to modernising AHP services which will help to improve access to services and quality of care for patients. This section should be read within the overall context of both the IEAP and the specific section governing the management of hospital outpatient services.

5.2.2 When looking at the experience of the patient it is important to consider the whole of their journey, with both the care and administrative pathways designed to support the patient's needs at each stage. The wait to receive outpatient therapy is likely to be one of many they experience in different parts of the system. It is the responsibility of all those involved to ensure that the patient wastes as little time as possible waiting and is seen by the right person as quickly as possible.

5.2.3 Booking will enable patients to have an opportunity to contact the hospital and agree a convenient time for their appointment. As outlined in paragraph 4.1.4, booking strategies should be developed in line with these Booking Principles. In the interim period, while fixed appointments are being issued, Trusts should ensure that the regional guidance is followed in the management of patients.

5.3 CALCULATION OF THE WAITING TIME

5.3.1 The waiting time clock for an AHP referral commences on the date the referral letter is received by the AHP service within the Trust. All referral letters, including faxed, emailed and electronically received referrals, will be date stamped on the date received.

5.3.2 The waiting time clock stops when the first definitive AHP treatment has commenced or when a decision is made that treatment is not required. Further information on definitions and sample patient pathways is contained in the Data Definitions and Guidance Document for AHP Waiting Times and can be found in **Appendix 12.**

5.3.3 As booking systems are introduced, patients should be made a reasonable offer, where clinically possible. Patients who refuse a reasonable offer of treatment, or fail to attend an AHP appointment, will have their waiting time clock re-set to the date the service was informed of the cancellation (CNAs) or the date the patient failed to attend (DNAs).

5.4 NEW REFERRALS

5.4.1 All AHP referrals will be registered on the relevant information system within 1 working day of receipt.

5.4.2 Trusts should work towards a system whereby all AHP referrals sent to the Trust are received at a dedicated registration function (s). Trusts should ensure that adequate systems are in place to deal with multiple referrals for the same patient regarding the same condition from a number of sources.

5.4.3 All referrals must be triaged or assessed to make a clear decision on the next step of a referral and clinical urgency (urgent or routine) clearly identified and recorded. All referrals will be prioritised and returned to the registration point with 3 working days.

5.4.4 Trusts must ensure that protocols are in place to prevent unnecessary delay from date stamping / logging of referrals to forwarding to the AHP department responsible for referral triage and/or initiation of treatment. It will be the responsibility of the relevant manager to monitor this performance indicator.

5.4.5 A robust system should be in place to ensure that cover is provided for referrals to be read and prioritised during practitioners' absence. A designated officer should oversee this and a protocol will be required for each service.

5.4.6 Where referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with AHPs whereby the referrer's prioritisation is accepted in order to proceed with booking patients.

5.4.7 Following prioritisation, referrals must be updated on the relevant information system and appropriate correspondence issued to patients within 1 working day. Where there is insufficient information for the AHP to make a decision, they should contact the originating referrer in the first instance to access the

necessary information. If this cannot be gained, the referral should be returned to the referral source.

5.4.8 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and letters which are not returned can be identified.

5.4.9 If at the referral stage the patient / client is identified as being clinically or socially unfit to receive the necessary service the referral should not be accepted (not added to a waiting list) and returned to the originating referrer with a request that they re-refer the patient / client when they are clinically or socially fit to be treated.

5.5 URGENT AND ROUTINE APPOINTMENTS

5.5.1 All routine patients should be appointed within the maximum waiting time guarantee. Urgent patients must be booked within locally agreed maximum waits from the date of receipt. Local booking process should be based upon the principles outlined in Section 1.7.

5.5.2 For routine waiting list patients, an acknowledgement letter will be sent to patients within 5 working days of receipt of the referral, which should provide information to patients on their anticipated length of wait and details of the booking process.

5.5.3 A minimum of three weeks' notice should be provided for all routine patients. This does not prevent patients being offered an earlier appointment. Patients refusing short notice appointments (i.e. less than three weeks notice) will not have their waiting time clock reset, in line with guidance on reasonable offers.

5.5.4 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

5.6 CHRONOLOGICAL MANAGEMENT

5.6.1 Patients, within each clinical priority category, should be selected for booking in chronological order, i.e. based on the date the referral was received. Trusts should ensure that local administrative systems have the capability and functionality to effectively operate a referral management and booking system that is chronologically based.

5.7 CAPACITY PLANNING AND ESCALATION

5.7.1 It is important for AHP services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.

5.7.2 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.

5.8 REASONABLE OFFERS

5.8.1 As booking systems are introduced, patients should be offered reasonable notice, where clinically possible. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused. To ensure a verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

5.8.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

5.8.3 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of cancellation as the patient has entered into an agreement with the Trust.

5.8.3 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above.

5.9 AHP SERVICE INITIATED CANCELLATIONS

5.9.1 No patent should have his or her appointment cancelled. If Trusts cancel a patient's appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable appointment date, ideally at the time of cancellation, and no more than 6 weeks in advance. The Trust must ensure that the new appointment date is within the maximum waiting time guarantee.

5.9.2 The patient should be informed of the reason for the cancellation and the date of the new appointment. This should include an explanation and an apology on behalf of the Trust.

5.9.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.

5.9.4 AHP service initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment as a result of AHP service initiated reasons, i.e. equipment failure, staff sickness, a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

5.10 MAXIMUM WAITING TIME GUARANTEE

5.10.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their referrer when they are ready to be seen. This will ensure that all patients waiting for an AHP appointment / treatment are fit and ready to be seen.

5.10.2 There will undoubtedly be occasions and instances where local discretion is required and sensitivity should be applied when short periods of time are involved; for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

5.11 COMPLIANCE WITH LEAVE PROTOCOL

5.11.1 Capacity lost due to cancelled or reduced clinics or visits at short notice has negative consequences for patients and on the Trust's ability to successfully implement robust booking processes. Clinic cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

5.11.2 It is therefore essential that AHP practitioners and other clinical planned leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of AHP clinics and the work associated with rebooking patient appointments. There should be clear practitioner agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient and comply with clinical governance principles.

5.11.3 The protocol should require a minimum of six weeks' notification of planned leave, in line with locally agreed HR policies.

5.11.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

5.12 CLINIC OUTCOME MANAGEMENT

5.12.1 All patients will have their attendance recorded or registered on the relevant information system upon arrival for their appointment. The patient must verify their demographic details on every visit. The verified information must be cross-checked on information system and the patient records. Any changes must be recorded and updated in the patient record on the date of the clinic.

5.12.2 When the assessment/treatment has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

5.13 REVIEW APPOINTMENTS

5.13.1 All review appointments must be made within the time frame specified by the practitioner. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the practitioner. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the practitioner.

5.13.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the service and PAS / information system updated. Patients requiring an appointment outside six weeks should be managed on a review waiting list, with the indicative date recorded when appointment is required and booked in line with the booking principles outlined.

5.13.3 If domiciliary review appointment is required within 6 weeks, the appointment date should be agreed with the patient and confirmed in writing by the booking office. Where a domiciliary review appointment is required outside 6 weeks, the patient should be managed on a review waiting list, within the indicative date recorded, and booking in line with the booking principles outlined.

5.14 CLINIC TEMPLATE MANAGEMENT

5.14.1 Clinic templates should be agreed between the practitioner and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

5.14.2 Templates will identify the number of slots available for new urgent, new routine and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

5.14.3 All requests for template and temporary clinic rule changes will only be accepted in writing to the relevant service manager. A minimum of six weeks notice will be provided for clinic template changes.

5.14.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

5.15 ROBUSTNESS OF DATA / VALIDATION

5.15.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a weekly basis and continually reviewed as waiting times reduce. This is essential to ensure Primary Targeting Lists are accurate and robust at all times.

5.15.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

5.15.3 For patients in AHP services that are not yet booked, they will be contacted to establish whether they will still require their appointment.

SECTION 6 PROTOCOL GUIDANCE FOR MANAGEMENT OF ELECTIVE ADMISSIONS

6.1 INTRODUCTION

6.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of elective waiting lists.

6.1.2 The administration and management of elective admissions within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

6.2 COMPUTER SYSTEMS

6.2.1 To ensure consistency and the standardisation of reporting with Commissioners and the Department, all waiting lists are to be maintained in the PAS system.

6.2.2 Details of patients must be entered on to the computer system within two working days of the decision to admit being made. Failure to do this will lead to incorrect assessment of waiting list size when the daily / weekly downloads are taken.

6.2.3 As a minimum 3 digit OPCS codes should be included when adding a patient to a waiting list. Trusts should work towards expanding this to 4 digit codes.

6.3 CALCULATION OF THE WAITING TIME

6.3.1 The starting point for the waiting time of an inpatient is the date the consultant agrees with the patient that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is medically fit to undergo such a procedure.

6.3.2 The waiting time for each inpatient on the elective admission list is calculated as the time period between the original decision to admit date and the date

at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

6.3.3 Patients who refuse a reasonable offer of treatment, or fail to attend an offer of admission, will have their waiting time reset to the date the hospital was informed of the cancellation (CNAs) or the date the patient failed to attend (DNAs). Any periods of suspension are subtracted from the patients overall waiting time.

6.4 STRUCTURE OF WAITING LISTS

6.4.1 To aid both the clinical and administrative management of the waiting list, lists should be sub-divided into a limited number of smaller lists, differentiating between active waiting lists, planned lists and suspended patients.

6.4.2 Priorities must be identified for each patient on the active waiting list, allocated according to urgency of the treatment. The current priorities are urgent and routine.

6.5 INPATIENT AND DAY CASE ACTIVE WAITING LISTS

6.5.1 Inpatient care should be the exception in the majority of elective procedures. Trusts should move away from initially asking "is this patient suitable for day case treatment?" towards a default position where they ask "what is the justification for admitting this patient?" The Trust's systems, processes and physical space should be redesigned and organized on this basis.

6.5.2 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient they are fit, ready, and able to come in.

6.5.3 All decisions to admit will be recorded on PAS within two working days of the decision to admit being taken.

6.5.4 Robust booking and scheduling systems will be developed to support patients having a say in the date and time of their admission. Further guidance will be provided on this.

6.5.5 Where a decision to admit depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure the result of the investigation is timely and in accordance with the clinical urgency required to admit the patient.

6.5.6 The statements above apply to all decisions to admit, irrespective of the decision route, i.e. direct access patients or decisions to directly list patients without outpatient consultation.

6.6 COMPLIANCE WITH TRUST HR LEAVE PROTOCOL

6.6.1 Trusts should have in place a robust protocol for the notification and management of medical and clinical leave and other absence. This protocol should include a proforma for completion by or on behalf of the consultant with a clear process for notifying the theatre scheduler of leave / absence.

6.6.2 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed consultant's contracts.

6.6.3 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

6.7 TO COME IN (TCI) OFFERS OF TREATMENT

6.7.1 The patient should be advised of their expected waiting time during the consultation between themselves and the health care provider/practitioner and confirmed in writing.

6.7.2 Patients should be made reasonable offers to come in on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.

6.7.3 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of admission, irrespective of provider, that gives the patient a minimum of three weeks' notice and two TCI dates. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the refused admission.

6.7.4 If the patient is offered an admission within a shorter notice period and it is refused, the waiting time cannot be recalculated.

6.7.5 If the patient however accepts an admission at short notice, but then cancels the admission, the waiting time can be recalculated from the date of that admission as the patient has entered into an agreement with the Trust.

6.7.6 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above.

6.8 SUSPENDED PATIENTS

6.8.1 A period of suspension is defined as:

- A patient suspended from the active waiting list for medical reasons, or unavailable for admission for a specified period because of family commitments, holidays, or other reasons i.e. a patient may be suspended during any periods when they are unavailable for treatment for social or

medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc).

- A maximum period not exceeding 3 months.

6.8.2 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or social reasons. These patients should be suspended from the active waiting list until they are ready for admission. All patients who require a period of suspension will have a personal treatment plan agreed by the consultant with relevant healthcare professionals. One month prior to the end of the suspension period, these plans should be reviewed and actions taken to review patients where required.

6.8.3 Every effort will be made to minimise the number of patients on the suspended waiting list, and the length of time patients are on the suspended waiting list.

6.8.4 Should there be any exceptions to the above, advice should be sought from the lead director or appropriate clinician.

6.8.5 Suspended patients will not count as waiting for statistical purposes. Any periods of suspension will be automatically subtracted from the patient's total time on the waiting list for central statistical returns.

6.8.6 No patient added to a waiting list should be immediately suspended. Patients should be recorded as suspended on the same day as the decision was taken that the patient was unfit or unavailable for surgery.

6.8.7 No patient should be suspended from the waiting list without a review date. All review dates must be 1st of the month to allow sufficient time for the patient to be treated in-month to avoid breaching waiting times targets.

6.8.8 No more than 5% of patients should be suspended from the waiting list at any time. This indicator should be regularly monitored.

6.8.9 Trusts should ensure that due regard is given to the guidance on reasonableness in their management of suspended patients.

6.9 PLANNED PATIENTS

6.9.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or surgical investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria (e.g. check cystoscopy).

6.9.2 These patients are not actively waiting for treatment, but for planned continuation of treatment. A patient is planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.

6.9.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients should have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

6.9.4 Ideally, children should be kept under outpatient review and only listed when they reach an age when they are ready for surgery. However, where a child has been added to a list with explicit clinical instructions that they cannot have surgery until they reach the optimum age, this patient can be classed as planned. The Implementation Procedure for Planned Patients can be found in **Appendix 13.**

6.10 CANCELLATIONS AND DNA'S

6.10.1 Patient Initiated Cancellations

Patients who cancel a reasonable offer will be given a second opportunity to book an admission, which should be within six weeks of the original admission date. If a second admission offer is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

6.10.2 Patients who DNA

If a patient DNAs their first admission date, the following process must be implemented:

- Where a patient has had an opportunity to agree the date and time of their admission, they will not normally be offered a second admission date.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second admission. The second admission date must be agreed with the patient.

6.10.3 In a period of transition where fixed TCIs are still being issued, patients should have two opportunities to attend.

6.10.4 Following discharge patients will be added to the waiting list at the written request of the referring GP and within a four week period from date of discharge. Patients should be added to the waiting list at the date of the written request is received.

6.10.5 It is acknowledged that there may be exceptional circumstances for those patients identified as being 'at risk' (children, vulnerable adults).

6.10.6 No patient should have his or her operation cancelled prior to admission. If Trusts cancel a patient's admission/operation in advance of the anticipated TCI date, the waiting time clock (based on the original date to admit) will not be reset and the patient will be offered an alternative reasonable guaranteed future date within a maximum of 28 days.

6.10.7 Trusts should aim to have processes in place to have the new proposed admission date arranged before the patient is informed of the cancellation.

6.10.8 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.

6.10.9 Trusts will make best efforts to ensure that a patient's operation is not cancelled a second time for non clinical reasons.

6.10.10 Where patients are cancelled on the day of surgery as a result of not being fit for surgery / high anaesthetic risk, they will be suspended, pending a clinical review of their condition either by the consultant in outpatients or by their GP. The patient should be fully informed of this process.

6.10.11 Hospital-initiated cancellations will be recorded and reported to the relevant department on a monthly basis.

6.11 PERSONAL TREATMENT PLAN

6.11.1 A personal treatment plan must be put in place when a confirmed TCI date has been cancelled by the hospital, a patient has been suspended or is simply a potential breach. The plan should:

- Be agreed with the patient
- Be recorded in the patient's notes
- Be monitored by the appropriate person responsible for ensuring that the treatment plan is delivered.

6.11.2 The listing clinician will be responsible for implementing the personal treatment plan.

6.12 CHRONOLOGICAL MANAGEMENT

6.12.1 The process of selecting patients for admission and subsequent treatment is a complex activity. It entails balancing the needs and priorities of the patient and the Trust against the available resources of theatre time and staffed beds.

6.12.2 The Booking Principles outlined in Section 1.7 should underpin the development of booking systems to ensure a system of management and monitoring that is chronologically as opposed to statistically based.

6.12.3 It is expected that Trusts will work towards reducing the number of prioritisation categories to urgent and routine.

6.13 PRE-OPERATIVE ASSESSMENT

6.13.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-operative assessment. This can be provided using a variety of methods including telephone, postal or face to face assessment. Please refer to the Design and Deliver Guide 2007 for further reference.

6.13.2 Pre operative assessment will include an anaesthetic assessment. It will be the responsibility of the pre-operative assessment team, in accordance with protocols developed by surgeons and anaesthetists, to authorise fitness for surgery.

6.13.3 If a patient is unfit for their operation, their date will be cancelled and decision taken as to the appropriate next action.

6.13.4 Only those patients that are deemed fit for surgery may be offered a firm TCI date.

6.13.5 Pre-operative services should be supported by a robust booking system.

6.14 PATIENTS WHO DNA THEIR PRE OPERATIVE ASSESSMENT

6.14.1 Please refer to the guidance outlined in the Outpatient section.

6.15 VALIDATION OF WAITING LISTS

6.15.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis, and ideally on a weekly basis as waiting times reduce. This is essential to ensure the efficiency of the elective pathway at all times.

6.15.2 As booking processes are implemented and waiting times reduce, there will no longer be the need to validate patients by letter. For patients in specialties that are not yet booked, they will be contacted to establish whether they will still require their admission.

6.15.3 Involvement of clinicians in the validation process is essential to ensure that waiting lists are robust from a clinical perspective. Trusts should ensure an ongoing process of clinical validation and audit is in place.

6.16 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

6.16.1 Where the same clinician is performing more than one procedure at one time, the first procedure should be added to the waiting list with additional procedures noted.

6.16.2 Where different clinicians working together will perform more than one procedure at one time the patient should be added to the waiting list of the clinician for the priority procedure with additional clinician procedures noted.

6.16.3 Where a patient requires more than one procedure performed on separate occasions or bilateral procedures by different (or the same) clinician, the patient should be placed on the active waiting list for the first procedure and the planned waiting list for any subsequent procedures.

6.17 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

6.17.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to Independent Sector Providers. Transfers should not be a feature of an effective scheduled system.

6.17.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly. The Implementation Procedure and Technical Guidance for Handling Inpatient Transfers can be found in **Appendix 15b.**

Appendix Question 13

Received from Anne McVey on 20/06/2022. Annotated by the Urology Services Inquiry.

2009 . 25 . 09

Q13.1.87.1

McVey, Anne

From: Agnew, Carolyn [redacted]
Sent: 25 September 2009 12:48
To: Centre, Laurels; Age Concern; Ageing Well; Anne Donnelly; anne.mccready[redacted]; SupportGroup, ArmaghTravellers; armaghcarers[redacted]; ASCF; barbara_react[redacted]; Austin, Marie; Camilla Reynolds; Cancer Choices; Cara -Friend; Carers NI; Catherine McBennett; CDHN; cloughran[redacted]; Community Network Craigavon; Confederation of Com Groups Newry; Contact Youth; costa.network[redacted]; Craigavon and Banbridge Carers; Craigreact[redacted]; Crossfire Trust; CRUSE; crusemoy[redacted]; crusenewry[redacted]; dermot.magorrian[redacted]; DermotGlackin[redacted]; elaine.devlin[redacted]; emma[redacted]; Health Improvement Worker A&D; Health Improvement Worker C&B; Health Improvement Worker N&M; helen.comiskey[redacted]; Help the Aged; info@carers-nm.org; info@equality2000.org; info@lilaccancer.org; isobelholmes[redacted]; kate[redacted]; Foy, Leo; Lennon, Lucille; Donnelly, Lyn; m.caldwel[redacted]; Abraham, Mairead; manager@craigavontravellers.org; martin.oneill[redacted]; maryddc[redacted]; Mencap; Newry & Mourne Carers Association; Newry Rainbow Project; NICMA; Parents Council; Skelly, Louise; patricia[redacted]; paul[redacted]; Pips Upper Bann; Princess Royal Trust for Carers; Rainbow Project; Rural Health Partnership; Rural Support; Cunningham, Stella; SDFHI; Seamus Donnelly; seamus[redacted]; seandooleyfriesian[redacted]; sheenagh.mcnally[redacted]; SHSCC; Sixth Sense; Southern Area Hospice Servicers; Southern Group Environmental Health Committee; springproject@live.com; STEP; Sure Start South Armagh; TADA; thewomenscentre@googlemail.com; Tiny Life; Mathews, Iris; Volunteer Bureau; West Armagh Consortium; WFHI; Williamson Consulting; Wraparound -CAH Task Group; Youth Justice Agency; Zero-8-Teen
Cc: laura.molloy[redacted]; Davidson, Alexis; Carroll, Anita; McVey, Anne; Cardwell, David; Corr, Edel; Youart, Joy; Stead, Lindsay; Carroll, Ronan2; Donaldson, Ruth; Gibson, Simon
Subject: FW: Urology Review
Attachments: Regional Review of Adult Urology Services 2009.doc; draft_letter_about_urology_review 240909.doc; Urology consultation questionairre.doc

For information

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Dear all

Please find attached the 2009 Adult Urology Services Review that is now out for public consultation. If you have any comments on the review please fill in the attached questionairre and email back to me. A letter from Mr Compton is also attached.

Many Thanks

Laura Molloy

Received from Anne McVey on 20/06/2022. Annotated by the Urology Services Inquiry.

Health and Social Care Board

2009 · 25 · 09

Q13 · 1 · 87 · 2

Review of Adult Urology Services in Northern Ireland

A modernisation and investment plan

March 2009

Ministerial Foreword

The health service in Northern Ireland has been able to make remarkable progress in improving access to services and sustaining the quality of those services. That work, as part of the current programme of modernisation and reform of health and social care services is ensuring that many more patients are gaining timely access to the services they need than was the case only a few short years ago. I am determined that this progress should continue.

However, whilst reducing waiting times generally there have been some concerns about the capability of our urology services as they are currently arranged, to continue to deliver care of the highest standard while striving to meet increasing demand. The capacity within the HSC to deal with an increasing demand for urology services was the principal reason why this review was commissioned.

The review considers workforce planning, training and development needs and future resourcing and proposes a model of service delivery which I am confident will produce a reformed service fit for purpose, with high quality services provided in the right place at the right time by appropriately trained and skilled staff.

Ensuring that the patients who need our health and social care services remain at the centre of everything we do is of course a fundamental step of developing and improving service provision. I hope that many of you, especially those with experience of the service, will respond with comments and suggestions which will inform the future development of this important
Speciality.

[redacted]
Personal Information redacted by the USI

Michael McGimpsey
Minister for Health, Social Services and Public Safety

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Appendices

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1. SUMMARY OF RECOMMENDATIONS

Section 2 – Introduction and Context

For the purposes of this review all Urology services and Urological related procedures should be taken in the context of Adult Urology only.

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

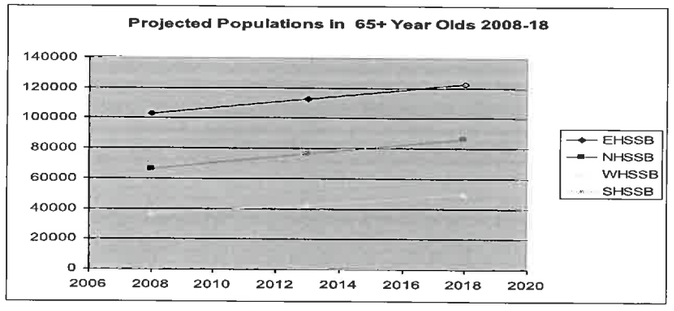
3. A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.

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

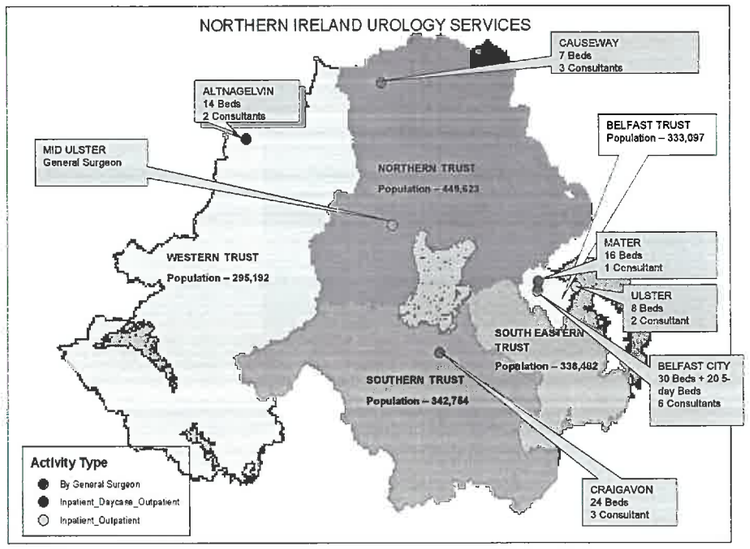
3.1 Consultant led Adult Urology Services are provided in each of the five Trusts. Table 2 below outlines the number of Consultants, Specialist Nurses and Main Hospital bases.

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	

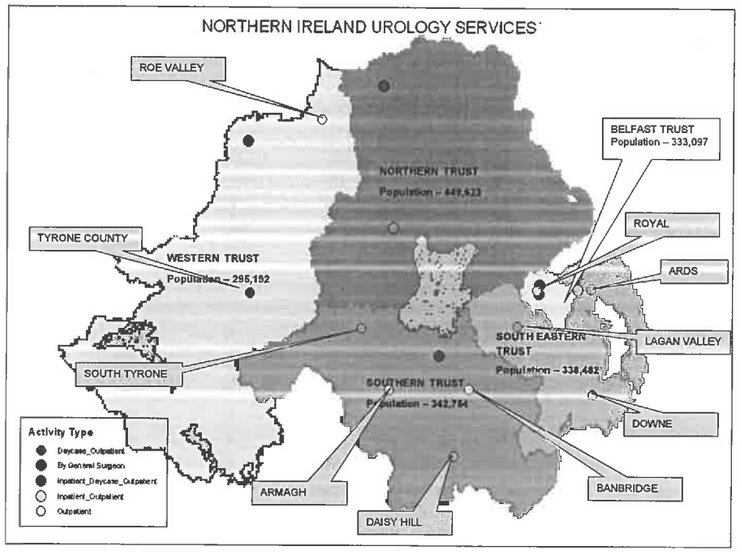
3.2 Figure 2 depicts the five Trusts, their respective resident population, and location and number of Inpatient beds.

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.

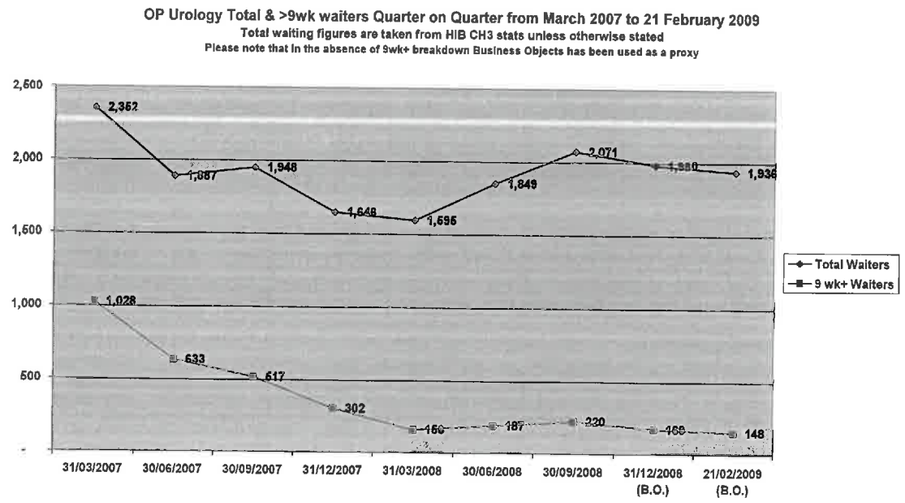
5. PERFORMANCE MEASURES

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.

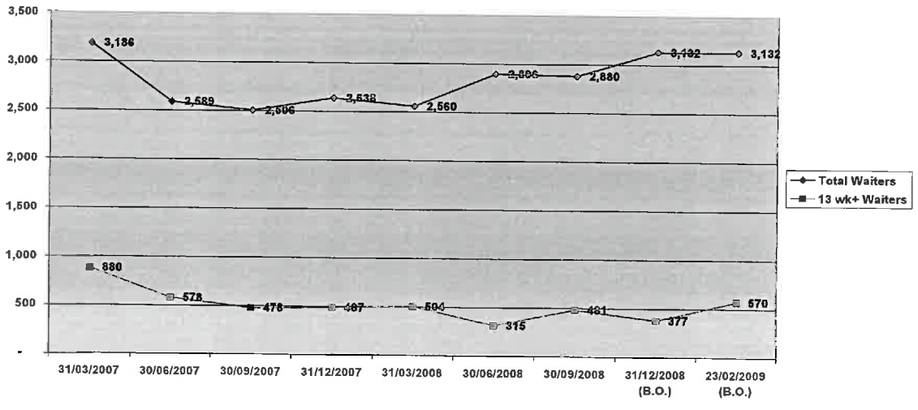
PFA 2008/2009: By March 2009, no patient should wait longer than 9 weeks for first outpatient appointment and/or diagnostics
By March 2009, no patient should wait longer than 13 weeks for Inpatient or daycase treatment.

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.

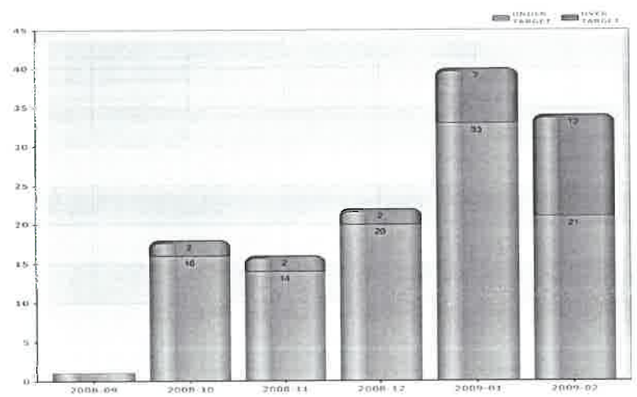
* decision to treat is the date on which the patient and clinician agree the treatment plan.

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.

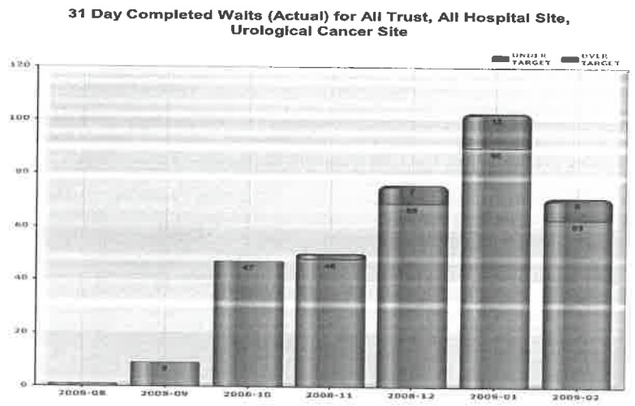
Figure 6

62 Day Completed Waits (Actual) for All Trust, All Hospital Site, Urological Cancer Site



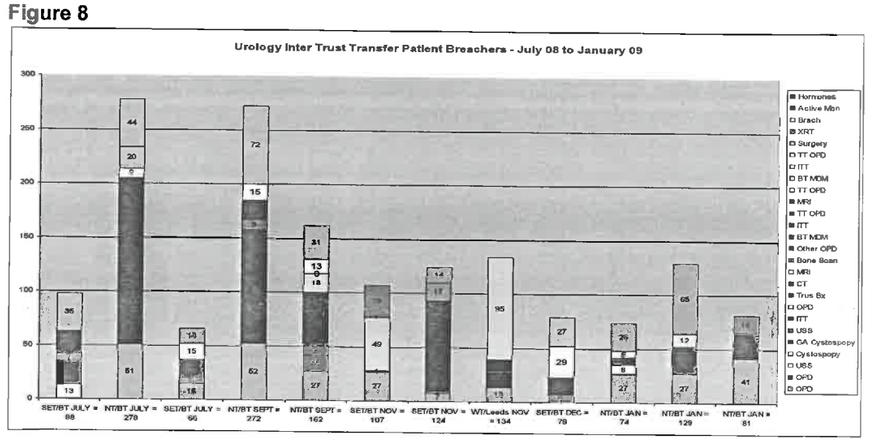
5.7 For the same period in February, the performance in relation to the 31 day standard shows that, only 87% of those Urological cancer patients (63 of 71 patients) were treated within 31 days of the decision to treat. From a sample of 9 patients that breached the 31 day standard in January 2009, they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

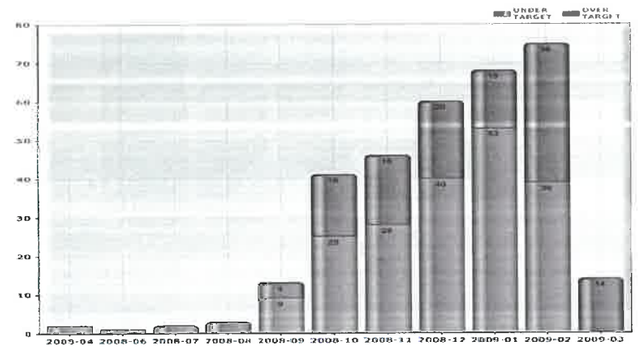
Figure 8



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

14 Day Current Waits (Actual) for All Trust, All Hospital Site, Urological Cancer Site



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.

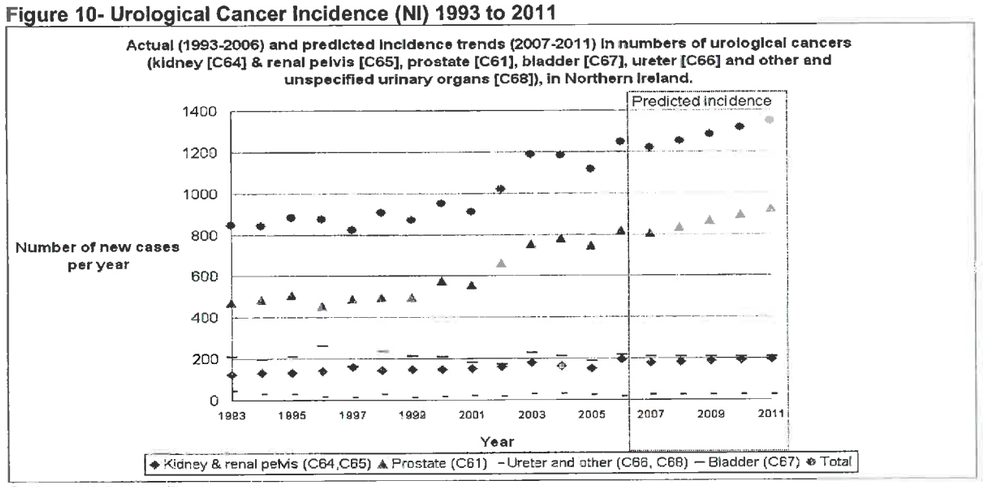
7. UROLOGICAL CANCERS

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.

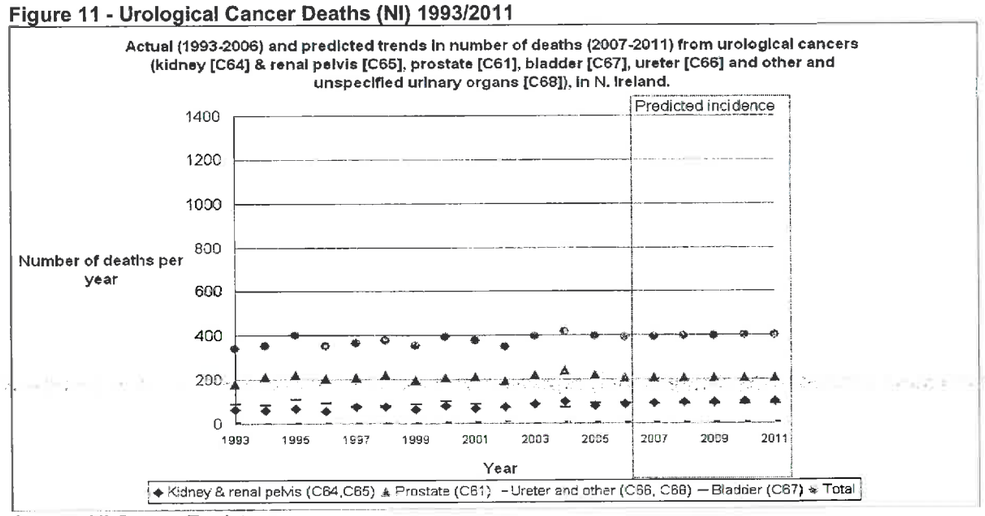
Cancer Incidence and Mortality

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, as should participation in MDM's for all Urologists.*

- *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.

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). One local MDT/MDM.*** 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). One local MDT/MDM.*** 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). One local MDT/MDM plus regional/specialist MDM.*** 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.

Table 14 Elements and Arrangements in Three Team Model

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

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

*** MDM reconfiguration has been approved by NICaN Group

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 Adult 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

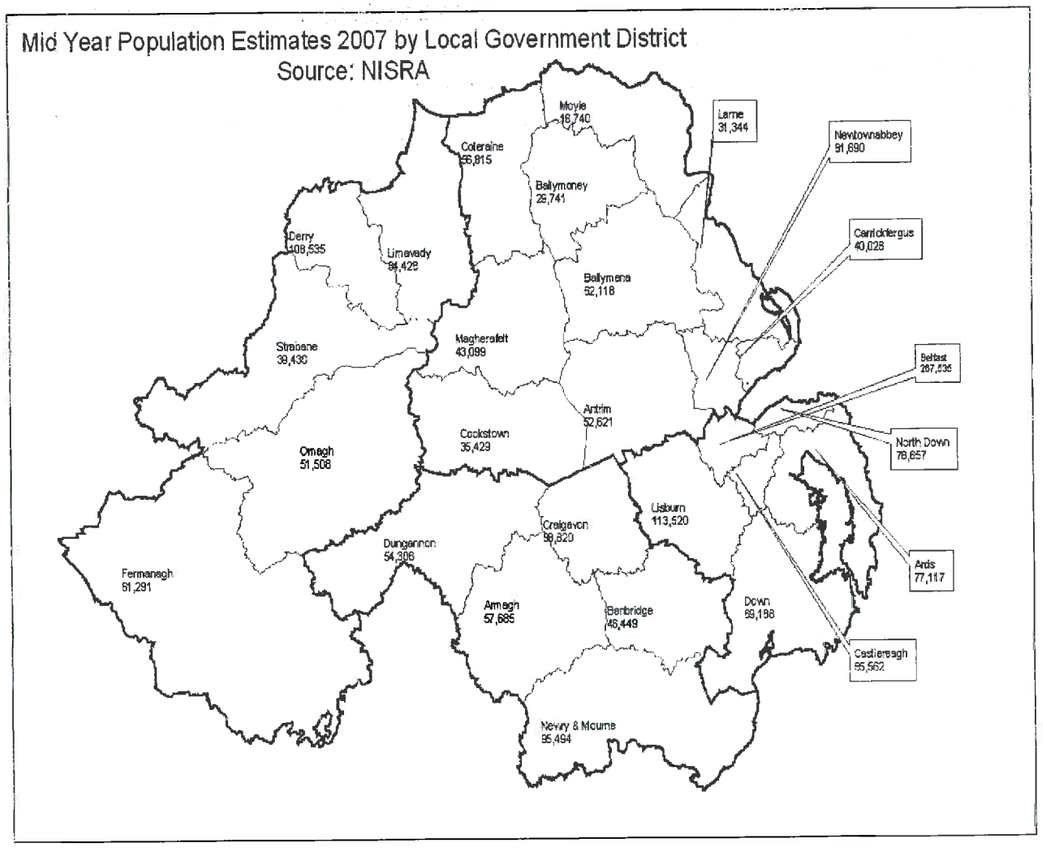
Team South and West:

- 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



Health and Social Care Board

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c.c: Chief Executives

Date: 23 September 2009

2009 . 25 . 09
Q13 . 1 . 87 . 3

Dear Sir/Madam

During 2008/09, a Regional Review of Adult Urology Services was undertaken in response to concerns regarding the Urology Services ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services.

The Minister has launched the Regional Review of Adult Urology Services today and has asked the Board to undertake a Public Consultation on the Review.

Please find attached a consultation questionnaire. The closing date for submission of the responses to the Consultation is Friday 18th December 2009.

A copy of the Regional Review of Adult Urology Services can be accessed on the Health and Social Care homepage, www.hscboard.hscni.net, or by requesting a copy from, Laura Molloy, Project Officer, Health and Social Care Board, Performance Management and Service Improvement Directorate Templeton House, 411 Holywood Road, Belfast BT4 2LP. Alternatively please email your request to Urology.consultation@hscni.net.

Yours sincerely

Personal Information redacted by the USI

John Compton
Chief Executive
Health and Social Care Board

Received from Anne McVey on 20/06/2022. Annotated by the Urology Services Inquiry.

Health and Social Care Board

REGIONAL REVIEW OF ADULT UROLOGY SERVICES

Consultation Response Questionnaire

2009 · 25 · 09
Q13 · 1 · 84 · 4

September 2009

CONSULTATION RESPONSE QUESTIONNAIRE

You can respond to the consultation document by e-mail, letter or fax.

Before you submit your response, please read Appendix 1 about the effect of the Freedom of Information Act 2000 on the confidentiality of responses to public consultation exercises.

Responses should be sent to:

E-mail: urology.consultation@hscni.net

Written: Laura Molloy, Project Officer
Health and Social Care Board
Performance Management and Service Improvement Directorate
Templeton House, 411 Holywood Road
Belfast BT4 2LP

Fax: Personal Information redacted by the USI

Responses must be received no later than Friday 18th December at 5.00pm

I am responding: as an individual ☐ on behalf of an organisation ☐
(please tick a box)

Name: _____
Job Title: _____
Organisation: _____
Address: _____

_____
Tel: _____
Fax: _____
e-mail: _____

Q1. This document makes a total of 26 Recommendations, 17 of which are set out in Table 1 below. Please indicate whether you agree or disagree with each of the recommendations. If you disagree with any of the recommendations please provide, in the space provided, detail of your reasons. We would also ask that you provide detail of any additional suggestions you may wish to make.

Recommendation		Y/N
3.	A separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance. (Section 2 – Introduction and Context, pg 5)	
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. (Section 3 –Current Service Profile, pg 5)	
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. (Section 3 –Current Service Profile, pg 5)	
9.	Trusts should ensure arrangements are in place to proactively manage and provide equitable care to those patients admitted under General Surgery in hospitals without Urology Units (e.g. Antrim, Daisy Hill, Erne). Arrangements should include 7 day week notification of admissions to the appropriate Urology Unit and provision of urology advice/care by telephone, electronically or in person, also 7 days a week. (Section 3 –Current Service Profile, pg 5)	
10.	In undertaking the ICATS review, there must be full engagement with secondary care Urology teams, current ICATS teams, as well as General Practitioners and LCGs. In considering areas of Urology suitable for further development they should look towards erectile dysfunction, benign prostatic disease, LUTS and continence services. The review should also take into account developments elsewhere within the UK and in particular developments within PCTs in relation to shifting care closer to home. (Section 3 –Current Service Profile, pg 5)	

Recommendation		Y/N
12.	Trust Urology Teams must as a matter of urgency redesign and enhance capacity to provide single visit outpatient and assessment (diagnostic) services for suspected urological cancer patients. (Section 5 – Performance Measures, pg 6)	
14.	Trusts should participate in a benchmarking exercise of a set number of elective (procedure codes) and non-elective (diagnostic codes) patients by Consultant and by hospital with a view to agreeing a target length of stay for these groups of patients. (Section 5 – Performance Measures, pg 6)	
15.	Trusts will be required to include in their implementation plans, an action plan for increasing the percentage of elective operations undertaken as day surgery, redesigning their day surgery theatre facilities and should work with Urology Team in other Trusts to agree procedures for which day care will be the norm for elective surgery. (Section 5 – Performance Measures, pg 6)	
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. (Section 7 – Urological Cancers, pg 6)	
19.	By March 2010, at the latest, all radical pelvic surgery should be undertaken on a single site, in BCH, by a specialist team of surgeons. The transfer of this work should be phased to enable BCH to appoint appropriate staff and ensure infrastructure and systems are in place. A phased implementation plan should be agreed with all parties. (Section 7 – Urological Cancers, pg 6)	
20.	Trusts should ensure that surgeons carrying out small numbers (<5 per annum) of either radical pelvic operation, make arrangements to pass this work on to more specialised colleagues, as soon as is practicably possible, (whilst a single site service is being established).(Section 7 – Urological Cancers, pg 6)	
21.	To deliver the level of activity from 2008/09 and address the issues around casemix and complexity it is recommended that the number of Consultant Urologists is increased to 23 wte. (Section 8 – Clinical Workforce Requirements, pg 6)	

22.	Urology Teams must ensure that current capacity is optimised to deliver the number FCEs by Consultant as per BAUS guidelines (subject to casemix and complexity). This may require access to additional operating sessions up to at least 4 per week (42 weeks per year) and an amendment to job plans. (Section 8 – Clinical Workforce Requirements, pg 6)	
23.	At least 5 Clinical Nurse Specialists (cancer) should be appointed (and trained). The deployment of these staff within particular teams will need to be decided and Trusts will be required to develop detailed job plans with caseload, activity and measurable outcomes agreed prior to implementation. A further review and benchmarking of cancer CNS's should be undertaken in mid 2010. (Section 8 – Clinical Workforce Requirements, pg 6)	
24.	Urology services in Northern Ireland should be reconfigured into a 3 team model, to achieve long term stability and viability. (Section 9 – Service Configuration Model, pg 7)	
25.	Teams North and East (Northern, Western, Belfast and South Eastern Trusts) should ensure that prior to the creation of the new Teams, there are clear, unambiguous and agreed arrangements in place with regard to Consultant on-call and out of hours arrangements. (Section 9 – Service Configuration Model, pg 7)	
26.	Each Trust must work in partnership with the other Trust/s within the new team structure to determine and agree the new arrangements for service delivery, including inter alia, governance, employment and contractual arrangements for clinical staff, locations, frequency and prioritisation of outreach services, areas of Consultant specialist interest based on capacity and expertise required and catchment populations to be served. (Section 9 – Service Configuration Model, pg 7)	

If you disagree with any of the above recommendations, please explain.

Please continue on an additional page if necessary

THANK YOU FOR YOUR COMMENTS.

Appendix 1

FREEDOM OF INFORMATION ACT 2000 – CONFIDENTIALITY OF CONSULTATIONS

The Board will publish a summary of responses following completion of the consultation process. Your response, and all other responses to the consultation, may be disclosed on request. The Board can only refuse to disclose information in exceptional circumstances. **Before** you submit your response, please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

The Freedom of Information Act gives the public a right of access to any information held by a public authority, namely, the Board in this case. This right of access to information includes information provided in response to a consultation. The Board cannot automatically consider as confidential information supplied to it in response to a consultation. However, it does have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity should be made public or be treated as confidential.

This means that information provided by you in response to the consultation is unlikely to be treated as confidential, except in very particular circumstances. The Lord Chancellor's Code of Practice on the Freedom of Information Act provides that:

the Board should only accept information from third parties in confidence if it is necessary to obtain that information in connection with the exercise of any of the Board's functions and it would not otherwise be provided
the Board should not agree to hold information received from third parties "in confidence" which is not confidential in nature
acceptance by the Board of confidentiality provisions must be for good reasons, capable of being justified to the Information Commissioner

For further information about confidentiality of responses please contact the Information Commissioner's Office (or see web site at: **http://www.informationcommissioner.gov.uk/**). For further information about this particular consultation please contact Laura Molloy (contact details are shown on page 1).

Produced by:
Performance Management and Service Improvement Directorate
Templeton House, Belfast BT4 2lp

Telephone Personal Information redacted by the USI

www.dhsspsni.gov.uk

September 2009

Received from Anne McVey on 20/06/2022. Annotated by the Urology Services Inquiry.

McVey, Anne

From: DeCourcyWheeler, Richard [redacted]
Sent: 05 October 2009 17:50
To: 'McVey, Anne'; 'Morton, JacquelineT'; Crinion, Lillian
Subject: RE: Urology Review

Dear Anne

Paragraphs 2.16.to 2.19 refer to urology of female incontinence. Recommendation 3 states that 'a separate review of urinary continence services should be undertaken, with a view to developing an integrated service model in line with NICE Guidance.'
This is the vital bit which affects gynaecology and is exactly what we have been talking about when discussing the urodynamics service. There is a large undeclared demand for continence services in the community which will only get bigger as the population ages.

2009 · 05 · 10
Q13 - 1 - 89

Richard de Courcy-Wheeler

-----Original Message-----
From: McVey, Anne [redacted]
Sent: 02 October 2009 00:46
To: DeCourcyWheeler, Richard
Subject: FW: Urology Review

Richard

For information can you advise me if you want to comment re Urodynamics service?

Anne

Anne McVey
Assistant Director of Acute Services - Integrated Maternity and Women's Health Admin Floor, Craigavon Area Hospital
Telephone: [redacted]
E-mail: [redacted]

-----Original Message-----
From: Agnew, Carolyn [redacted]
Sent: 25 September 2009 12:48
To: Centre, Laurels; Age Concern; Ageing Well; Anne Donnelly; anne.mccready [redacted]; SupportGroup, ArmaghTravellers; armaghcarers@hotmail.co.uk; ASCF; barbara_react [redacted]; Austin, Marie; Camilla Reynolds; Cancer Choices; Cara -Friend; Carers NI; Catherine McBennett; CDHN; cloughran [redacted] Community Network Craigavon; Confederation of Com Groups Newry; Contact Youth; costa.network [redacted] Craigavon and Banbridge Carers; Craigreact [redacted] Crossfire Trust; CRUSE; crusemoy [redacted]; crusenewry [redacted]; dermot.magorrian [redacted]; DermotGlackin [redacted] elaine.devlin [redacted]; emma [redacted]; Health Improvement Worker A&D; Health Improvement Worker C&B; Health Improvement Worker N&M; helen.comiskey [redacted]; Help the Aged; info@carers-nm.org; info@equality2000.org; info@lilaccancer.org; isobelholmes [redacted]; kate [redacted]; Foy, Leo; Lennon, Lucille; Donnelly, Lyn; m.caldwell [redacted]; Abraham, Mairead; manager@craigavontravellers.org; martin.oneill [redacted]; maryddct [redacted]; Mencap; Newry & Mourne Carers Association; Newry Rainbow Project; NICMA; Parents Council; Skelly, Louise; patricia [redacted]; paul [redacted]; Pips Upper Bann; Princess Royal Trust for Carers; Rainbow Project; Rural Health Partnership; Rural Support; Cunningham, Stella; SDFHI; Seamus Donnelly; seamus [redacted]; seandooleyfriesian [redacted];

Received from Anne McVey on 20/06/2022. Annotated by the Urology Services Inquiry.

sheenagh.mcnally [redacted]; SHSCC; Sixth Sense; Southern Area Hospice Servicers; Southern Group Environmental Health Committee; springproject@live.com; STEP; Sure Start South Armagh; TADA; thewomenscentre@googlemail.com; Tiny Life; Mathews, Iris; Volunteer Bureau; West Armagh Consortium; WFHI; Williamson Consulting; Wraparound -CAH Task Group; Youth Justice Agency; Zero-8-Teen
Cc: laura.molloy [redacted]; Davidson, Alexis; Carroll, Anita; McVey, Anne; Cardwell, David; Corr, Edel; Youart, Joy; Stead, Lindsay; Carroll, Ronan2; Donaldson, Ruth; Gibson, Simon
Subject: FW: Urology Review

For information

Carolyn Agnew
Head of User Involvement and Professional Lead for Community Development St Luke's Hospital
71 Loughgall Road
ARMAGH
BT61 7 NQ
Tel: [redacted]
Mobile: [redacted]
Fax: [redacted]

Dear all

Please find attached the 2009 Adult Urology Services Review that is now out for public consultation. If you have any comments on the review please fill in the attached questionairre and email back to me. A letter from Mr Compton is also attached.

Many Thanks

Laura Molloy

ID	Directorate	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3191	ACUTE	03/09/2012	Safe, High Quality and Effective Care	62 Day Cancer Performance	Trust fails to meet performance standard due to increase in red flag, capacity issues, inability to downgrade and Regional issues.	Daily monitoring of referrals of patients on the 62 day pathway. Escalations to HoS/AD when patients do not meet milestone on pathway. Continuous communication with Regional with regard to patients who require PET and ITT patients for Thoracic Surgery, 1st oncology appointment. Monthly performance meetings with AD/HoS and escalations of all late triaging	7/10/21- All tumour site pathways continue to have capacity problems throughout due to the ongoing pandemic. Referral levels for majority of tumour sites have continued to increase and are back to pre covid levels and in some instances higher than original volumes. Most tumour sites are affected by limited access to surgery. The trust continues to engage with RPOG and participate in theatre equalisation meetings. There are internal weekly meetings to review cat 2 surgeries and decisions regarding allocation of theatre sessions are made accordingly. Fortnightly cancer check point meetings continue involving MDT leads and senior management, where clinical teams have opportunities to escalate areas of concerns and potential solutions where possible. Fortnightly cancer reset meetings with HSCB are also continued. 20/09/2021- Covid has continued to have a negative impact on the 62 day pathway due to the fact that face to face appointment slots at outpatients and procedure lists such as endoscopy have been reduced in order to comply with IPC precautions. Attempts have been made to negate some of these losses by increasing virtual activity in the form of enhanced triage and virtual clinic appointments. However, the Trusts access to theatres and endoscopy lists has been reduced due to the fact of ICU beds being increased from 8 to 16 beds. Surgical specialties continue to prioritise their cases in line with the FSSA guidance. This is collated weekly and reported monthly to HSCB. 18/08/2021- Access times monitored but high volumes of new patients waiting to be seen at our Respiratory Clinics. Continue to monitor access for bronch. 24/02/2021- cancer access times have increased throughout due to COVID . Fortnightly meetings with specialties and escalated to HSCB. June 2020 Review of risk remains high due to COVID pandemic. Reduction in services due to social distancing and risk of COVID. Clinical space, theatre capacity availability is a challenge across all services. Dec19 Review of same risk remains	HIGH

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Appendix Question 16

2019 · 18 09
Q16 · 105 !

McVey, Anne

From: Trouton, Heather [redacted]
Personal Information redacted by the USI
Sent: 18 September 2019 12:53
To: Carroll, Ronan; McVey, Anne
Cc: Judt, Sandra
Subject: Patient and Client Experience Committe Meeting Sept 2019.pptx
Attachments: Patient and Client Experience Committe Meeting Sept 2019.pptx

Ronan and Anne

Can you please see attached presentation that kate O'Neill is giving at the Patient and Client Experience Committee tomorrow. It is just through today.

I am sure Ronan you have already seen it and Anne I thought as you are representing Melanie and Acute tomorrow , you would want to preview same also.

Kate was asked personally by John NED to present at the committee .

Kind regards
Heather

Reflections on Patient Experience In The Thorndale Unit CAH

The Establishment of Thorndale Unit and its impact on the Patient/Client Experience

Patient and Client Experience Meeting September 2019 K O'Neill Urology Nurse Specialist

Establishment of New Clinic Format

All new referrals are triaged into Red Flag / Urgent / Routine category and appointed accordingly to a New Clinic One Stop clinic. The immediate benefit being a reduction in visits as a result of the majority of investigations performed at this initial appointment

Documentation altered following patient feedback over first few months (arrive with full bladder, expect to be here for few hours)

The patient leaves the clinic with one of the following outcomes:

- Added to a waiting list for a procedure
- Further investigations eg. CT, MRI requested
- Commenced on treatment and with a review plan
- Discharged

Independent Nurse Activity

Many of the procedures are performed independently by the nursing team:

- Flexible Cystoscopy > 1000's
- TRUS biopsy > 800
- Lower Urinary Tract Symptom (LUTS) Clinic
- Complex catheter changes
- Urodynamic Services
- Intravesical treatment for Bladder Cancer
- Injection of Botox into Bladder
- Ongoing revalidation of Consultant review list
- PSA tracking for those with Prostate Cancer
- Virtual clinics
- Nurse Prescribing

Benefits to Staff and Patients

- Opportunities for the Nursing Team to expand their practice (combination of recognised courses and Consultant supervision)
- Allows Consultants to concentrate on more complex decisions/treatments
- Robust process in place for those with suspect cancer
- No formal complaints regarding care provided within the unit, lots of compliments
- New clinic format has been recognised regionally as example of good practice with visits from all other Trusts and DOH representatives
- Awarded Frontline Team of the Year and Overall winner in Trust Excellence Awards in 2016

Notable Improvement in Patient/Client Experience

- The staff are familiar to the patient
- Less visits required throughout investigative/diagnostic process
- All patients with a cancer diagnosis have their care formally discussed at a MDT meeting
- There are protected review slots to receive results
- These patients are assigned a Keyworker who speaks with them, provides site specific information and a contact number
- Engagement with voluntary/charitable organisations - patients are involved in new initiatives such as pre-hab prior to surgery (pilot) and Move More campaigns supported by Macmillan and local agencies
- Improvements have been evidenced through patient feedback via formal Peer Review process, Cancer Patient Experience survey, letters and thank you cards

Challenges as we move forward

Are we achieving our Trust Values?

- Have we come full circle again?
- At present unable to meet the cancer targets
- Not the same government focus on non-cancer surgery (quality of life issues)
- Lengthy waiting lists for inpatient procedures (comparisons to other specialties)
- Multiple attendances at ED for urology related problems e.g. stents and stones
- Recruitment and retention issues (BSO processes lengthy for medicine & nursing)
- Equipment needs
- Service Improvement initiatives
- **If you wish to go fast go alone, if you wish to go far go together!**

Questions???

Appendix Question 21

Best Practice - Best Care

A framework for setting standards, delivering services and improving monitoring and regulation in the HPSS

A Consultation Paper
April 2001

Department of Health, Social Services and Public Safety
An Roinn Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

Contents

Réamhrá

Thug an Coiste Feidhmiúcháin gealltanas i gClár um Rialtas chun creatlach a chur i bhfeidhm a thógfaidh caighdeán na seirbhísí a sholáthar don phobal agus go rachadh sé i ngleic le lag-ghníomhú fud fad na SSSP. Cuireann sé áthas orm an doiciméad a chur os bhur gcomhair ina bhfuil moltaí leagtar amach chun seo a chur i gcrích. Is é an aidhmn atá agam córas cúraim shóisialta agus sláinte ardcaighdeánaí a sholáthar a bhíonn áisiúil agus furasta a úsáid, a fhreastalaíonn ar riachtanais daoine agus a chuireann muinín iontu siúd a úsáideann é.

Molann an doiciméad coras le dul i ngleic le lag-ghníomhú, nuair a tharlaíonn sin, chun cinntiú gur lú na héagsúlachtaí i gcaighdeán an chúraim agus an cóireála a thugtar. Ina theannta seo tógann sé ar a bhfuil déanta go maith sna SSSP agus san am céanna ag aithint go bhfuil gá ann le freagracht agus trédhearcacht agus fócas nua ar ghníomhú.

Rachaidh an chreatlach sa doiciméad seo i bhfeidhm ar gach duine i soláthar seirbhísí sláinte agus sóisialta. Is buneochair páirteachas an úsáideora.

Cuireann na moltaí atá leagtha amach sa doiciméad síos ar an dóigh ar féidir caighdeán na seirbhísí a ardú. Tá sé riachtanach go dtuigeann gach duine a bhfuil páirt aige nó aici an gá le seirbhísí ardchaighdeánacha a sholáthar. Caithfidh an fhoireann barúlacha agus dea-chleachtadh a roinnt agus a bheith freagracht as caighdeán na seirbhísí a sholátharaíonn siad. Léiríonn scileanna na foirne cheana infheistíocht shunstach agus mar sin de is gá le heagraíochtaí an infheistíocht a chothabháil agus an deis a thabhairt dá bhfoireann a scileanna agus a gcleachtadh a fhorbairt.

Tá sé costasach cúram ardcaighdeánach a sholáthar ach tá sé costasach cúram d'ísealchaighdeán a sholáthar chomh maith. Is cur amú airgead é gach punt a chaitear ar athsrúduithe nó ar fhiosrúcháin nó ar mheancóga a cheartú, airgead nach bhfuil ar fáil chun cóireáil ná cúram a sholáthar.

Fáiltím roimh bhur mbarúil ar na moltaí sa doiciméad seo air sin atá mar dhúshraith do thodhchaí ár seirbhísí cúraim.

An Aire Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

Foreword

In the Programme for Government the Executive has given a commitment to put in place a framework to raise the quality of services provided to the community and tackle issues of poor performance across the HPSS. I am pleased to present this consultation paper which sets out proposals to deliver this. My aim is to provide a high quality system of health and social care which is easy and convenient to use, which is responsive to people's needs and which provides a service that instills confidence in those who use it.

This paper proposes systems to deal with under-performance, when that occurs, to ensure there are fewer variations in the standard of care and treatment delivered. In addition it builds on what is already being done well in the HPSS while recognising that there is a need for increased accountability and transparency with a new focus on performance.

The framework proposed in this paper will apply to everyone involved in the provision of health and social care services. User involvement will be a key requirement.

The proposals set out in this paper describe how the quality of services can be improved. It is essential that everyone involved recognises the need to deliver high quality services. Staff need to share ideas and good practice and take responsibility for the quality of services they provide. The skills of the staff represent already a significant investment, therefore organisations need to maintain that investment and provide staff with the opportunity to develop their skills and practice.

Providing high quality care is expensive but poor quality also costs money. Every pound wasted on repeated examinations or investigations, or on correcting mistakes is money that is not available for providing treatment and care.

I welcome your views on the proposals in this paper on what is fundamental for the future of our caring services.

[redacted]
Personal Information redacted by the USI

Minister for Health, Social Services and Public Safety

Executive Summary

Introduction

1. This paper sets out proposals for new arrangements aimed at providing high quality services in the HPSS. The many medical, professional and technological advances and increased public expectation of the standards of services delivered, make it vital that the HPSS is modernised and improved in the future to enable it to provide a fast, effective high quality service. The proposals in this paper aim to put in place new arrangements which will do just that. These proposals are for public consultation.

Proposals

2. The proposals in this document centre on:
   - setting standards - improving services and practice;
   - delivering services - ensuring local accountability; and
   - improving monitoring and regulation of the services.

Setting standards - improving services

3. In order to ensure that standards are applied in a consistent manner throughout the HPSS and to reduce unacceptable variations in care provided, it is considered essential that a single more focussed approach is taken on the development and dissemination of standards and guidelines for the HPSS. Three options are offered for consideration.

   - **Option One:** establish an independent body to research and appraise the evidence of new drugs and technologies or existing procedures based on priorities within the HPSS.
   - **Option Two:** establish an internal body within the Department to carry out research and appraise the evidence on new drugs and technologies or on existing procedures in line with identified priorities for the HPSS.
   - **Option Three:** the Department would make arrangements with other standard setting bodies e.g. NICE and SCIE, whereby the Department would have early warning of the standards and guidelines to be produced. In addition the Department would act as a filter for the standards and guidelines emanating from NICE and SCIE.

Executive Summary

Setting Standards - improving practice

4. Investing in the workforce is crucial to the provision of high quality services. Many initiatives are ongoing at present to promote continuous professional development through lifelong learning and through strengthening professional regulation. The framework proposed in this paper will bring together these various initiatives so that they can be managed and monitored within one framework for improving the quality of services.

Delivering Services - ensuring local accountability

5. It is proposed to introduce a system of clinical and social care governance, backed by a statutory duty of quality and supported by continuous professional development.

6. The introduction of clinical and social care governance will mark a major change for the HPSS. Governance arrangements are already in place to ensure overall probity, transparency and adherence to public service values. Clinical and social care governance, backed by a statutory duty of quality will mean that for the first time Health and Social Services Boards and HSS Trusts will have to place the provision of high quality services to the forefront of their statutory duties in the same way they must currently adhere to statutory financial duties.

7. A system of clinical and social care governance will bring together all the existing activity relating to the delivery of high quality services for example, education and research; audit; risk management and complaints management.

Improving monitoring and regulation of services

8. This paper proposes that an independent means of monitoring the delivery of services should be introduced. In addition, it is proposed to extend and improve the range of social care services currently regulated. It is also proposed to improve current regulation of private and voluntary healthcare services and to extend that regulation to cover a wider range of services delivered by that sector.

Executive Summary

Proposals to monitor the delivery of services

9. It is proposed to monitor the delivery of services through the introduction of a new independent body - a Health and Social Services Improvement Authority. This body would carry out independent reviews of clinical and social care governance arrangements in Health and Social Services Boards and HSS Trusts and would also carry out investigations where significant or persistent problems occur.

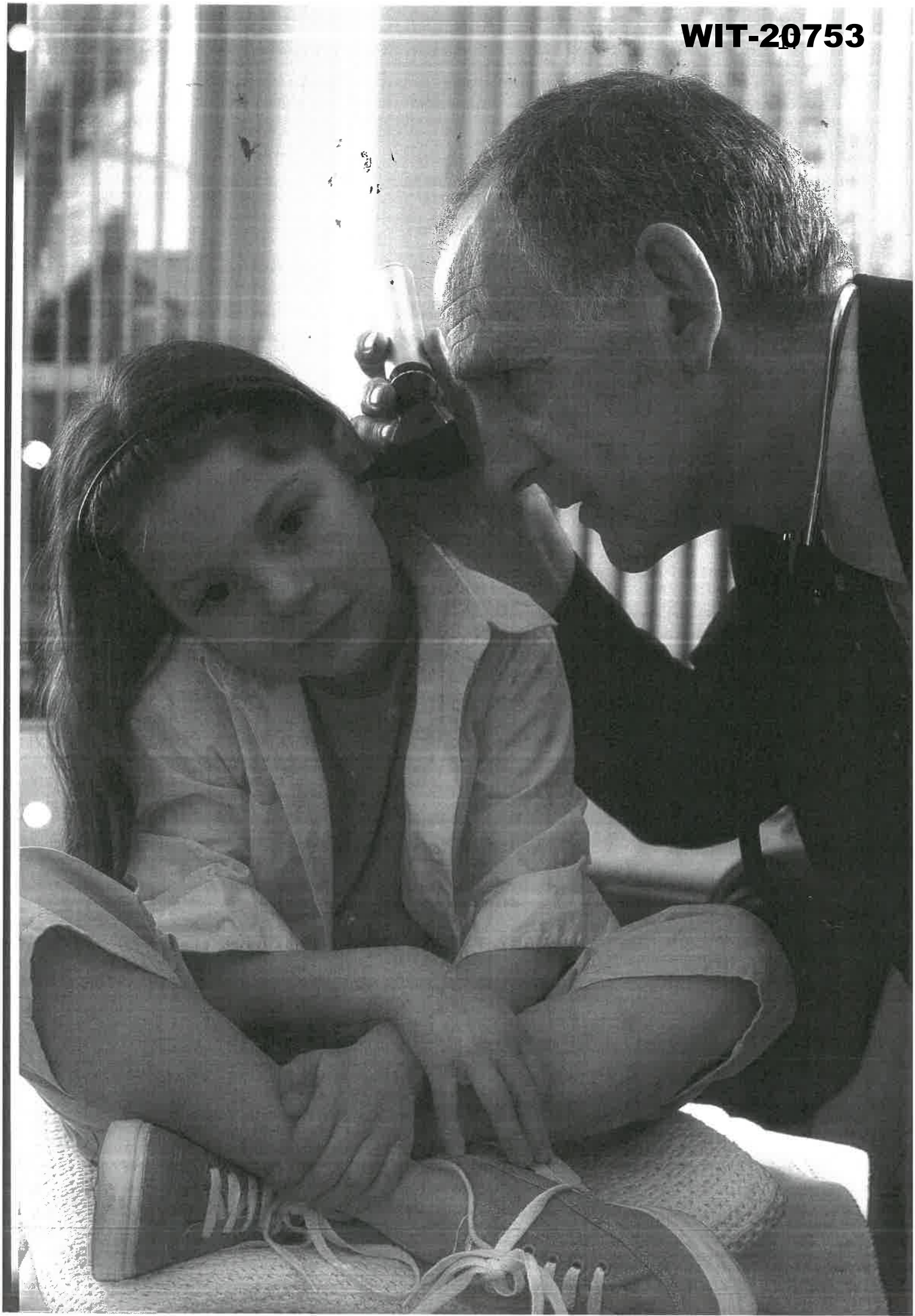
Proposals to extend and improve the regulation of services

10. It is proposed to extend and improve the regulation of services to cover: statutory homes, homes covered by Charters and Acts of Parliament, small residential homes for adults, day care for adults, supported accommodation, nursing agencies, schools with boarding departments, the private and voluntary healthcare sector and agencies providing domiciliary care, fostering, adoption, services for Under 12s and nursing home care.

11. To discharge this more comprehensive regulation of services it is proposed that a Northern Ireland Commission for Care Services be established. This body would take over responsibility for the work currently carried out by the Registration and Inspection Units within the four Health and Social Services Boards; register and inspect a wider range of care services including the private and voluntary healthcare sector and where necessary take appropriate enforcement action to ensure standards are improved.

Equality Issues

12. During the consultation process, the Department will pay particular attention to the equality aspects of its proposals. It will make a special effort to obtain views from representatives of the nine categories specifically identified in the equality legislation.



About this paper

1.1 Securing more responsive, caring public services which strive towards excellence is at the heart of the commitment in the Programme for Government. Raising the quality of health and social services and tackling under-performance within the HPSS will require a concerted effort on the part of everyone involved in the HPSS.

1.2 Quality means the provision of high standards of care and treatment, given by the right person at the right time and in the appropriate setting. This paper sets out the Department's proposals for a framework designed to modernise and continuously improve the delivery of health and social care services. The paper suggests a framework consisting of three strands:

- setting standards - improving services & practice;
- delivery of services - through increased accountability at local levels; and
- monitoring performance, and improved regulation of services.

How to Respond

1.3 Comments on the proposals in this paper can be sent by e-mail or in writing to the address shown at the end of this Section. Unless otherwise requested, it will be assumed that responses are not intended to be confidential.

Timescale for Response

1.4 The closing date for receiving comments on this paper is 18th July 2001.

Additional Copies and Accessible Versions

1.5 The consultation paper is being widely circulated to key interest groups and will be available in libraries and on the Department's website. The Department will make the document available in audio tape, Braille, Irish and Cantonese. The Department will also consider requests for translations into other minority ethnic languages.

1 About this paper

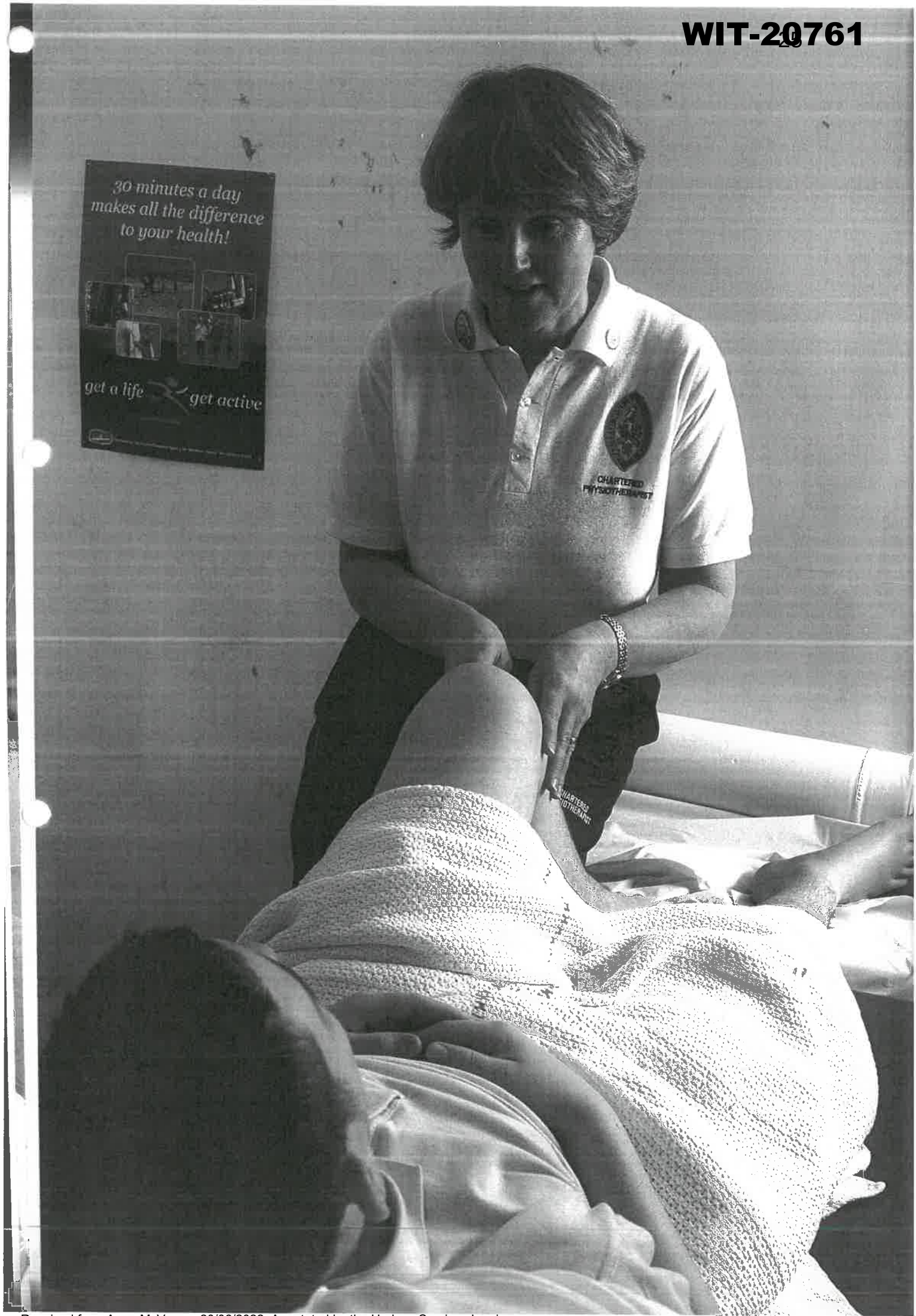
What Happens Next?

1.6 Following the consultation period all the responses to the paper will be analysed. A separate report summarising the views expressed during the consultation will be published for information. The Minister for Health, Social Services and Public Safety will take decisions on the issues raised in this paper, taking account of the views expressed during the consultation exercise.

Contact Address

1.7 Quality & Performance Improvement Unit
Department of Health, Social Services & Public Safety
Room 118B
Dundonald House
Stormont
Belfast
BT4 3SF
Email address: quality.consultation@dhsspsni.gov.uk

Telephone: 028 9052 4310



Focusing on quality

2.1 Every year our hospitals provide over a million outpatient treatments. There are half a million admissions to hospital or day procedure clinics every year. Every day, 30,000 people see a doctor or a practice nurse. Every working day 120,000 people will visit a community pharmacy. In an average year, over 180,000 people will have contacted social services and more than 24,000 older people will be supported in their own homes.

2.2 The vast majority of people who need health or social care services are dealt with quickly and effectively. However some are dissatisfied with the way the service deals with them. Higher public expectation in the HPSS along with rapid advances in medicine, technology and in professional practice along with changing demography, mean that the HPSS has to modernise and improve in the future to enable it to provide a fast, effective high quality service.

2.3 Added to this is the new environment of local democratic control within which all public services now operate. The Programme for Government contains a clear commitment to raise the standard of public services. The Executive will be held to account for the commitments given in the Programme for Government. In parallel with the political changes, major developments have taken place in the NHS in England, Wales and Scotland which are aimed at raising the standard of services provided. There are now expectations in the HPSS that no less emphasis will be placed on the drive to raise the quality of services here.

2.4 As well as a need to modernise the HPSS there is also a need to ensure that unacceptable variations in the standards of care and treatment delivered are addressed. Recent events have shaken the public's confidence in our services. The revelations about organ retention and the Bristol enquiry[1] into the deaths of babies following heart surgery have highlighted shortcomings in hospital services, while the Shipman case[2] has underlined the need for closer scrutiny of general practice.

1 Public inquiry into Paediatric Cardiac Surgery Services at Bristol Royal Infirmary

2 Harold Shipman's Clinical Practice 1974-1993 - A Clinical Audit, CMO, DoH(L) ("The Baker Report") in addition an independent inquiry into the Shipman Case commenced on 31st January 2001.

2 Focusing on quality

2.5 There is no room for complacency in the HPSS. Similar incidents can happen here. The McLernon case[3] drew attention to the need to enhance and improve professional practice in assessment and care management arrangements to secure the continuity of care within and between primary, secondary and community sectors. In addition many people have to wait too long for their treatment or care. The experience of many is still of a disjointed and impersonal service which puts the needs of the organisation before the needs of individuals.

2.6 The challenge now facing the HPSS is to guarantee a standard of service that the public can expect no matter where they go for treatment or care. This challenge must be met head on with a co-ordinated approach to the raising of standards and robust accountability arrangements to ensure that those standards are met.

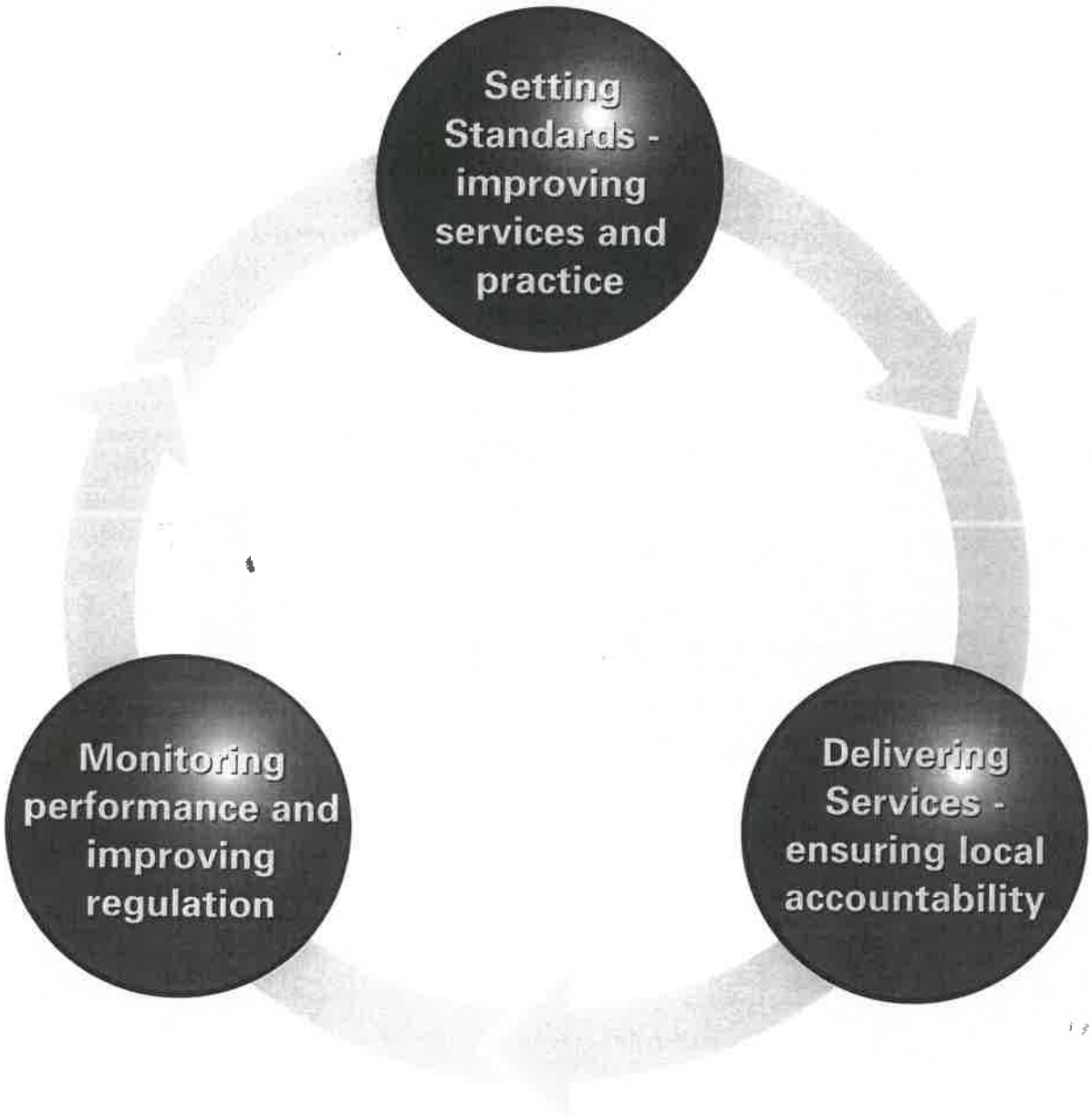
2.7 The starting point must be the development of staff who provide the services. A highly trained, competent and confident workforce is fundamental to securing the delivery of high quality services. The HPSS is one of the largest employers here with a total workforce of approximately 60,000. The skills of the staff represent already a significant investment for the benefit of the community. The great majority of these staff are highly motivated and continually strive for higher standards, despite the fact that demands and pressures on services have been rising inexorably. It is crucial therefore that we continue to invest in staff and enable them to develop their skills and expertise.

2.8 As well as supporting staff to continually develop their skills and knowledge it is essential that there are in place systems to monitor how the organisation and individuals are performing. It is only by establishing a full picture of what is being done well, and what falls short of this, that changes can be made and services improved.

2.9 This document proposes a framework which aims to improve quality in order to provide reassurance to those

3 "Community Care From Policy to Practice" - the Case of Mr Frederick Joseph McLernon (deceased), SSI, September 1998

Focusing on quality



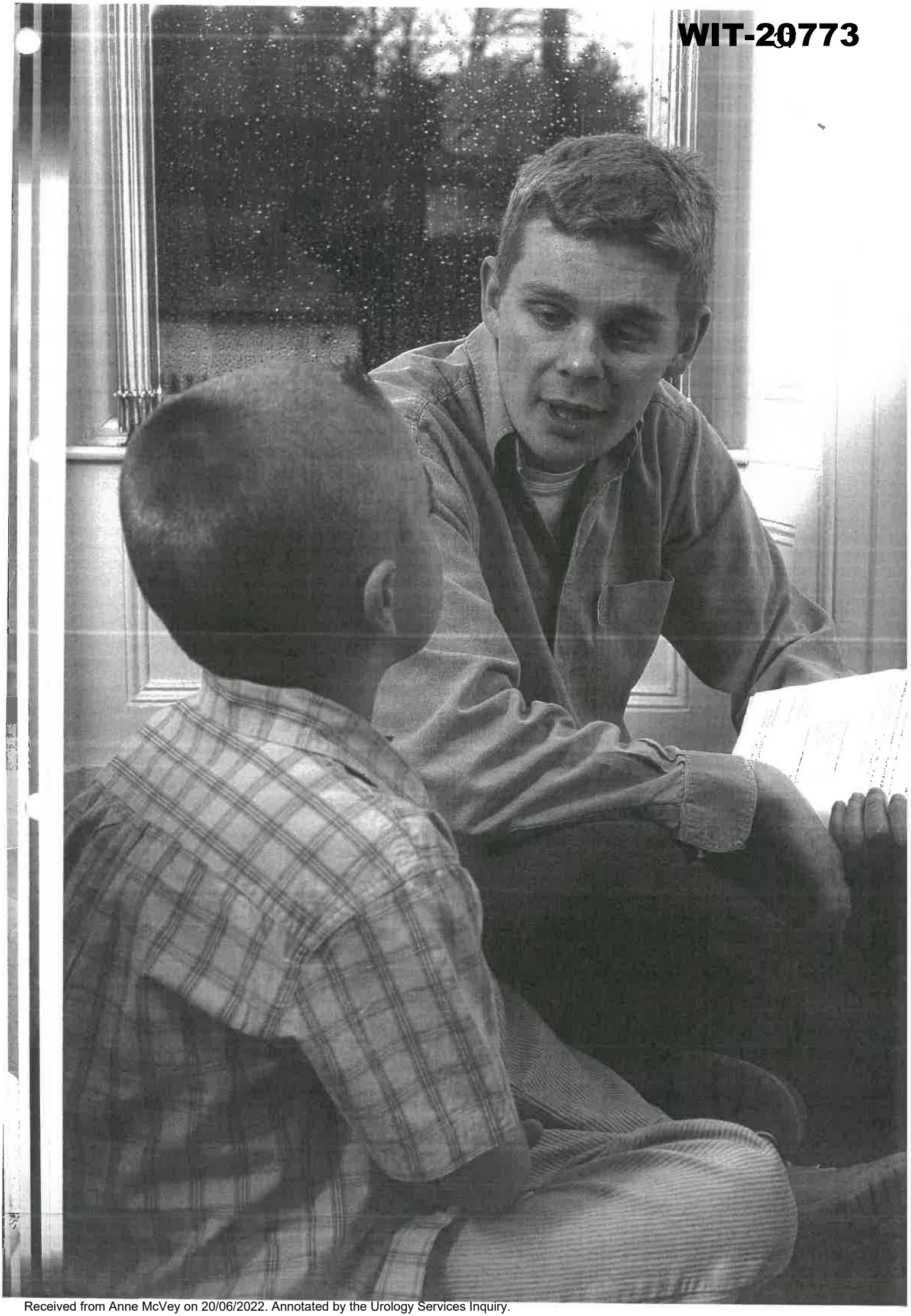
who use the services that they will receive high standards of care and treatment wherever or however they are treated. The framework applies to everyone who works in, commissions and delivers services. Everyone must become involved in developing and nurturing a culture and environment where quality always comes first.

2.10 Those who use the service can bring valuable knowledge of how their local services are actually performing and how they would like to see services shaped in their local area. Through the greater involvement of the community in the planning, delivery and monitoring of services, the HPSS should aim to improve the quality of the services it provides.

2.11 The framework proposed in this paper centres on three interlocking strands. Each strand, while easily identified in its own right can only work to maximum effect if the other two strands are fully implemented. They are:

- setting standards - improving services and practice;
- delivering services - ensuring local accountability; and
- monitoring performance and improving regulation.

2.12 The delivery of high quality services using consistent standards, based on sound research and best practice, delivered by a competent and confident workforce will go some way in providing the public with access to a uniform standard of high quality health and social care. It is recognised that many HPSS organisations have been putting in place arrangements to raise the quality of services they deliver. These organisations are to be commended for their attempts to raise standards and provides further proof of the commitment of staff within the HPSS. It is important, however, that there is a comprehensive and uniform approach to raising the standard of services delivered. The proposals within this document should now build on the arrangements already in place in some organisations and enable all HPSS organisations to work within a single consistent framework for raising standards.



Setting Standards - Improving Services

3.1 Much work is underway to ensure high standards of care in the HPSS, through continuous professional development and strengthened professional regulation. There are still, however, many gaps and inconsistencies in the way standards and guidelines for services are produced and applied here. A more co-ordinated and structured approach is needed. Providing the HPSS with clear, consistent, evidence based guidelines and standards, which can be incorporated into standards for service delivery will improve outcomes for users. A structured approach to these developments would include for example, consideration of HPSS priorities, clinical and social care governance implications and the views of local professionals and lay people here in addition to the standards set by professionals.

3.2 This means identifying and reducing unacceptable variations in the delivery of services and ensuring the best use of resources to achieve the greatest benefit for all. To accomplish this, standards and guidelines must be based on:

- robust research and evidence of good practice;
- the effectiveness of care and treatment (including cost effectiveness);
- the experience of HPSS professionals and managers;
- the values and experience of the people receiving and using the services; and
- the requirements of legislation.

3.3 It is proposed therefore that standards and guidelines for the HPSS should be provided through:

- the introduction of service development frameworks; and
- the provision of a single, easily accessible source for producing and disseminating standards and guidelines for services.

Service Development Frameworks

3.4 Consideration is being given to the introduction of service development frameworks. Service development

frameworks would cover the whole system of care for a particular service and provide a holistic approach to planning, delivery and monitoring of services. Service development frameworks would spell out where care is best provided e.g. in a primary care setting, in hospital or in a specialist unit. They would set the standard of care that people should be offered in each setting and establish performance measures against which progress within agreed timescales will be measured.

3.5 Service development frameworks will take time to develop and will focus on the main priorities flowing from the Programme for Government. The framework for cancer services[4] here is an example of how a service has been remodelled using a service framework approach.

Questions for consultation

? Do you consider the service development framework approach should be introduced for the HPSS?

? How can user involvement be best secured in the development of service development frameworks?

? What services could be considered for development using a service framework approach?

A single, easily accessible source for the production and dissemination of guidelines and standards for services

3.6 Currently there is no single focus for the production and dissemination of service guidelines or standards for health and social services. Up until recently guidelines and standards for clinical and social care were developed by a range of bodies across Great Britain and here. These include professional and regulatory organisations and Social Services Inspectorates. Locally, the Clinical

4 Cancer Services - Investing for the Future. Report of the Cancer Working Group. DHSS 1996.

Resource Efficiency Support Team (CREST) and the Regional Multi-professional Audit Group (RMAG) contribute to this work.

3.7 These guidelines related to areas such as standards for good practice and cost effectiveness in health and social care services. Areas covered included guidelines from particular conditions or circumstances as well as guidelines on new health technologies such as new medicines, devices and products. Many of these guidelines were produced on a reactive basis rather than on a planned agenda flowing from the priorities within the HPSS, knowledge of forthcoming new health technologies and a systematic approach to the identification of gaps.

3.8 In England and Wales, recognising that guidelines and standards emanating from so many different sources can lead to variations in care, the National Institute for Clinical Excellence (NICE) was established on 1st April 1999. A similar body - the Social Care Institute for Excellence (SCIE) - for social care services is being established later this year for England and Wales.

National Institute for Clinical Excellence (NICE)

NICE covers the NHS in England and Wales. Its functions are to:

* promote clinical and cost effectiveness and audit through guidance to support front line staff;
* advise on best practice in the use of existing treatment options;
* appraise new health interventions such as newly developed drugs, devices and procedures and advise the NHS on how they can be implemented and how best they might sit alongside existing treatments.

NICE involves professionals, patients, carers and NHS service interests. It works to a programme agreed and funded by the Department of Health, in conjunction with the National Assembly for Wales. NICE brings together work such as the National Prescribing Centre appraisals and bulletins; the effectiveness bulletins produced by the NHS Centre for Reviews and Dissemination at York University; The National Centre for Clinical Audit has also come under the umbrella of NICE.

3 Setting Standards - Improving Services

Social Care Institute for Excellence (SCIE)

SCIE will cover social care services in England and Wales. Its functions will be to:

* pull together information about good practice in social care;
* assess social work practice through service reviews or research;
* issue guidance on good practice for the services.

SCIE will work closely with NICE, taking account of the views of users and carers, research evidence, findings from inspections, joint reviews and other sources of good practice.

Proposals

3.9 The absence of a single focus here for the production and dissemination of clear consistent guidelines for the HPSS is already leading to uncertainty. As a result it is likely to lead to variations in the standards of services. Added to this is the need to ensure that the HPSS knows how to handle guidelines and standards emanating from NICE, SCIE and other standard setting bodies.

3.10 It is proposed that the HPSS should receive clear consistent guidelines from a single source. In judging what is the most appropriate way to produce guidelines and standards it is considered that any local arrangements should:

- minimise bureaucracy and not involve the establishment of new public bodies unless absolutely necessary;
- avoid "re-inventing the wheel";
- provide for a single, easily accessible source of guidelines and standards;
- utilise the range of expertise within the HPSS and elsewhere;
- promote a multi-disciplinary approach to the production and dissemination of standards and guidelines;
- ensure standards and guidelines are endorsed and promulgated in a timely manner;
- be sensitive to issues specific to the HPSS e.g. integration of health and social care services and challenges to viability of specialist services;
- be aware of local views of users;

- be able to respond rapidly to any emergency need for guidance and
- provide the mechanism to produce standards which will form part of service development frameworks.

3.11 The following options are offered for consideration:

- **OPTION ONE**: establish an independent body to research and appraise the evidence of new drugs and technologies or existing procedures and services based on priorities for the HPSS - to replicate much of what NICE and SCIE and other standard setting bodies are producing;
- **OPTION TWO**: establish an internal body within the Department to carry out research and appraise the evidence on new drugs and technologies or on existing procedures in line with identified priorities for the HPSS - replicate much of what NICE and SCIE and other standard setting bodies are producing;
- **OPTION THREE**: the Department would make arrangements with the standard setting bodies e.g. NICE, SCIE whereby the Department would have early warning of the standards and guidelines being produced. In addition the Department would act as a filter for the standards and guidelines emanating from NICE, SCIE and other standard setting bodies.

OPTION ONE

3.12 Option One would entail the establishment of a new independent body with its own staff, budget and a board of directors, drawn from the HPSS (including Research & Development Office), lay and user fields. This body would be seen to be operationally more independent than either Option Two or Three and this model would ensure that the focus remains on producing and disseminating standards and guidelines.

3.13 It is clear that this option would involve substantial costs. It is also doubtful if the HPSS, due to its size would have the relevant expertise and access to the relevant interests that would need to be represented on such a body, to replicate the research and production work involved in producing standards and guidelines. There is a danger, that under this Option the HPSS would lose access to the wide range of expertise available in England, Scotland and Wales. There is also the possibility that the production and dissemination of standards and guidelines would be considerably delayed under this Option. It is considered a waste of resources to seek to replicate the research and appraisal of evidence that will have already been undertaken by a much larger body such as NICE or SCIE.

OPTION TWO

3.14 Under this Option an internal body within the Department would replicate many of the standards and guidelines emanating from both NICE and SCIE. The research and appraisal of the evidence on new drugs, technologies and existing procedures would be undertaken by the internal body. The independence of this body would not be as apparent as for Option One, however the focus would remain as for Option One on producing and disseminating standards and guidelines.

3.15 A considerable number of experts and lay interests would need to be represented on the board of such an internal body. As for Option One this would involve substantial costs and again it is doubtful if the HPSS would have the relevant expertise and access to the relevant interests that would need to be represented on the internal body. As for Option One there is a danger of losing access to the wide range of expertise available in the other three countries and there is a possibility of delays in producing and disseminating the standards and guidelines to the HPSS under this Option.

Setting Standards - Improving Services

OPTION THREE

3.16 Under Option Three it is proposed that the Department would seek to secure arrangements with NICE, SCIE and other agenda setting bodies to ensure early access to and indications of the programme of work for these bodies. In this way the Department would be in a position to filter the standards and guidelines through to the HPSS, having had an opportunity to consider their applicability to the HPSS. To provide for an easily recognisable source for these guidelines it is suggested that the Department would provide the vehicle for filtering the guidelines and standards to the HPSS through an internal mechanism known as the HPSS Standards Board.

3.17 It is envisaged that the majority of guidelines and standards emanating from NICE, SCIE and other standard setting bodies would generally be applicable for use within the HPSS. However, the HPSS Standards Board would as the need arises, be able to produce or commission specific guidelines for the HPSS, or adapt NICE, SCIE or other guidelines for use in the HPSS, as appropriate. When commissioning specific guidelines for the HPSS or adapting NICE or SCIE guidelines, the HPSS Standards Board would constitute a group of relevant expertise, including user representatives to develop the required standards and guidelines.

3.18 Under this Option the costs involved would be kept to a minimum. Any arrangements with bodies such as NICE and SCIE would involve costs and there would be administrative costs within the Department. In addition, if a group of experts were commissioned to produce specific guidelines and standards, funding would be required. Guidelines and standards would be disseminated quickly to the HPSS as the early indication of the standards and guidelines to be produced by NICE, SCIE and other bodies would allow the Department to consider the applicability of such standards and guidelines for the HPSS in advance of them being disseminated from NICE or SCIE etc.

3 Setting Standards - Improving Services

Preferred Option

3.19 The preferred option for the production and dissemination of guidelines and standards for the HPSS is Option Three. Taking account of the parameters set at paragraph 3.10, it is considered that this Option best reflects what would be required of any local arrangements.

3.20 Clearly any arrangements introduced for the HPSS will have an impact on the current role of the Clinical Resource Efficiency Support Team (CREST) and the Regional Multi-professional Audit Group (RMAG). Obviously the provision of a single source for the production and dissemination of standards and guidelines will reflect some of the work currently undertaken by these groups. Your views are sought on how the work of these groups can best be progressed under any new local arrangements.

Questions for consultation

? Does there need to be a local focus to disseminate and produce guidelines and standards for the HPSS?

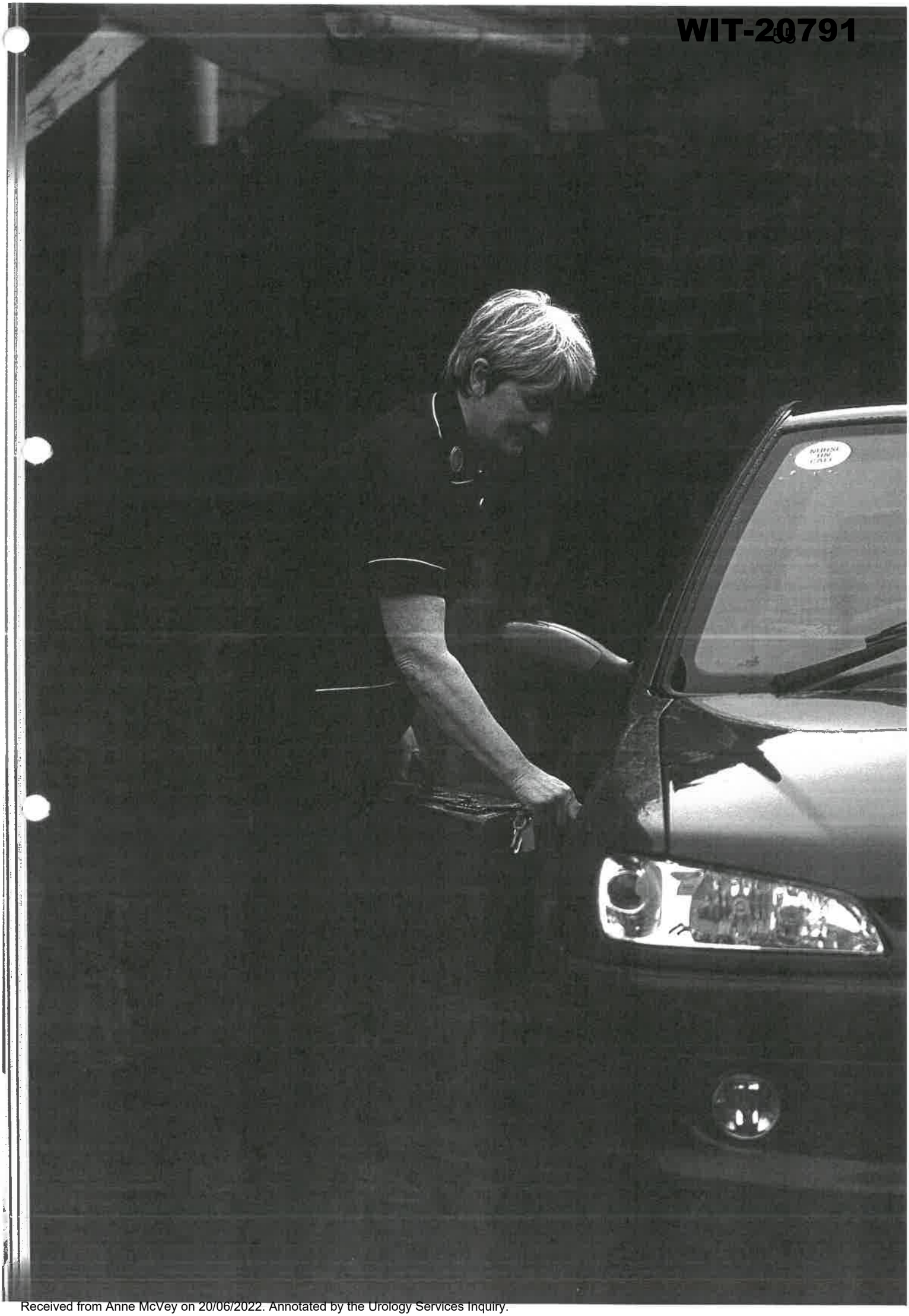
? Do you agree with the parameters set out at paragraph 3.11? Are there any others which have not been included?

? What are your views on the options - are there any other options which should be considered?

? Do you agree that Option Three best reflects the parameters set for a local arrangement?

? How can users best be represented on any group set up to produce specific standards and guidelines for the HPSS?

? Any option considered will have an impact on the current role of the Clinical Resource Efficiency Support Team (CREST) and Regional Multi-Professional Audit Group (RMAG). Should the work of these bodies be linked to the local arrangements or should they be retained as self-standing groups? Taking account of the parameters set for the local arrangements what future role do you see for CREST and RMAG?



Setting Standards - Improving Practice

4.1 It is essential that the workforce has the opportunity to keep up to date with best practice and develop their skills. This can only happen in a culture where sharing information and best practice is a normal part of everyday life.

Continuous Professional Development

4.2 The concept of Continuous Professional Development (CPD) or lifelong learning is not new. CPD is already providing opportunities for staff to develop their skills and improve the quality of services they deliver. The aim of CPD is to promote lifelong learning and development in individuals and teams and ensure that they remain up to date and competent to practice. It applies to all those who work in the HPSS, both professionals and non-professionals. For professionals it may also be a requirement to maintain registration. CPD is a key building block to supporting quality improvements in practice. The Department, employers, professional bodies and service users all have interests in the provision and promotion of CPD.

4.3 The Department wants to see the same standards of practice applied to everyone who uses the HPSS no matter where they live. Employers have a substantial investment in the skills of their staff which they would seek to maintain and improve. Professional bodies want to assist their members in retaining the necessary skills required for the job and service users need to be assured that their care and treatment is up to date and effective and that it is provided by those whose skills have been kept up to date.

What does CPD mean?

4.4 CPD is the systematic maintenance, improvement and broadening of knowledge and skill and the development of personal qualities necessary for the execution of professional, technical or other duties throughout the individuals working life. This means that for an individual

to work properly, the systematic acquisition of knowledge, skills and personal qualities is essential. In addition, once acquired, the same knowledge, skills and personal qualities must be methodically kept up to date to maintain them at an adequate level. They must then be developed and broadened.

CPD and the Individual

4.5 CPD is essentially about individuals, their development needs and what they are doing to achieve them. Individuals are ultimately responsible for managing their own CPD, although most people have obligations to employers and professional bodies. The CPD cycle places responsibility on the individual to identify their own learning needs and decide on how best to meet these needs. They should then identify how learning might take place to meet these needs, record these activities and evaluate the effectiveness of the CPD intervention. Following evaluation they must then identify any additional training needs, thus commencing the CPD cycle again.

4.6 CPD is not just about courses or qualifications. CPD includes a wide variety of activities which lead to learning and development. These include open learning, private study, work experience and many more.

CPD within Organisations

4.7 For organisations, CPD is about the identification of staff needs, taking account of organisational development and facilitating achieving those personal and professional needs and development of all the organisation's staff. Employers should provide support to individuals by developing procedures which support CPD; providing development opportunities (particularly those that can be experienced in-house); assisting with resources and expertise and by giving positive encouragement and recognition. This does not need highly formal and inflexible systems. It can happen in other ways. It can

result from shared experiences between members of staff or the development of an individual's leadership skills following a well considered delegation of authority and responsibility. It might even result from undertaking a challenging new task. A successful CPD system is a reflection of the enthusiasm of those operating, participating in and supporting it.

Strengthening Professional Regulation

4.8 CPD will help develop staff to enable them to deliver higher quality services. In addition to CPD a number of initiatives are currently taking place with the aim of improving standards of professional practice. These initiatives will further support the concept of staff development and learning through strengthening professional regulation. Current initiatives are detailed below.

General Medical Council Proposals

4.9 The vast majority of doctors are competent and conscientious. However the current systems of medical regulation do not give the public sufficient confidence that poorly performing doctors are being identified and early action is being taken to protect patients.

4.10 The proposals for revalidation - the regular demonstration by doctors that they remain fit to practice, are part of the response to concerns raised. Proposals for a comprehensive revalidation model are being drawn up at present and legislation will then be required to make participation in revalidation mandatory. Legislation will apply here as well.

Confidence in the Future - a consultation document on the prevention, recognition and management of poor performance of doctors in Northern Ireland

4.11 In October 2000 the Department issued the consultation document "Confidence in the Future - for patients and for

doctors". The overall aim of the proposals in this document is to create a supportive environment within which all doctors are able to practice, and one in which the vast majority of doctors will be able to explicitly demonstrate their high level of clinical practice.

4.12 This will be achieved through such things as:

- the introduction of a compulsory and comprehensive system of professional appraisal;
- the participation of all doctors in clinical audit;
- participation of all doctors in programmes of continuing medical education (CME), and continuing professional development (CPD);
- comprehensive induction programmes for all new staff;
- clear guidance and appropriate supervision from senior doctors for all doctors in training;
- proposals to review and strengthen occupational health services for all doctors; and
- by recording adverse events from which doctors can learn to prevent similar occurrences in future.

Strengthened regulation of Nursing, Midwifery and Health Visitors

4.13 The recommendations made following an independent review of the UK wide legislation regulating the nursing, midwifery and health visiting professions resulted in the proposal to establish a new Nursing and Midwifery Council to replace the United Kingdom Central Council (UKCC) and the four National Boards.

4.14 The new Council will have increased lay and user involvement and will be responsible for setting and monitoring standards of professional training, performance and conduct. It will also have wide powers to deal with nurses and midwives who present unacceptable risk to patients.

Proposals aimed at supporting the education, practice and performance of Nurses, Midwives and Health Visitors within the HPSS

4.15 A Project Board chaired by the Chief Nursing Officer has been established to consider the needs and opportunities for improved structures to develop nurse, midwife and health visiting education, practice and performance.

4.16 The Project Board carried out a three month consultation exercise proposing the creation of a new local body to support the initial and ongoing education, practice and performance of nurses, midwives and health visitors with the primary purpose of enhancing the quality of care provided to patients and users. Following the consultation process, work is now underway to implement the proposals.

Strengthened Regulation of the Professions Allied to Medicine

4.17 Following an independent review of the UK wide legislation regulating the Professions Allied to Medicine, proposals were formulated on the establishment of a new Health Professions Council. The proposals, which have been the subject of extensive consultation, will strengthen professional regulation to make public protection paramount, by increasing lay involvement to balance professional interest.

4.18 The new Council will have powers to tackle poor professional conduct and performance and will have streamlined procedures to ensure fitness for practice including quality assurance of professional training. The proposed new Health Professions Council will have scope to regulate professions which are not regulated now.

The Northern Ireland Social Care Council

4.19 The Northern Ireland Social Care Council (NISCC) is being established from 1st October 2001. It will have two key

responsibilities - to register and regulate the social care workforce and draw up codes of practice both for social care workers and their employers; and to ensure that staff are properly trained and qualified to do their jobs. The functions of Central Council for the Education and Training in Social Work (CCETSW) will be transferred to the Northern Ireland Social Care Council as will the functions of the Training Organisation for Personal Social Services (TOPSS). This should ensure that education, training and qualifications are to a high standard, fit for their purpose and meet the needs of the social care workforce.

4.20 A recent review of the professional training within social work has recommended improvements for the reform of social work professional training. The Department issued "Reforming Professional Social Work Training" for consultation on 24th November 2000. The document is consulting on seven key areas for reform.

Strengthened Regulation of the Pharmaceutical Profession

4.21 The practice of pharmacy and, in particular, the control of medicines is highly regulated. Nevertheless, to provide added assurance to the public in regard to professional competency to practise, further regulatory powers are envisaged to maintain and enhance the quality and safety of pharmaceutical services.

4.22 The scope of the provision made in the HPSS Act (Northern Ireland) 2001 allows for further legislative powers to be made pertaining to for example:

- the education and training requirements before and after admission to practice;
- standards of conduct and performance;
- discipline and fitness to practice; and
- investigation and enforcement.

Strengthened Regulation of the Dental Profession

4.23 The General Dental Council (GDC) has a statutory responsibility to promote high standards of dental education and has long favoured mandatory continuing

education. A preparatory scheme was introduced on 1st October 2000 and a statutory scheme commences on 1st January 2002. It will be phased in over a three year period according to the date of registration of the dentist. Legislation which will apply equally here is being prepared presently.

Summary

4.24 These regulatory mechanisms provide important and powerful assurance controls at practitioner level and will help to improve professional standards and ultimately the quality of care that people get. Continuous professional development and strengthened professional regulation will help to assure the public that those who are providing the services on which they depend are competent and reliable.

4.25 Building on the current developments in CPD and professional regulation and placing them within this framework will ensure a consistent approach to quality which can be managed and monitored within one single framework. CPD and professional regulation will be key building blocks in raising standards of services.

Delivering Services - Local Accountability

5.1 Governance arrangements are already in place in HPSS bodies to ensure overall probity, transparency and adherence to public service values. It is vital that comparable arrangements are in place to guarantee the delivery of high quality services. The production and dissemination of guidelines and standards for services, revising and strengthening standards for professional practice and the workforce and ensuring that staff are appropriately educated, trained and supported to help them deliver to the required standards will help to ensure higher quality services.

5.2 Placing responsibility for the standard of services delivered on local organisations will provide a guarantee that standards are being applied consistently throughout the HPSS. A system of local accountability will help the HPSS to continuously improve the quality of their services and safeguard high standards of delivery.

Proposals

5.3 It is therefore proposed to introduce a system of clinical and social care governance, underpinned by a statutory duty of quality and backed by continuous professional development and other training programmes.

What does clinical and social care governance mean?

5.4 Clinical and social care governance is about organisations taking corporate responsibility for performance and will provide guarantees for the standards of clinical and social care. It is the framework within which HPSS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment.

5.5 Clinical and social care governance will help those planning and delivering services to identify and build on good practice; to assess and minimise risk of untoward

events; to investigate problems as they arise and to ensure that lessons are learnt. It will also help professionals by ensuring that lifelong learning through continuous professional development is addressed by and within their organisation.

5.6 A system of clinical and social care governance which is simple to use and easily understood will help to identify areas where improvements can be made and where there are risks, that these can be easily identified and reduced. In addition such a system should set in place procedures to identify and rectify poor practice e.g. through increased awareness of proper procedures or additional training. Such a system will also offer reassurance to the public that checks are in place to ensure that they receive the highest standards of care and treatment.

5.7 A system of clinical and social care governance will build on and strengthen existing activity relating to the delivery of high quality care and treatment. This includes activity on:

- education and research;
- continuing professional and personal development;
- professional regulation and learning lessons from poor performance;
- quality standards;
- audit;
- risk management;
- complaints management;
- clinical effectiveness;
- effectiveness in social care services in meeting identified needs; and
- evidence-based practice.

5.8 The system of clinical and social care governance is designed to bring all of these components together and to secure a co-ordinated approach to the provision of high quality care and treatment, while ensuring a greater focus on the standard of clinical and social care practice.

Delivering Services - Local Accountability

Duty of Quality

5.9 To strengthen the clinical and social care governance systems it is proposed to introduce a statutory duty of quality on Health and Social Services Boards, HSS Trusts and those Special Agencies which provide services directly to users e.g. The Northern Ireland Blood Transfusion Agency. The duty of quality will place a statutory requirement on these bodies *to put and keep in place arrangements for improving and monitoring the quality of health and social care services* ***they provide directly*** *to individuals.* That is, they will have to put and keep in place a system of clinical and social care governance.

5.10 Clinical and social care governance systems backed by a statutory duty of quality will mean that each Health and Social Services Board, HSS Trust and where appropriate, Special Agency will have to establish clear lines of responsibility and accountability for the overall quality of care and treatment provided. Health and Social Services Boards, HSS Trusts and Special Agencies will be required to prepare regular reports for their boards and report annually on quality. This will mean that for the first time, Health and Social Services Boards, HSS Trusts and Special Agencies will have to place the provision of quality services at the forefront of their statutory duties in the same way they must adhere currently to statutory financial duties.

5.11 While the duty of quality will not extend to services which a Health and Social Services Board, HSS Trust or Special Agency commissions from individual practitioners, or Family Health Services under service agreements or contractual arrangements, these Family Health Services practitioners will be expected to implement clinical and social care governance systems. Commissioners will ensure their duty to the quality of services delivered is met through their contractual arrangements with the organisations concerned.

5 Delivering Services - Local Accountability

Questions for Consultation

? Do you consider the duty of quality should be placed on those services ***commissioned*** by an HSS Trust?

Family Health Services

5.12 While clinical and social care governance is an organisational concept, the principles of clinical and social care governance apply to all Family Health Services, such as general medical and dental practitioners, community pharmacists and opticians. Health and Social Services Boards, HSS Trusts and Special Agencies will be expected to actively promote clinical and social care governance principles with all those to whom they look to deliver services.

5.13 Practice teams and organised groups can identify areas for development and ways to make necessary quality improvements e.g. through:

- working together to determine practice and local health and social care priorities;
- encouraging development of personal and practice development plans aligned with identified priorities; and
- engaging in a range of quality activities such as audit, risk management, significant event analysis and seeking and incorporating patient views.

5.14 Proposals for new arrangements in primary care have already been set out in the consultation paper "Building the Way Forward in Primary Care"[5]. That paper proposed the creation of Local Health and Social Care Groups, which envisages groups of primary care professionals working together at local level to improve the delivery of primary care services and to become involved in the commissioning of services.

5 Building the Way Forward in Primary Care - A Consultation document, DHSSPS, December 2000

5.15 Subject to the outcome of the consultation on those proposals, it is considered that the creation of such groups would provide an organisational platform around which a model of clinical and social care governance could be developed in primary care.

Questions for Consultation

? In view of the Independent contractor status of Family Health Services Practitioners, how best can clinical and social care governance be applied in primary care?

? Do the proposals for Local Health and Social Care Groups set out in "Building the Way Forward in Primary Care" provide a possible structure to support clinical and social care governance in this area of primary care?

Clinical & social care governance in practice

5.16 For clinical & social care governance to be successful all HPSS organisations, in tackling issues of performance or poor quality must move away from a culture of blame to one of learning. They will need to adopt a partnership and collaborative approach within health and social care teams and between health and social care professionals and managers.

5.17 In an organisation where good clinical and social care governance systems are working, multi-disciplinary teams will be working at all levels, professional staff will be contributing to the improvement of standards, ideas and good practice will be shared and education and research will be prized. Staff will feel valued and supported and those using the services will be confident of receiving high quality services and their views will be central to the design and delivery of services. Information will be used to full advantage to plan and assess progress.

5.18 These values will be the key to good clinical and social care governance within organisations, family health services and at individual practice level.

5 Delivering Services - Local Accountability

Developing staff

5.19 While the system of clinical and social care governance is an organisational concept, the development of staff through continuous professional development (CPD) will be crucial to the success of clinical and social care governance and the organisations' ability to guarantee that quality services are being delivered within their organisation.

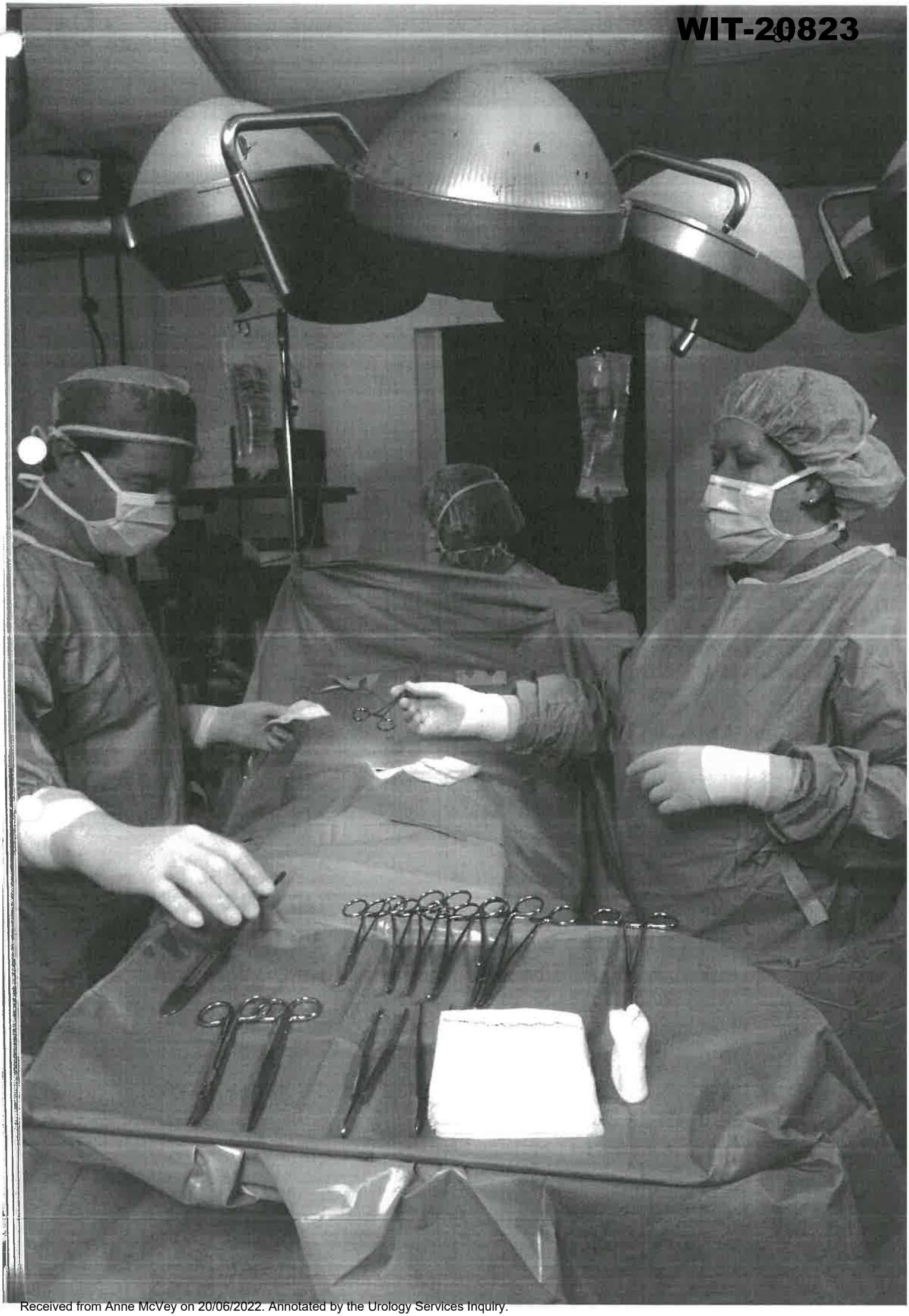
5.20 CPD is not new. CPD is being actively promoted throughout the HPSS and many developments have taken place to ensure that all organisations will be able to support their workforce by providing opportunities for education and training through CPD programmes.

Questions for Consultation

? Do you consider that this system of clinical and social care governance will help to improve the quality of services?

? Should the statutory duty of quality be placed on an HSS Trust for the services it commissions as well as those services it provides?

? How best do you think clinical and social care governance principles can be applied in primary care?



6

Monitoring Performance

6.1 It is crucial that the Minister, the HPSS Committee and the Assembly can be assured that the resources allocated to the HPSS are used effectively to develop and deliver high quality services in line with the objectives set out in the Programme for Government. There must also be a clear line of accountability from front line delivery back to the Executive. Nowhere is this more relevant than in the HPSS. People must have assurances that services are being delivered to the highest standards by a competent and confident workforce. They need to know that they will receive a high standard of service no matter who they are or where they live.

6.2 Setting standards for the workforce, putting in place a mechanism to produce and disseminate standards and guidelines for the services, putting in place local accountability arrangements to assure the delivery of high quality services to the standards set are very important elements of this framework. Standards, the way in which services are delivered and clinical and social care practice must be continually reviewed, challenged and where necessary changed. More robust monitoring arrangements will help to ensure that this happens.

Current monitoring arrangements

6.3 Standards and service performance are currently monitored at Departmental, HSS Board and HSS Trust levels. Groups including the Social Services Inspectorate (SSI), Pharmaceutical Inspectorate, Registration and Inspection Units, the Regional Multi-professional Audit Group (RMAG) and the Clinical Resource Efficiency Support Team (CREST) all make a significant contribution to support monitoring in the HPSS.

Proposals

6.4 More needs to be done. Robust performance management arrangements of individuals and of services must be in place throughout the HPSS to provide service users, the

6 Monitoring Performance

Department, those who commission and those who provide services with a clear picture of what is being done well in the service and what needs to be changed.

6.5 Improving clinical and social care practice will be supported through the clinical and social care governance framework, together with continuous professional development and professional regulation. It is proposed that improvements in the assessment of service performance should be addressed by:

- a new Performance Management Framework; and
- the establishment of a new independent body to monitor and report on clinical and social care governance arrangements within Health and Social Services Boards, HSS Trusts, Special Agencies and where appropriate, Family Health Services.

A new Performance Management Framework

6.6 The Department is currently working on proposals to develop a Performance Management Framework, which it is envisaged will provide an overall template to judge performance of the HPSS at all levels. The Performance Management Framework will focus on measuring performance against six key areas:

- improved health and social well-being;
- fair access to health and social care services;
- effectiveness in the delivery of appropriate health and social care services;
- the experience of service users and their contribution to the planning and delivery of services;
- efficiency in the delivery of health and social care services; and
- health and social care outcomes.

6.7 Indicators will need to be identified and/or developed which will enable the Department to assess how well the HPSS is performing in each of the six key areas above. The

Monitoring Performance

Performance Management Framework will continue to be developed to provide the mechanism of measuring performance against key planning priorities.

6.8 Health and Social Services Boards should be able to use the Performance Management Framework to help identify areas for Health and Wellbeing Investment Programmes. HSS Trusts should be able to use the Performance Management Framework to help them continuously improve and benchmark against other similar organisations and to demonstrate that they are delivering services to the agreed standards. Ultimately the Performance Management Framework will provide a vehicle for the Assembly to assess progress against the priorities set in the Programme for Government and will help inform future Programmes.

6.9 Work is progressing on the development of the Performance Management Framework and proposals will be brought forward at a later date.

Independent monitoring of services

6.10. Independent scrutiny of clinical and social services is currently limited. Valuable work is carried out by professional groups and bodies to promote and support improvements in clinical practice. Bodies such as the Mental Health Commission and the Northern Ireland Hospital Advisory Service (NIHAS) and groups such as CREST and RMAG all contribute to this work. Independent scrutiny of social services is carried out through the Social Services Inspectorate. Registration and inspection of pharmacies is carried out by the Pharmaceutical Inspectorate, which also has wider inspection and enforcement powers under legislation.

Proposals

6.11. To further strengthen monitoring and accountability systems it is proposed that a more independent system of monitoring services should be introduced in the HPSS. An

6 Monitoring Performance

independent examination of the governance and delivery of all services should provide the public with assurances that the HPSS is fulfilling its responsibilities for quality and should afford greater protection for service users. When things are going wrong in the HPSS, people need to know that failures are identified quickly, openly investigated and put right. Indeed the establishment of the Commission for Health Improvement for England and Wales has already raised expectations that similar independent assurances about the quality of services will be given here.

The Commission for Health Improvement (CHI) was established in April 2000 with the aim of improving the quality of patient care in the NHS across England and Wales. Working to a programme which aims to reduce unacceptable variation in care and ensuring every NHS patient receives a high level of care, the core functions of CHI are:

- to provide national leadership to develop and disseminate clinical governance principles;
- independently scrutinise local clinical governance arrangements to support, promote and deliver high quality services. CHI will conduct a rolling programme of reviews of clinical governance arrangements visiting every NHS Trust, Primary Care Trust and Health Authority every four years and will make its findings public;
- review and monitor local and national implementation of national guidelines in the form of National Service Frameworks (NSFs) and National Institute for Clinical Excellence (NICE) guidance;
- help the NHS identify and tackle serious or persistent clinical problems. CHI has the capacity for rapid investigation and intervention to help put these right;
- increasingly take on responsibility for overseeing and assisting with external NHS incident enquiries in England and Wales; and
- seek to identify excellence and celebrate and share good practice, thus producing bench marks.

CHI does not have the powers to remove or replace any member of staff, management teams or board members. However it will report any serious finding to the Secretary of State for Health in England or the National Assembly for Wales.

Monitoring Performance

6.12. In considering how best to secure independent monitoring in the HPSS, it is regarded as essential that any new arrangements here would need to be truly independent, reflect the integrated services and should add as little as possible to bureaucracy.

The Health and Social Services Improvement Authority

6.13. Taking account of the stipulations above it is proposed to establish an independent body, called the Health and Social Services Improvement Authority. This body would be required to:

- monitor, assure and provide advice and information on clinical and social care governance arrangements;
- review the clinical and social care governance arrangements as part of rolling three or four year visits to every Health and Social Services Board, HSS Trust, Special Agency and Family Health Services where appropriate;
- investigate incidents where significant or persistent clinical or social care problems occur; and
- work closely with the Health Services Audit; the Northern Ireland Audit Office; the Health and Safety Inspectorate; the Commission for Health Improvement; professional regulatory bodies and the Northern Ireland Commission for Care Services.

6.14. The Health and Social Services Improvement Authority would be established as a non-departmental public body to carry out the functions detailed in paragraph 6.13 above. The Health and Social Services Improvement Authority would be directly accountable to the Minister and would carry out investigations at the request of the Minister reporting back to the Minister on the findings.

6.15. The Health and Social Services Improvement Authority would have a chair, board of directors and full administrative support. In addition the Health and Social Services Improvement Authority would have an executive team responsible for carrying out the review visits and

6 Monitoring Performance

investigations. A pool of experts from within the HPSS would be established, from which the executive team would draw when carrying out review visits.

6.16. Where in exceptional cases it is considered that expertise from elsewhere is required to assist in investigations, the Department has secured provision in the Health Act 1999 to allow it, subject to the Minister's approval to approach the Commission for Health Improvement in England, to provide the relevant expertise in clinical issues.

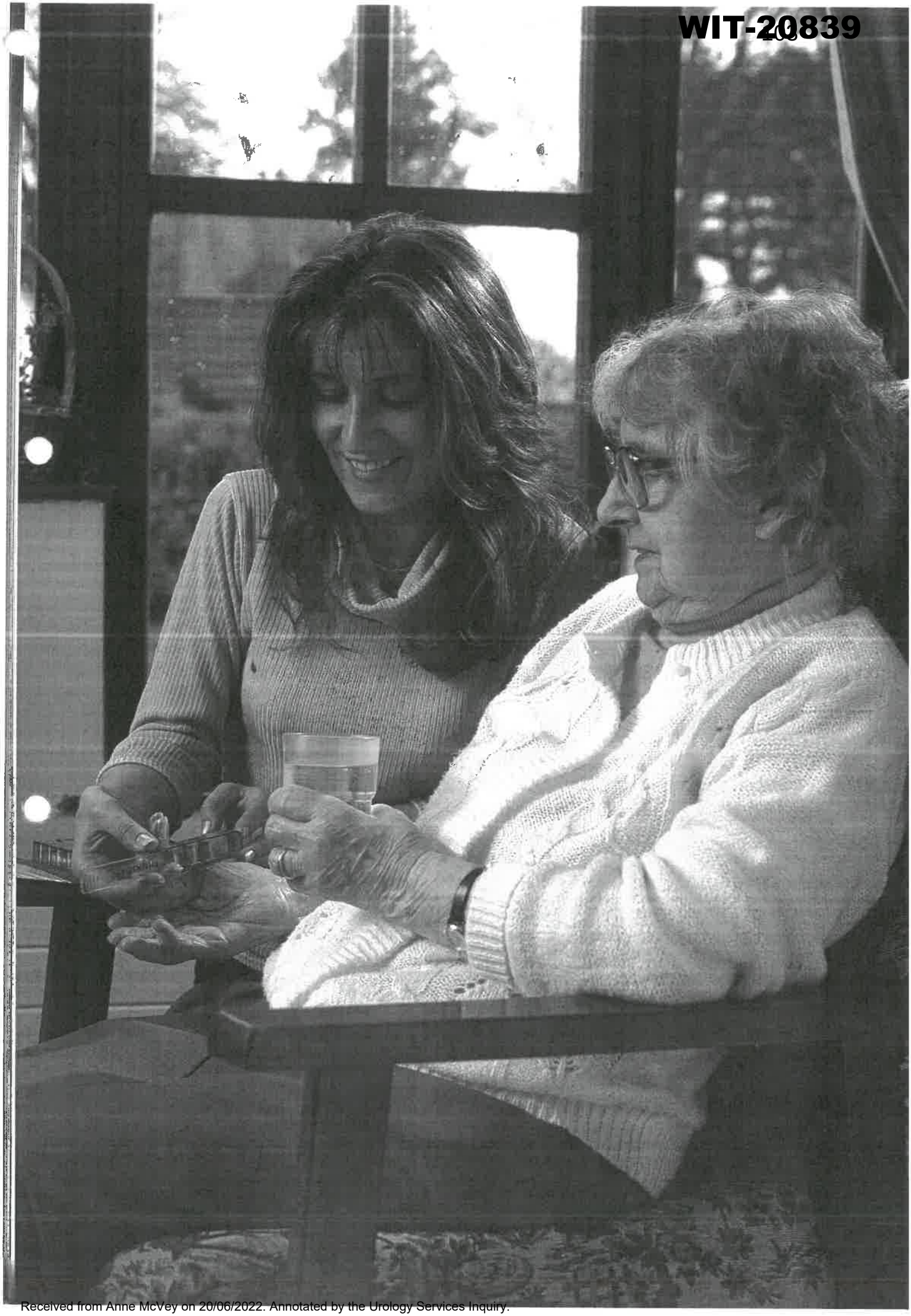
Questions for Consultation

? Do you consider there is a need for independent scrutiny of clinical and social care services?

? Are there any other options which should be considered to secure independent monitoring?

? What representation would need to be included on this body?

? How could user representation be secured - on the board of the Health and Social Services Improvement Authority and when carrying out reviews and investigations?



7

Improving and Extending the Regulation of Services

7.1 Another vital link in seeking improvements in the standard of services delivered is the need to improve and extend the range of social care services that are currently regulated. Regulation is based on legislation and involves the whole process of registration, inspection and enforcement, distinct sets of activities which ensure compliance with statutory requirements.

7.2 The Registered Homes (Northern Ireland) Order 1992, the Children (Northern Ireland) Order 1995 and their accompanying regulations govern the current arrangements for regulating nursing, residential and children's services and schools with boarding departments.

7.3 The current system of regulation has developed over a number of years in a fragmented and piecemeal fashion and has led to numerous problems, including inconsistency in the standards set and applied across the sectors.

7.4 An earlier consultation exercise carried out by the Department in 1998, indicated a need to improve the current system of regulation of social care services and to extend regulation to cover a wider range of social care services. For example residential care homes run by Trusts and homes provided under Royal Charters or Acts of Parliament are not subject to regulation, nor is support to people in their own homes and day care centres. Extending regulation to cover these services will offer better protection to vulnerable people using these services. Improving and extending regulation will ensure that services are regulated and monitored against agreed minimum standards.

Private and Voluntary Healthcare

7.5 The private and voluntary healthcare sector is currently subject to regulation under the Registered Homes (Northern Ireland) Order 1992. Under this Order, private and voluntary hospitals are classed as nursing homes. This is inappropriate given the range of work they do.

7 Improving and Extending the Regulation of Services

7.6 The current regulatory arrangements have a number of shortcomings. In particular Registration and Inspection Units have few powers other than to decline to register a new establishment or to de-register an existing one and cannot for example require an establishment to cease undertaking particular treatments even if the inspectors are concerned about the safety of patients. This undermines the effectiveness of current regulatory work.

Proposals

7.7 The current system of regulation is carried out by the Registration and Inspection Units within the four Health and Social Services Boards in relation to residential and nursing home care and by eleven HSS Trusts in relation to Under 12's services. This makes it more difficult to set and enforce standards in a consistent and independent manner here. It is proposed therefore to extend regulation of social care services to include a wider range of services and to establish a Northern Ireland Commission for Care Services to carry out the regulation of the current and extended range of services.

7.8 It is proposed to extend and improve the regulation of services to cover: statutory homes, homes covered by Charters and Acts of Parliament, small residential homes for adults, day care for adults, supported accommodation, nursing agencies, schools with boarding departments, the private and voluntary healthcare sector and agencies providing:

- domiciliary care;
- fostering;
- adoption;
- services for children under 12; and
- nursing home care.

Northern Ireland Commission for Care Services

7.9 To discharge this more comprehensive regulation of services it is proposed that a Northern Ireland Commission

Improving and Extending the Regulation of Services

for Care Services be established. The Northern Ireland Commission for Care Services would carry out the regulation of the current and extended range of services and would mirror the National Care Standards Commission established for England and Wales.

The National Care Standards Commission (NCSC) is a new independent regulatory body for social care services and private and voluntary health care. The NCSC will be responsible for the regulation of the whole range of care services from care homes for the elderly, children's homes, domiciliary care, fostering and adoption agencies through to private hospitals and clinics. The Secretary of State for England and the National Assembly for Wales have powers to make regulations governing the conduct of services regulated and to issue minimum national standards applicable to all the services to which the registration authorities and providers must have regard. The NCSC will ensure all regulated care services are provided to national minimum standards laid down by the Secretary of State in England and the National Assembly for Wales, through regulation and inspection. It will investigate complaints against registered services and report to the Secretary of State (or National Assembly for Wales) on the range and quality of regulated services. The NCSC will encourage improvement in the quality of services (through e.g. disseminating examples of good practice and giving advice to providers on how to meet the national minimum standards) and make information available to the public about the quality of services. This might include information about the location and types of services available, as well as the results of its inspections of individual providers. The NCSC will advise the Secretary of State or provide information about any aspect of the provision of services and about changes to the national minimum standards with a view to seeking improvement in the quality of services.

Functions of the Northern Ireland Commission for Care Services (NICCS)

7.10 The Northern Ireland Commission for Care Services (NICCS) would be established as an independent non-departmental public body. The functions of the NICCS would be to:

- take over responsibility for the work currently carried out by the Registration & Inspection Units within the four HSS Boards;
- register and inspect a wider range of care services;
- investigate complaints against registered services;
- where necessary take appropriate enforcement action to ensure standards are improved;
- serve improvement notices, prosecute and where necessary de-register services;
- regulate the private and voluntary healthcare sector;
- monitor and enforce the adherence to the Codes of Practice for employers as laid down by the Northern Ireland Social Care Council; and
- work in collaboration with other bodies including the Health and Social Services Improvement Authority and the Mental Health Commission on issues pertaining to that area of work.

7.11 Standards for care services will be developed through a process of consultation between the Department and a range of interested parties. The NICCS will be expected to apply these standards and will introduce a consistent and thorough approach to the conduct of registration and inspection and the application of standards and recommend changes where necessary. The NICCS would be expected to work in collaboration with the Northern Ireland Social Care Council and The Health and Social Services Improvement Authority. The NICCS would have its own management board comprising of chair and members drawn from the wide range of key stakeholders in the health and social services field including user and provider representation.

Social Care Tribunal (Enforcement and Appeals)

7.12 All regulated services including statutory services will be subject to appropriate enforcement action. This action includes the power to serve improvement notices, prosecute and where necessary de-register. Providers will have rights of appeal against de-registration decisions.

Improving and Extending the Regulation of Services

7.13 The Social Care Tribunal as established under the HPSS (Northern Ireland) Act 2001, will replace the existing Registered Homes Tribunal and will consider appeals for the extended range of services.

Questions for Consultation

? What other social care services do you consider should be subject to regulation?

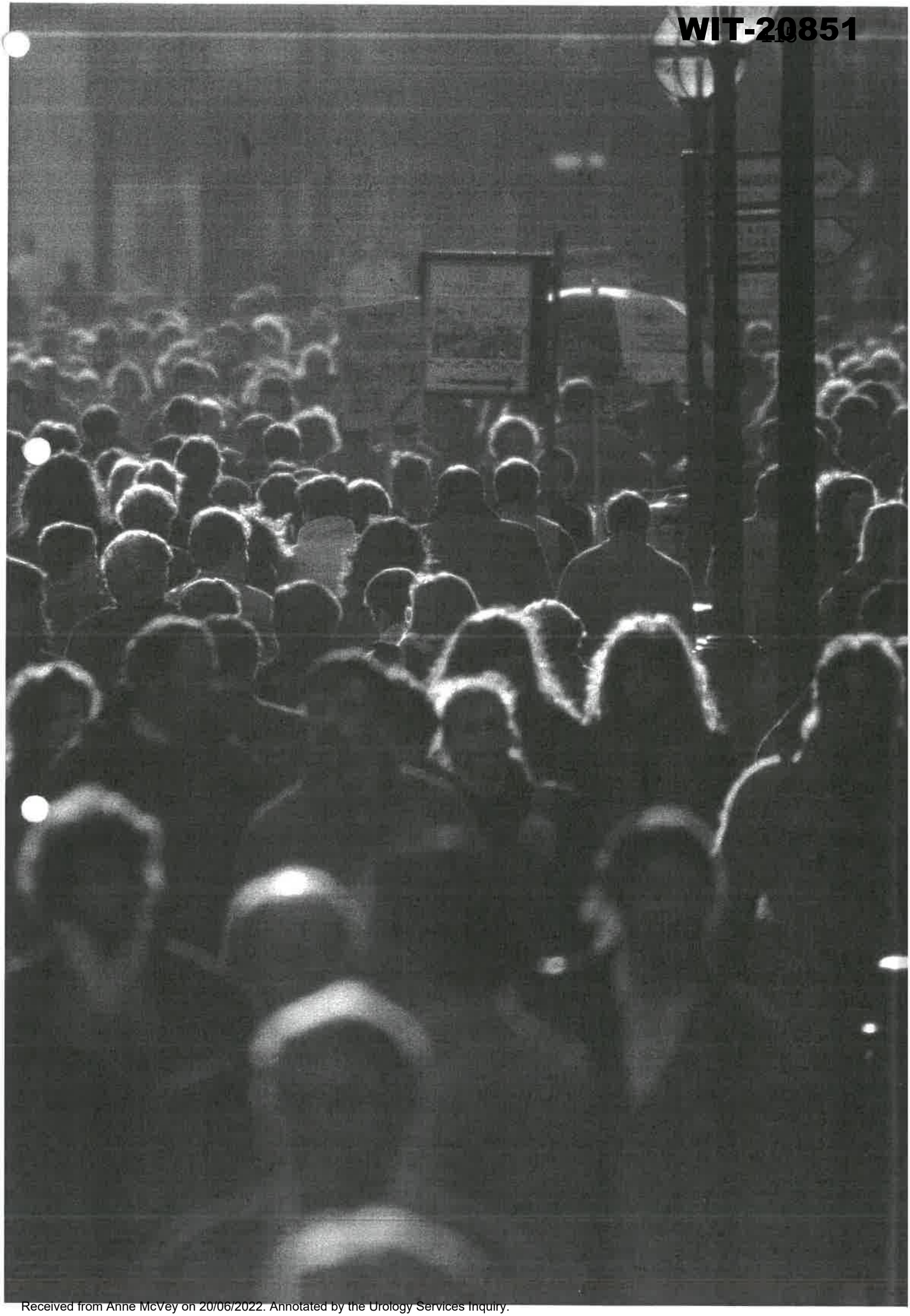
? What health and social care services currently delivered by the private and voluntary healthcare sector do you consider should be regulated under these proposals?

? How could user/lay input be best represented on the new Northern Ireland Commission for Care Services?

? What other representatives should be on the board of the new Northern Ireland Commission for Care Services?

? Given the current and extended range of services to be regulated and the specialist nature of those services should the new Northern Ireland Commission for Care Services be structured on a specialist or on a generic basis with specialist oversight?

? What powers should the Northern Ireland Commission for Care Services have in addition to those already mentioned?



8

Equality Issues

8.1 Section 75 of and Schedule 9 to the Northern Ireland Act 1998 place new statutory obligations on Departments and other public authorities in carrying out their functions. Such bodies are to have due regard to the need to promote equality of opportunity:

- between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
- between men and women generally;
- between persons with a disability and persons without; and
- between persons with dependants and persons without.

8.2 Without prejudice to the above, they are also to have regard, in carrying out their functions, to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

8.3 As part of this consultation process, the Department wishes to pay particular attention to the equality aspects of its proposals. The purpose of this framework is to improve the quality of the services delivered by the HPSS, thereby raising standards and ensuring a consistency in the standards applied. It should result in providing assurance to everyone who uses the services that they will be provided with the highest standard of care, no matter where they live or what HPSS facility they use.

8.4 The proposals to provide a single focus for the production and dissemination of standards and guidelines for the HPSS should result in a consistent approach to the provision of services across the HPSS, thereby removing inequalities and inequities in service provision.

8.5 Subject to the outcome of this consultation, should the two new non-departmental public bodies - the Health and Social Services Improvement Authority and the Northern Ireland Commission for Care Services be established, they will be subject to statutory equality obligations under Section 75 of the Northern Ireland Act 1998 and as such will be required to produce their own equality schemes.

8 Equality Issues

Questions for Consultation

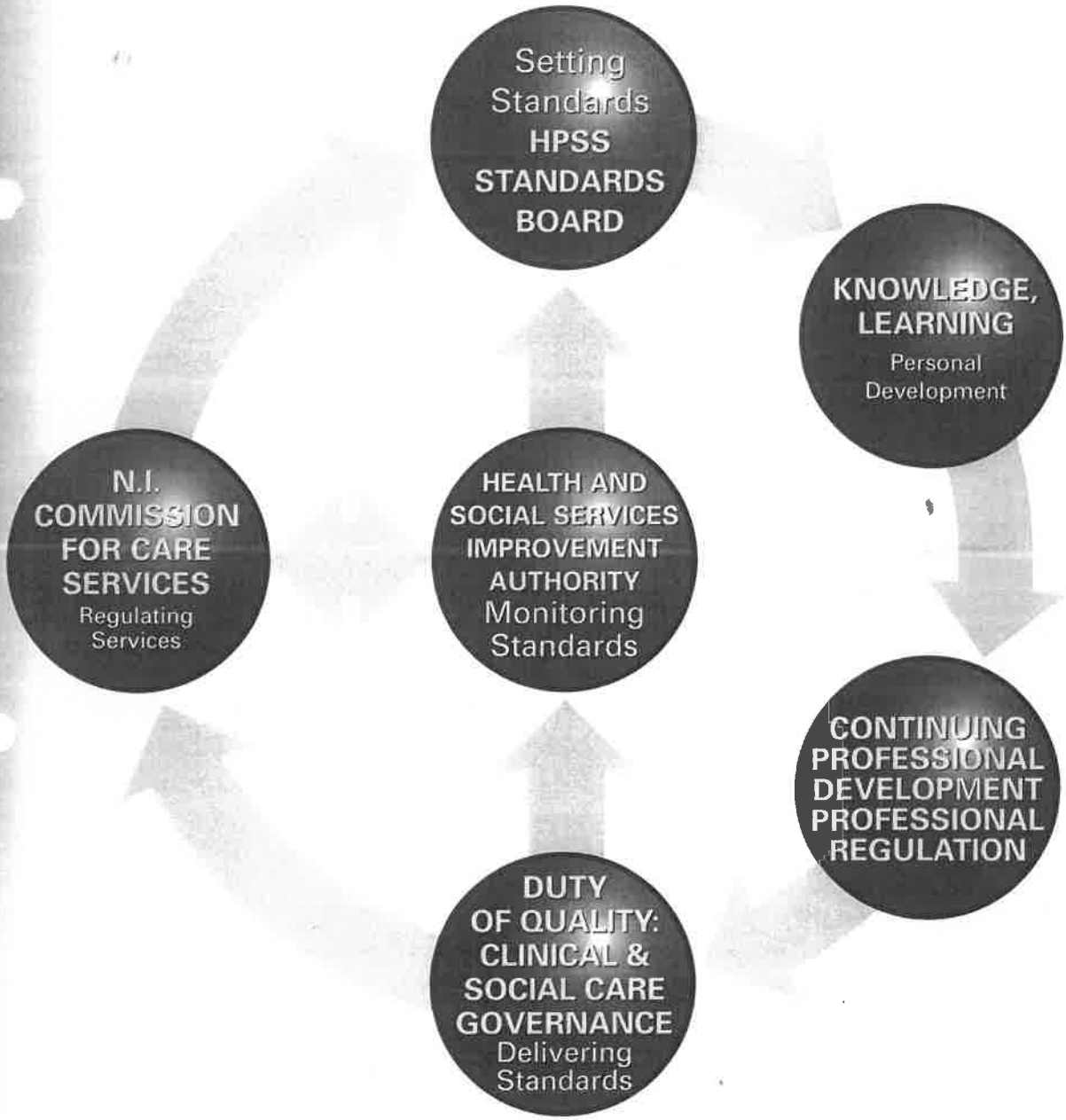
? Comments are invited on whether the proposals in this paper have any particular implications for equality of opportunity between the nine categories specified in the equality legislation in the Northern Ireland Act; or for promoting good relations between persons of different religious belief, political opinion or racial group.

? If so, can you state where and to what extent you think this might be the case?

? Do you consider that these proposals will have a differential impact on any of the categories specified in the equality legislation in the Northern Ireland Act 1998?

? Is there a better way of meeting the objectives set out in this document, which will better promote equality of opportunity? If yes, how?

THE QUALITY CIRCLE



Department of
Health, Social Services
and Public Safety

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The Quality Standards for Health and Social Care

SUPPORTING GOOD GOVERNANCE AND BEST PRACTICE IN THE HPSS

March 2006

FOREWORD BY THE MINISTER

The people of Northern Ireland are entitled to the highest standards of health and social care. Having standards in place to ensure that people have the right care wherever they live in Northern Ireland is a fundamental principle of reform and modernisation of the health and social care system.

I am committed to putting patients, clients and carers first. The *Quality Standards for Health and Social Care* set out the standards that people can expect from Health and Personal Social Services (HPSS). In developing these standards, my aim is to raise the quality of services and to improve the health and social wellbeing of the people of Northern Ireland. At the heart of these standards are key service user and carer values including dignity, respect, independence, rights, choice and safety.

The standards have five key quality themes:

- Corporate leadership and accountability of organisations;
- Safe and effective care;
- Accessible, flexible and responsive services;
- Promoting, protecting and improving health and social well-being; and
- Effective communication and information.

The publication of the quality standards is an important milestone in the process of putting patients first. They will be used by the new Regulation and Quality Improvement Authority to assess the quality of care provided by the HPSS. The new Authority will be looking to see how the HPSS provide quality services and will be reporting their findings both to the Department and to the public.

Given the rapidly changing environment in which the HPSS now operates including changes arising from the Review of Public Administration, it is important that these standards do not become outdated or serve to stifle innovation. Therefore, the standards will be reviewed by the end of 2008.

SHAUN WOODWARD MP
Minister for Health, Social Services and Public Safety

CONTENTS

Section 1: Introduction to the Development of Standards

1.1 Introduction

Almost 95% of the population of Northern Ireland makes contact with health and social services on an annual basis. This contact may be through primary care services, community care services or through hospitals. In all of these contacts, people are entitled to the highest standards of health and social care.

This document sets out clearly for the public, service users and carers, and those responsible for the commissioning, planning, delivery, and review of services, the quality standards that the Department considers people should expect from Health and Personal Social Services (HPSS). It represents a significant step in the process of placing the needs of the service user and carer, and the wider public, at the centre of planning, delivery and review of health and social care services.

1.2 Background to the development of standards

Quality improvement is at the forefront of the development of health and social care services in Northern Ireland. These improvements are centred around five main areas, which are an integral part of modernisation and reform:

- setting of standards – to improve services and practice;
- improving governance in the HPSS - in other words, the way in which the HPSS manages its business;
- improving the regulation of the workforce, and promoting staff development through life-long learning and continuous professional development;
- changing the way HPSS organisations are held to account for the services they provide; and
- establishing a new, independent body to assess the quality of health and social care.

The consultation document "Best Practice – Best Care", published in April 2001, sets out the detail of this framework to improve the quality of care. This included links to national standard setting bodies such as the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE).

1.3 Improving governance in health and social care

The outcome of the Review of Public Administration, announced in November 2005, signalled major changes to the structure and functions of HPSS organisations. Regardless of these changes there remains a statutory duty of quality on HSS Boards and Trusts. This means that each organisation has a legal responsibility for satisfying itself that the quality of care it commissions and/or provides meets a required standard. This requirement is just as important as the responsibility to demonstrate financial regularity and propriety. Organisations must ensure that there are visible and rigorous structures, processes, roles and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care. This process is known as *Governance*.

1.4 The setting of standards

In addition to drawing on national and professional standards, a range of local standards is being developed to enhance governance arrangements in the HPSS. These include controls assurance standards, so that by 2006-07, there will be a comprehensive set of specific assurance standards, which the HPSS can use to assess compliance against the required attainment levels. In addition, a number of care standards have been developed to facilitate the inspection and regulation of specific health and social care services provided by the HPSS and the independent sector. These care standards are specified in legislation and will be inspected, regulated and monitored by a new organisation called the Health and Personal Social Services Regulation and Improvement Authority (the Regulation and Quality Improvement Authority - RQIA).

The development of the *Quality Standards for Health and Social Care*, as outlined in this document, is intended to complement standards already issued or currently in development. Consequently, evidence of compliance with existing or new standards, such as professional standards, charter standards, controls assurance and/or care standards will form part of the evidence of practitioner or organisational commitment to these new quality standards.

1.5 What is a standard?

A standard is a level of quality against which performance can be measured. It can be described as 'essential'- the absolute minimum to ensure safe and effective practice, or 'developmental', - designed to encourage and support a move to better practice. The *Quality Standards for Health and Social Care*, which are contained in this document, are classed as essential.

Given the rapidly changing environment in which the HPSS operates, it is important that standards do not become outdated or serve to stifle innovation.

To prevent this, standards need to be regularly reviewed and updated. It will be the Department's responsibility, drawing on the best evidence available, including advice, reports and/or information from the RQIA, to keep the quality standards under consideration, with a formal review being completed by the end of 2008.

1.6 Why are standards important?

Raising and maintaining the quality of services provided by the HPSS is a major objective for all involved in the planning, provision, delivery and review of health and social care services. Currently, there remains unacceptable variation in the quality of services provided, including timeliness of delivery and ease of access.

In order to improve the quality of these services, change is needed, underpinned and informed by a more cohesive approach to standards development.

Standards:

- give HPSS and other organisations a measure against which they can assess themselves and demonstrate improvement, thereby raising the quality of their services and reducing unacceptable variations in the quality of services and service provision;
- enable service users and carers to understand what quality of service they are entitled to and provide the opportunity for them to help define and shape the quality of services provided by the HPSS and others;
- provide a focus for members of the public and their elected representatives, to consider whether their money is being spent on efficient and effective services, and delivered to recognised standards;
- help to ensure implementation of the duty the HPSS has in respect of human rights and equality of opportunity for the people of Northern Ireland; and
- promote compliance, and underpin the regulation and monitoring of services to determine their quality and safety and to gauge their continuous improvement.

By promoting integration, these *Quality Standards for Health and Social Care* will contribute to the implementation of clinical and social care governance in the HPSS and will be used by HPSS and other organisations, service users and carers, the wider public and the RQIA to assess the quality of care provision.

1.7 The five quality themes

There are five quality themes on which the standards have been developed to improve the health and social well-being of the population of Northern Ireland. These themes have been identified through consultation with service users, carers and HPSS staff and through a review of standards developed elsewhere at local, national and international level.

The five quality themes are:

1. Corporate Leadership and Accountability of Organisations;
2. Safe and Effective Care;
3. Accessible, Flexible and Responsive Services;
4. Promoting, Protecting and Improving Health and Social Well-being; and
5. Effective Communication and Information.

1.8 Assessing quality

The RQIA was established by the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and began work on 1 April 2005. It has two main functions:

- inspection and regulation of specified health and social care services provided by the HPSS and the independent sector; and

- inspection and review of the services provided by the HPSS in Northern Ireland.

The RQIA has a general duty to encourage improvements in the quality of services commissioned and provided by HPSS and other organisations. It will promote a culture of continuous improvement and best practice through inspection and review of clinical and social care governance arrangements.

The RQIA has taken over responsibility for the registration, inspection and regulation of providers of care, for example, residential care, nursing homes and day care facilities. On a phased basis, the RQIA will assume further responsibilities over the coming years, including reporting on the quality of care provided by the HPSS. Where serious and/or persistent clinical and social care governance problems come to light, it will have a key role to play, in collaboration with other regulatory and inspectoral bodies, in the investigation of such incidents. It will report on its findings to the Department and to the public.

1.9 How will the standards be used to measure quality?

The RQIA, in conjunction with the HPSS, service users and carers, will agree how the standards will be interpreted to assess service quality. It is envisaged that specific tools will be designed to allow the RQIA to measure that quality and to assist the HPSS in assessing themselves. Once developed, not only will these tools assess HPSS structures and processes but they will also contribute to the assessment of clinical and social care outcomes.

Whilst it is for the RQIA to provide guidance on what assessment methods it will use, it is recognised that collecting the evidence to demonstrate that relevant standards have been successfully achieved may be a time consuming process for the HPSS. Therefore, information that is currently compiled on existing standards will also be able to be used to contribute to the demonstration of achievement for these standards.

The RQIA will commence reviewing clinical and social care governance within the HPSS in 2006/07, using the five themes contained within this document. RQIA will report on the quality of care provided by the HPSS following its review. This approach will promote quality improvement across organisations.

Section 2: Values and Principles Underpinning the Standards

2.1 Introduction

There are three key premises, which underpin these quality standards and are central to all aspects of planning, provision, delivery, review and improvement of the HPSS. They are that:

- people in receipt of services should be actively involved in all decisions affecting their lives and should fully contribute to any planning for, delivery and evaluation of, services;
- clinical and social care governance in the HPSS must take account of the organisational structures, functions and the manner of delivery of services currently in place. Clinical and social care governance must also apply to all services provided in community, primary, secondary and tertiary care environments;
- service users and carers should be fully valued by HPSS staff who, in turn, should be valued by service users, carers and others.

2.2 The values underpinning the Standards

The quality of a service provided is dependent on managers and HPSS staff basing their practice on the following values and principles; these complement those already outlined in the care standards for independent agencies, establishments and certain other services provided by HPSS organisations.

They are:

DIGNITY AND RESPECT	The uniqueness and intrinsic value of the individual is acknowledged and each person is treated with dignity and respect. This is applicable to service users, carers, staff and others who come in contact with services.
INDEPENDENCE	A balance between the promotion of independence and risk taking is needed. Service users have as much control as possible over their lives. Service users are informed about risk whilst being protected against unreasonable risks.
PROMOTION OF RIGHTS	In the context of services delivered to them, the individual and human rights of service users are promoted and safeguarded. Where necessary, appropriate advocacy arrangements are put in place.
EQUALITY AND DIVERSITY	Equality of opportunity and positive outcomes for service users and staff are promoted; their background and culture are valued and respected.
CHOICE AND CAPACITY	Service users are offered, wherever possible, according to assessed need and available resources, the opportunity to select independently from a range of options based on clear and accurate information, which is presented in a manner that is understood by the service user and carer.
PRIVACY	Service users have the right to be free from unnecessary intrusion into their affairs and there is a balance between the consideration of the individual's safety, the safety of others and HPSS organisational responsibilities.
EMPOWERMENT	Service users are enabled and supported to achieve their potential in health and social well-being. Staff are supported and developed to realise their ability and potential.
CONFIDENTIALITY	Information about service users and staff is managed appropriately and everyone involved in the service respects confidential matters.
SAFETY	Every effort is made to keep service users, staff and others as safe as is possible. In all aspects of treatment and care, service users are free from exploitation, neglect or abuse.

2.3 The principles underpinning the Standards

The following principles are fundamental to the development of a quality service.

PUBLIC AND SERVICE USER INVOLVEMENT	The views and experiences of service users, carers, staff and local communities are taken into account in the planning, delivery, evaluation and review of services. Service users and carers, wherever possible, are involved in, and informed about, decisions made when they seek access to or receive services during their treatment or care.
SAFETY AND EFFECTIVENESS	Systems are in place to ensure that the safety of service users, carers, staff and the wider public, as appropriate, underpin all aspects of health and social care delivery. For example, the imperative to protect children and vulnerable adults may take precedence over the specific wishes of the service user and their carers. In addition, the protection of staff may need to be balanced with the specific wishes of service users, carers, families and friends. Quality systems are in place to enable staff to play a full and active role in providing effective and efficient health and social care services for all who use these services. Staff are fully supported, regularly supervised and appropriately trained and educated, to provide safe and effective health and social care services.
ROBUST ORGANISATIONAL STRUCTURES AND PROCESSES	Robust organisational structures and processes are in place, which are regularly reviewed to promote safe and effective delivery of care. Timely information is shared and used appropriately to optimise health and social care.
QUALITY of SERVICE PROVISION	Policies, procedures and activities are in place to encourage and enable continuous quality improvement. Service developments and provision are based on sound information and knowledge of best practice, as appropriate.

Section 3: Format of the Standards

3.1 The five quality themes

The five quality themes are applicable to the whole of the HPSS, including those services, which are commissioned or provided by HPSS organisations and family practitioner services. They are underpinned by the duty of quality on HSS Boards and Trusts. Where care is commissioned outside Northern Ireland, commissioners must ensure that the quality of care is commensurate with these and other associated standards.

The five quality themes, encompassing the standards, are set out in sections four to eight of this document. These are:-

- Corporate Leadership and Accountability of Organisations (Section 4);
- Safe and Effective Care (Section 5);
- Accessible, Flexible and Responsive Services; (Section 6);
- Promoting, Protecting and Improving Health and Social Well-being (Section 7); and
- Effective Communication and Information (Section 8).

3.2 Format of the standards

Each theme has a **title**, which defines the area upon which the standard is focused. Then, a **standard statement** will explain the level of performance to be achieved. The reason why the standard is seen to be important will be covered by the **rationale**. The standard statement will then be expanded into a series of **criteria**, which will provide further detail of areas for consideration by the HPSS and by RQIA.

Section 4: Corporate Leadership and Accountability of Organisations (Theme 1)

4.1 Standard Statement

The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.

4.2 Rationale

The HPSS must provide effective leadership and a clear direction to make the most of its resources (people, skills, time and money), and to deliver high quality services to the public in as safe an environment as is possible. The aim is to ensure a competent, confident workforce and an organisation that is open to learning and is responsive to the needs of service users and carers. This will facilitate staff in the organisation to take individual, team and professional responsibility in order to promote safe, sustainable and high quality services. The organisation needs to maintain and further enhance public confidence.

4.3 Criteria

The organisation:

a) has a coherent and integrated organisational and governance strategy, appropriate to the needs, size and complexity of the organisation with clear leadership, through lines of professional and corporate accountability;

b) has structures and processes to support, review and action its governance arrangements including, for example, corporate, financial, clinical and social care, information and research governance;

c) has processes in place to develop leadership at all levels including identifying potential leaders of the future;

d) actively involves service users and carers, staff and the wider public in the planning and delivery, evaluation and review of the corporate aims and objectives, and governance arrangements;

e) has processes in place to develop, prioritise, deliver and review the organisation's aims and objectives;

f) ensures financial management achieves economy, effectiveness, efficiency and probity and accountability in the use of resources;

g) has systems in place to ensure compliance with relevant legislative requirements;

h) ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory functions and in relation to inter-agency working;

i) undertakes systematic risk assessment and risk management of all areas of its work;

j) has sound human resource policies and systems in place to ensure appropriate workforce planning, skill mix, recruitment, induction, training and development opportunities for staff to undertake the roles and responsibilities required by their job, including compliance with:

- Departmental policy and guidance;
- professional and other codes of practice; and
- employment legislation.

k) undertakes robust pre-employment checks including:

- qualifications of staff to ensure they are suitably qualified and are registered with the appropriate professional or occupational body;
- police and Protection of Children and Vulnerable Adults checks , as necessary;
- health assessment, as necessary; and
- references.

l) has in place appraisal and supervision systems for staff which support continuous professional development and lifelong learning, facilitate professional and regulatory requirements, and informs the organisation's training, education and workforce development;

m) has a training plan and training programmes, appropriately funded, to meet identified training and development needs which enable the organisation to comply with its statutory obligations; and

n) has a workforce strategy in place, as appropriate, that ensures clarity about structure, function, roles and responsibilities and ensures workforce development to meet current and future service needs in line with Departmental policy and the availability of resources.

Section 5: Safe and Effective Care (Theme 2)

5.1 Standard Statement

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

5.2 Rationale

A quality service is one which is safe, effective and sustainable. Diminished standards on safety reflect a poor quality of service. The provision of health and social care is complex and will never be one hundred percent error-free. However, more can always be done to avoid injury and harm to service users, from the treatment and care that is intended to help them. This is an integral part of continuous quality improvement. Services must be delivered in a way that appropriately manages risk for service users, carers, staff, the public and visitors. Where an adverse incident has occurred or has been prevented from happening (a near miss), then systems need to be in place to assist individuals and organisations to learn from mistakes in order to prevent a reoccurrence.

It is acknowledged, however, that in some situations, living with a risk can be outweighed by the benefit of having a lifestyle that the individual really wants and values. In such circumstances, risk taking can be considered to be a positive action. Health and social care staff need to work in partnership with service users and carers to explore choices and agree on how risk can be managed and minimised for the benefit of individual service users, carers, families and communities.

The promotion of safe care must be complemented by the provision of effective care. Care should be based on the best available evidence of interventions that work and should be delivered by appropriately competent and qualified staff in partnership with the service user. Systems and processes within organisations should facilitate participation in, and implementation of, evidence-based practice.

This theme of "Safe and Effective Care" has been subdivided into three areas:

- ensuring safe practice and the appropriate management of risk;
- preventing, detecting, communicating and learning from adverse incidents and near misses; and
- promoting effective care.

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

a) has effective person-centred assessment, care planning and review systems in place, which include risk assessment and risk management processes and appropriate interagency approaches;

b) acknowledges and promotes the central place that patients, service users and carers have in the prevention and detection of adverse incidents and near misses;

c) has policies and procedures in place to identify and protect children, young people and vulnerable adults from harm and to promote and safeguard their rights in general;

d) promotes effective interagency working in relation to raising awareness of the risk factors associated with abuse, including domestic violence and in the promotion of effective interagency responses;

e) has a safety policy in place which takes account of the needs of service users, carers and staff, the public and the environment; and

f) has properly maintained systems, policies and procedures in place, which are subject to regular audit and review to ensure:

- efficacy and comparability of outcomes in health and social care;
- compliance with professional and other codes of practice;
- effective and efficient procedures for obtaining informed consent for examination, treatment and/or care;
- accurate, timely and consistent recording of care given or services provided and associated outcomes;
- protection of health, welfare and safety of staff;
- awareness raising and staff knowledge of reporting arrangements for adverse incidents and near misses, and whistleblowing arrangements when poor performance and/or unsafe practice in examination, treatment or care comes to light;
- there is choice where food and/or fluid is provided, which reflects cultural and spiritual preferences and that procedures are in place to promote the safe handling of food and a healthy diet;

- safe practice in the selection, procurement, prescription, supply, dispensing, storage and administration of medicines across the spectrum of care and support provided, which complies with current medicines legislation;

- promotion of safe practice in the use of medicines and products, particularly in areas of high risk, for example:

    - intrathecal chemotherapy;
    - blood and blood products;
    - intravenous fluid management;
    - methotrexate;
    - potassium chloride; and
    - anticoagulant therapy.

- risk assessment and risk management in relation to the acquisition and maintenance of medical devices and equipment, and aids and appliances across the spectrum of care and support provided;

- promotion of general hygiene standards, and prevention, control and reduction in the incidence of healthcare acquired infection and other communicable diseases;

- appropriate decontamination of reusable medical devices;

- safe and effective handling, transport and disposal of waste, recognising the need to promote the safety of service users and carers, staff and the wider public, and to protect the environment;

- interventional procedures and/or any new methods undertaken by staff are supported by evidence of safety and efficacy;

- address recommendations contained in RQIA reports (when available), service and case management reviews; and

- participation in and implementation of recommendations contained in local or national enquiries, where appropriate, e.g. National Confidential Enquiries.

5.3.2 Preventing, Detecting, Communicating and Learning from Adverse Incidents and Near Misses

The organisation:

a) has systems and processes in place to prevent, identify, assess and manage and review adverse incidents and near misses across the spectrum of care and support provided;

b) promotes an open and fair culture, rather than one of blame and shame, to encourage the timely reporting and learning from adverse incidents and near misses;

c) has reporting systems in place to collate, analyse and learn from all adverse incidents, and near misses, share knowledge and prevent reoccurrence of adverse incident or near miss; and

d) has systems in place that promote ongoing communication with service users and carers when treatment or care goes wrong, and puts in place an individual care plan to minimise injury or harm.

5.3.3 Promoting Effective Care

The organisation:

a) provides relevant, accessible, information to support and enhance service user and carer involvement in self-management of their health and social care needs;

b) promotes a person-centred approach and actively involves service users and carers in the development, implementation, audit and review of care plans and care pathways;

c) promotes a culture of learning to enable staff to enhance and maintain their knowledge and skills;

d) ensures that clinical and social care interventions are carried out under appropriate supervision and leadership, and by appropriately qualified and trained staff, who have access to appropriate support systems;

e) uses recognised clinical and social care standards and outcomes as a means of measuring health and social care quality;

f) promotes the implementation of evidence based practice through use of recognised standards and guidelines including guidance from the Department, NICE, SCIE and the National Patient Safety Agency (NPSA);

g) has in place systems to promote active participation of staff in evidence based practice, research, evaluation and audit;

h) has systems in place to prioritise, conduct and act upon the findings of clinical and social care audit and to disseminate learning across the organisation and the HPSS, as appropriate;

i) provides regular reports to the organisation's executive and non-executive board directors on clinical and social care governance arrangements and continuous improvement in the organisation; and

j) promotes the involvement of service users and carers in clinical and social care audit activity.

Section 6: Accessible, Flexible and Responsive Services (Theme 3)

6.1 Standard Statement

Services are sustainable, and are flexibly designed to best meet the needs of the local population. These services are delivered in a responsive way, which is sensitive to individual's assessed needs and preferences, and takes account of the availability of resources.

Each organisation strives to continuously improve on the services it provides and/or commissions.

6.2 Rationale

To meet the needs of local communities and to narrow inequalities in health and social well-being, services should take account of the current and anticipated needs of the local community. Service users, carers, front line staff and the wider public should be meaningfully engaged in all stages of the service planning and decision-making cycle. Assessment of need should be undertaken in partnership with the statutory, voluntary, private and community sectors. This should be informed by the collation and analysis of information about the current health and social well-being status of the local population, unmet need, legislative requirements, and evidence of best practice and review of current service provision. Service planning should also take account of local and regional priorities and the availability of resources.

In order to promote systematic approaches to the development of responsive, flexible and accessible services for the local population and for individuals, this theme has been sub-divided into two main areas:

- service planning processes; and
- service delivery for individuals, carers and relatives.

6.3 Criteria

6.3.1 Service Planning Processes

The organisation:

a) has service planning processes which promote an equitable pattern of service provision or commissioning based on assessed need, having regard to the particular needs of different localities and people, the availability of resources, and local and regional priorities and objectives;

b) integrates views of service users, carers and local communities, and front line staff into all stages of service planning, development, evaluation and review of health and social care services;

c) promotes service design and provision which incorporates and is informed by:

- information about the health and social well-being status of the local population and an assessment of likely future needs;
- evidence of best practice and care, based on research findings, scientific knowledge, and evaluation of experience;
- principles of inclusion, equality and the promotion of good relations;
- risk assessment and an analysis of current service provision and outcomes in relation to meeting assessed needs;
- current and/or pending legislative and regulatory requirements;
- resource availability; and
- opportunities for partnership working across the community, voluntary, private and statutory sectors.

d) has service planning and decision-making processes across all service user groups, which take account of local and/or regional priorities;

e) has standards for the commissioning of services which are readily understood and are available to the public; and

f) ensures that service users have access to its services within locally and/or regionally agreed timescales.

6.3.2 Service Delivery for Individuals, Carers and Relatives

The organisation:

a) ensures that all service users, carers and relatives are treated with dignity and respect and that their privacy is protected and promoted, including, where appropriate, the use of advocates and facilitators;

b) has systems in place to ensure that service users, carers and relatives have the appropriate information to enable them to make informed decisions and choices about their treatment and care, or service provision;

c) ensures that information, where appropriate, is provided in a number of formats, which may include, large print, audio format on tape or compact disc, computer readable format, Braille, etc. and is:

- written in easy to understand, non-technical language;
- laid out simply and clearly;
- reproduced in a clear typeface;
- available on the internet; and
- in the preferred language of the reader, as necessary;

d) incorporates the rights, views and choice of the individual service user into the assessment, planning, delivery and review of his or her treatment and care, and recognises the service user's right to take risks while ensuring that steps are taken to assist them to identify and manage potential risks to themselves and to others;

e) ensures that individual service user information is used for the purpose for which it was collected, and that such information is treated confidentially;

f) promotes multi-disciplinary team work and integrated assessment processes, which minimise the need for service users and carers to repeat basic information to a range of staff; and

g) provides the opportunity for service users and carers to provide comment on service delivery.

Section 7: Promoting, Protecting and Improving Health and Social Well-being (Theme 4)

7.1 Standard Statement

The HPSS works in partnership with service users and carers, the wider public and with local and regional organisations to promote, protect and improve health and social well-being, and to tackle inequalities within and between geographic areas, socio-economic and minority groups, taking account of equality and human rights legislation.

7.2 Rationale

Individuals, families and carers have a major part to play in their own and their dependents' health and social well-being. Although many factors influence the health and social well-being of individuals, many of these factors are societal issues and are outside the control of individuals. Examples include poverty, social exclusion, poor education, unemployment, crime, and poor housing. Resolving these issues requires a broad-based approach and concerted action by a wide range of people and agencies including the statutory, voluntary, community and business sectors. The HPSS, working in partnership with these other agencies and community groups, should actively seek to influence and support better decision-making, and establish systems to promote and improve the health and social well-being of the public and to reduce inequalities. The goal is to improve the health and social well-being of the population of Northern Ireland, by increasing the length of their lives, improving the quality of life through increasing the number of years spent free from disease, illness, or disability, and by providing better opportunities for children and support for families.

7.3 Criteria

The organisation:

a) has structures and processes in place to promote and implement effective partnership arrangements, to contribute to improvements in health and social well-being, and promote social inclusion and a reduction in inequalities;

b) actively involves the services users and carers, the wider public, HPSS staff and the community and voluntary sectors, in the planning and development of local solutions to improve health and social well-being and to reduce inequalities;

c) is committed to human rights, as identified in human rights legislation and United Nations Conventions, and to other Government policies aimed at tackling poverty, social need and the promotion of social inclusion;

d) actively pursues equality screening and, where appropriate, equality impact assessment in compliance with section 75 of the Northern Ireland Act 1998;

e) promotes ownership by service users, carers and communities to enable service users and the public to take responsibility for their own health, care and social well-being, and to participate as concerned citizens in promoting the health and social well-being of others;

f) collects, collates, develops and uses health and social care information to assess current and future needs of local populations, taking account of health and social well-being inequalities;

g) has effective and efficient emergency planning processes and co-ordinated response action plans in place, as appropriate, to deal with major incidents or emergency situations and their aftermath. The planning processes and action plans are compliant with Departmental guidance;

h) has processes to engage with other organisations to reduce local environmental health hazards, as appropriate;

i) has evidence-based chronic disease management programmes and health promotion programmes and, as appropriate, community development programmes, which take account of local and regional priorities and objectives;

j) has systems to promote a healthier, safer, and "family friendly" workforce by providing advice, training, support and, as appropriate, services to support staff;

k) has quality assured screening and immunisation programmes in place, as appropriate, and promotes active uptake among service users, carers and the public;

l) uses annual public health and social care reports in the development of priorities and planning the provision and delivery of services; and

m) provides opportunities for the use of volunteers, as appropriate.

Section 8: Effective Communication and Information (Theme 5)

8.1 Standard Statement

The HPSS communicates and manages information effectively, to meet the needs of the public, service users and carers, the organisation and its staff, partner organisations and other agencies.

8.2 Rationale

Good communication and effective use of information are the basis for decision-making by individuals, the public and organisations. They ensure that all relevant facts are collated and used to inform treatment and care, and the assessment, planning, service delivery and resource allocation processes. For information to be useful, it needs to be in an understandable format, accessible to those who need it and readily available. The communication and information management processes within an organisation must take account of the needs of service users and carers, staff and the public and the media, and any legislative or regulatory requirements. Protecting personal information and confidentiality are important to ensure that information is appropriately communicated to those who need to know and effectively used to inform any decisions made. The HPSS should be sensitive to the range of information needs required to support individuals, communities and the organisation itself.

8.3 Criteria

The organisation has:

a) active participation of service users and carers and the wider public. This includes feedback mechanisms appropriate to the needs of individual service users and the public;

b) an effective information strategy and communication strategy, appropriate to the needs of the public, service users and carers, staff and the size, functions and complexity of the organisation;

c) an effective and integrated information technology and information systems which support and enhance the quality and safety of care and provision of services;

d) system(s) and process(es) in place to ensure that urgent communications, safety alerts and notices, standards and good practice guidance are made available in a timely manner to relevant staff and partner organisations; these are monitored to ensure effectiveness;

e) clear communication principles for staff and service users, which include:

- openness and honesty;
- use of appropriate language and diversity in methods of communication;
- sensitivity and understanding;
- effective listening; and
- provision of feedback.

f) clear information principles for staff and service users, which include:

- person-centred information;
- integration of systems;
- delivery of management information from operational systems;
- security and confidentiality of information; and
- sharing of information across the HPSS, as appropriate;

g) the organisation has effective training for staff on how to communicate with service users and carers and, where needed, the public and the media;

h) effective records management policies and procedures covering access and the completion, use, storage, retrieval and safe disposal of records, which it monitors to assure compliance and takes account of Freedom of Information legislation;

i) procedures for protection of service user and carer information which include the timely sharing of information with other professionals, teams and partner organisations as appropriate, to ensure safe and effective provision of care, treatment and services, e.g. in relation to the protection of children or vulnerable adults, and the safe and efficient discharge of individuals from hospital care;

j) effective and efficient procedures for obtaining valid consent for examination, treatment and/or care;

k) an effective complaints and representation procedure and feedback arrangements, which is made available to service users, carers and staff and which is used to inform and improve care, treatment and service delivery; and

l) a range of published up-to-date information about services, conditions, treatment, care and support options available, and how to access them both in and out of service hours, which are subject to regular audit and review.

APPENDIX 1

GLOSSARY OF TERMS

Adverse incident	Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation.
Carer	Carers are people who, without payment, provide help and support to a family member or friend who may not be able to manage at home without this help because of frailty, illness or disability.
Care plan	The outcome of an assessment. A description of what an individual needs and how these needs will be met.
Care Standards	Care Standards are service specific standards currently being developed. They will cover a range of services provided by public, voluntary and private organisations such as nursing homes, residential homes, independent clinics etc.
Clinical and Social Care Governance	A framework within which HPSS is accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment.
Community care	Health and social services aimed at supporting individuals to remain safely in their own homes for as long as possible.
Community development	Consultation with, and involvement of local communities and groups in improving health and social well-being of the community.
Controls Assurance Standards	These standards focus on key areas of potential risk and help HPSS organisations demonstrate that they are doing their reasonable best to manage themselves and protect stakeholders from risk. They support effective governance.
Equality impact assessment	Consideration of a policy having regard to its impact on and the need to promote equality of opportunity between: persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation, men and women generally, persons with a disability and persons without and between persons with dependants and persons without.
Evidence based practice	Provision of services which are based on best practice as proven by research findings, scientific knowledge and evaluation of experience.
Family Practitioner Services (FPS)	The principal primary care services i.e. family doctors, opticians, dentists and pharmacists.
HPSS (Health and Personal Social Services)	An organisation which either commissions or provides health and social services, e.g. HSS Boards, Strategic Health and Social Care Authority, a Trust providing hospital and community services, a local commissioning body, and Family Practitioner Services.

NPSA	The National Patient Safety Agency promotes safe practice in clinical care and supports the development of solutions and the cascade of learning to reduce areas of high risk.
Person-centred assessment	An assessment, which places the individual at the centre of the process and which responds flexibly and sensitively to his/her needs.
Primary care	The many forms of health and social care and/or treatment accessed through a first point of contact provided outside hospitals e.g. family doctors, pharmacists, nurses, allied health professionals (physiotherapists, psychologists, dieticians etc) social workers, care assistants, dentists, opticians and so on.
Secondary care	Specialist services usually provided in an acute hospital setting following referral from a primary or community healthcare professional.
Statutory duty	A legal responsibility.
Statutory sector	Government-funded organisations e.g. HSS Boards, Strategic Health and Social Services Authority, Trusts, Special Agencies and Local Commissioning Groups.
Tertiary care	Highly specialised services usually provided in an acute hospital setting by medical and other staff with expertise in a particular medical specialty.

APPENDIX 2

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Produced by:
Department of Health, Social Services and Public Safety,
Castle Buildings, Belfast BT4 3SQ

Telephone (028) 9052 8332

Textphone (028) 9052 7668

www.dhsspsni.gov.uk

March 2006

Ref: 223/06

Title: Trust fails to meet performance standard due to administrative pressure on the cancer coordinators tracking of cancer patients

ID: 2977

Risk Type:	Safety of patient or client	Risk Subtype:	Health & Safety
Ref:		HoS:	Alison Porter, Head of Cancer Services
Facility:		TC Group:	
Directorate:	Acute Services	Division:	Cancer and Clinical Services
Type of Facility:	Hospital	Location (exact):	Macmillan Suite - Mandeville Unit
Principal objectives:	Provide safe, high quality care	Register Holding:	DIV
Manager:	Ronan Carroll		

Opened:	10/05/2011	No. of actions:	1
Review date:	20/09/2011	Open actions:	1
Closed date:	01/03/2012		

Des/Pot for Harm:

Trust fails to meet performance standard due to administrative pressure on the cancer coordinators tracking of cancer patients on the pathway. Patient is delayed in diagnostics and treatment for cancer - 95% for patients on the 62 day pathway and 98% for patients on the 31 day pathway. Patients referred with suspected cancer are delayed on their cancer pathway due to lack of resources/ capacity to see in the time frame required within the cancer pathway. Delays experienced during coordinators bank holidays and annual leave throughout the year as no backfill available. In addition there has been an increase in the number of red flag referrals, and an increase in the number of Multi disciplinary meetings in operation (both local and regional). Key areas most at risk - urology, lung, Upper GI, gynae, skin, but all pathways under pressure. Patient delays leads to a poorer outcome for the patient's overall survival, or ability to have the optimum treatment for their cancer, and breach of targets.

Controls in place:

A system for identifying suspected cancer patients in in use (red flag labeling). A tracking team are in place to monitor patients and identify patients at risk. Weekly meetings take place with the service administrator and coordinators to highlight risks. An escalation process is in place to expedite patients, where possible, to catch up time in the pathway.

Risk rating

	Initial	Current	Target
Consequence:	4	4	
Likelihood:	5	5	
Rating:	20	20	
Level:	HIGH	HIGH	
Cost of risk:			
Type:			
Investment:	£0.00		
Cost/benefit:			

Title: Trust fails to meet performance standard. Patient is delayed in diagnostics and treatment for cancer ID: 2978

Risk Type:	Safety of patient or client	Risk Subtype:	Health & Safety
Ref:		HoS:	Alison Porter, Head of Cancer Services
Facility:		TC Group:	
Directorate:	Acute Services	Division:	Cancer and Clinical Services
Type of Facility:		Location (exact):	Macmillan Suite - Mandeville Unit
Principal objectives:	Provide safe, high quality care	Register Holding:	HOS
Manager:	Ronan Carroll		

Opened:	10/05/2011	No. of actions:	1
Review date:	26/11/2013	Open actions:	1
Closed date:	14/11/2017		

Des/Pot for Harm:

Trust fails to meet performance standard. Patient is delayed in diagnostics and treatment for cancer - 95% for patients on the 62 day pathway and 98% for patients on the 31 day pathway. Patients referred with suspected cancer are delayed on their cancer pathway due to lack of resources/ capacity to see in the time frame required within the cancer pathway. Further delays experienced due to bank holidays and annual leave in April 2011. In addition there has been an increase in the number of red flag referrals.
Key areas most at risk - urology, lung, Upper GI, gynae, but all pathways under pressure. Patient delays leads to a poorer outcome for the patient's overall survival, or ability to have the optimum treatment for their cancer.

Controls in place:

A system for identifying suspected cancer patients in in use (red flag labeling). A tracking team are in place to monitor patients and identify patients at risk. An escalation process is in place to expedite patients, where possible, to catch up time in the pathway.

Risk rating

	Initial	Current	Target
Consequence:	4	4	
Likelihood:	5	5	
Rating:	20	20	
Level:	HIGH	HIGH	
Cost of risk:			
Type:			
Investment:	£0.00		
Cost/benefit:			

Title: Serious concerns following June 2015 Cancer Peer Review ID: 3728

Risk Type:	Safety of patient or client	Risk Subtype:	
Ref:		HoS:	Alison Porter, Head of Cancer Services
Facility:		TC Group:	
Directorate:	Acute Services	Division:	Cancer and Clinical Services
Type of Facility:	Hospital	Location (exact):	Trustwide
Principal objectives:	Provide safe, high quality care	Register Holding:	DIV
Manager:	Ronan Carroll		

Opened:	01/09/2015	No. of actions:	1
Review date:	14/11/2017	Open actions:	1
Closed date:	16/12/2019		

Des/Pot for Harm:

Serious concerns for skin, urology and H&N following assessment against the cancer peer review standards. Potential for Harm; The highlighted serious concerns may result in risk to patients who are/should be on the cancer pathway.

Controls in place:

Recognised capacity gaps exist, consultation with HSCB ongoing with IPTs submitted where appropriate and participate and await the outcome of the Regional outpatient reform exercise. With regards to CNS's await outcome of the Regional CNS prioritisation project.

Risk rating

	Initial	Current	Target
Consequence:	4	4	3
Likelihood:	5	3	3
Rating:	20	12	9
Level:	HIGH	MOD	LOW
Cost of risk:			
Type:			
Investment:	£0.00		
Cost/benefit:			

Title: Urology Access Waiting Times ID: 3166

Risk Type:	Safety of patient or client	Risk Subtype:	
Ref:		HoS:	Martina Corrigan, Head of Urology & ENT
Facility:	Craigavon Area Hospital	TC Group:	
Directorate:	Acute Services	Division:	Surgery and Elective Care
Type of Facility:	Hospital	Location (exact):	Urology Clinic
Principal objectives:	Provide safe, high quality care	Register Holding:	DIREC
Manager:	Heather Troughton		

Opened:	25/06/2012	No. of actions:	1
Review date:	13/05/2014	Open actions:	1
Closed date:	03/03/2015		

Des/Pot for Harm:

Urology access waiting times have increased significantly from 36 weeks for inpatient and daycases. First appointment ICAT patients has increased from 17 weeks.

Controls in place:

This is currently being addressed via approval to go to Independent Sector and the appointment of new consultants.

Risk rating

	Initial	Current	Target
Consequence:	3	3	
Likelihood:	5	5	
Rating:	**15**	15	
Level:	MOD	MOD	
Cost of risk:			
Type:			
Investment:	£0.00		
Cost/benefit:			

Title: Mis-timing of pre operative assessment investigations- extension of patient pathway to 17 weeks in T/O and Urology

ID: 2745

Risk Type:	Safety of patient or client	Risk Subtype:	Health & Safety
Ref:		HoS:	Connie Connolly, Head of Outpatients/Opthalmology/Oral/ Dentistry/Orthodontics
Facility:		TC Group:	Non-staff
Directorate:	Acute Services	Division:	Surgery and Elective Care
Type of Facility:	Hospital	Location (exact):	Outpatients Dept
Principal objectives:	Provide safe, high quality care	Register Holding:	DIV
Manager:	Heather Troughton		

Opened:	22/03/2010	No. of actions:	2
Review date:	30/09/2010	Open actions:	2
Closed date:	19/05/2011		

Des/Pot for Harm:

Due to the extension of the patient pathway for Urology and T/O patients to 17 weeks, current pre operative assessment validity dates of 13 weeks, will no longer provide accurate pre op assessment. Risks are around having to facilitate patients coming back to the POA service for screening once the TCI date has been issued. Due to limited Band 5 availability for screening there is a risk that there will insufficient time to manage any pre op issues that may arise. Risk that POA clerical staff do not have the resources to ensure the patients pass through assessment twice at a time allowing for any management issues. Risk that patients having screening done too close to TCI, will have to be cancelled at short notice due to not having enough time to resolve any clinical issues. POA then has no capacity to assess patients who may have been selected to backfill at short notice. Risk of inefficient utilisation of bed and theatre capacity if there are persistent day of surgery cancellations due to inappropriate or inadequate screening.
Potential harm to patients if surgical procedure is cancelled Financial harm to SHSCT due to poor theatre and bed utilisation secondary to delayed pre op screening. Potential for financial harm if pre op screening is out of date and has to be repeated. Potential for financial harm if patients are being admitted to ward prior to surgery if pre op investigations are incomplete.

Controls in place:

Band 5 Nurses in POA to cease preliminary screening in T/O & Urology when patients are added to IPWL immediately. POA clerical team chronologically inviting patients who are listed within the next month, to attend for repeat screening. (done on receipt of theatre lists)PCR testing being done for T/O patients if surgery is within 3 days

Risk rating

	Initial	Current	Target
Consequence:	3	3	
Likelihood:	5	3	
Rating:	15	9	
Level:	MOD	LOW	
Cost of risk:			
Type:			
Investment:	£0.00		

Title: Increased waiting time for New out-patients and Elective Surgery

ID: 3690

Risk Type:		Risk Subtype:	
Ref:		HoS:	
Facility:		TC Group:	
Directorate:	Acute Services	Division:	Surgery and Elective Care
Type of Facility:	Hospital	Location (exact):	
Principal objectives:		Register Holding:	DIV
Manager:	Mr Simon Gibson		
Opened:	08/06/2015	No. of actions:	0
Review date:		Open actions:	0
Closed date:	24/09/2015		

Des/Pot for Harm:

Surgery & Elective Care: Breast Surgery, General Surgery, Endoscopy, ENT, Urology, Orthopaedics Urgent Out-Patients: Waiting times have been growing across the specialties, in some cases exceeding clinically accepted waiting times for urgent appointments. Current urgent waiting times for new out-patients are: General Surgery - 21 weeks, ENT - 28 weeks, Urology - 30 weeks, Orthopaedics - 43 weeks
Current urgent waiting times for elective surgery are: Breast Surgery - 33 weeks, General Surgery - 54 weeks, Endoscopy - 12 weeks, ENT - 13 weeks, Urology - 87 weeks, Orthopaedics - 56 weeks
Delay in treatment plan and diagnosis. Increased waiting time for Routine patients may result on patients being reprioritised as urgent putting increased pressure on existing capacity and bottle-necking available urgent slots

Controls in place:

Monitoring measures are being put in place to ensure that patients triaged/categorised as urgent are being seen within the clinically accepted waiting time.
Patients exceeding this waiting time will be escalated to management and clinical teams for further advice.
Active plans to reduce urgent waits within specialties are on-going
Increasing urgent waiting times have been escalated to HSCB and they are aware of limited control due to demand vs capacity mismatch.

Risk rating

	Initial	Current	Target
Consequence:	3	3	
Likelihood:	4	3	
Rating:	12	9	
Level:	MOD	LOW	
Cost of risk:			
Type:			
Investment:			
Cost/benefit:			

Title: Cancer performance risk ID: 2991

Risk Type:	Safety of patient or client	Risk Subtype:	Health & Safety
Ref:		HoS:	Alison Porter, Head of Cancer Services
Facility:		TC Group:	
Directorate:	Acute Services	Division:	Cancer and Clinical Services
Type of Facility:		Location (exact):	Trustwide
Principal objectives:	Provide safe, high quality care	Register Holding:	DIREC
Manager:	Ronan Carroll		
Opened:	26/05/2011	No. of actions:	1
Review date:		Open actions:	1
Closed date:	07/12/2011		

Des/Pot for Harm:

Decrease in cancer performance from previous years. 10/11 = 85% for 62 day pathway. Highest risk is urology cancer pathways.

Controls in place:

Escalation policy and action plans drafted. Meeting with urology teams. Working towards 1-stop clinics.

Risk rating

	Initial	Current	Target
Consequence:		3	
Likelihood:		4	
Rating:		12	
Level:		MOD	
Cost of risk:			
Type:			
Investment:	£0.00		
Cost/benefit:			

Appendix Question 23

Received from Anne McVey on 20/06/2022. Annotated by the Urology Services Inquiry.

2022 · 11 · 04

Q23 · 128 · 1

McVey, Anne

From: Poland, Orla
Sent: 11 April 2022 13:27
To: Campbell, PatriciaM; Connolly, Mick; Damani, Laila; Flannery, Daniel; Gray, Alastair; McAleavey, Neil; McClelland, Anthony; McEneaney, David; McKeown, Peadar; Menown, Ian; Mlodzianowski, Artur; Moore, Michael; Moriarty, Andrew; Tweedie, Jude; Carroll, Anita; Carroll, Kay; Cunningham, Lucia; McVey, Anne; Robinson, Katherine
Subject: CARDIOLOGY.xlsx
Attachments: CARDIOLOGY.xlsx

Hi All,

Please find attached Cardiology backlog report for March 2022, sent on behalf of Lucia

Kind Regards

Orla Poland
Service Administrator SEC
Second Floor | Tower Block | Craigavon Area Hospital | 68 Lurgan Road | Craigavon | BT63 5QQ |
T: External [redacted] Internal [redacted] Mob: [redacted] | E: [redacted]

Received from Anne McVey on 20/06/2022. Annotated by the Urology Services Inquiry.

Consultant/ Service	No of discharges awaiting Dictation (do not include e-discharges)	No of discharges for typing	No of clinic charts to be dictated	No of Clinic Charts to be typed	Oldest date to be typed	No of results to be matched to chart	No of results to be dictated	Oldest results to be dictated	Results to be typed	Oldest results for typing	Date of last DARO validation	Filing backlog & other comments
STH Cardiology (MCKEOWN)	-	-	-	8	31.3.22	2	7	10.3.22	12	31.3.22	23.3.22	UP-TO-DATE
Dr Moore	-	-	-	7	11.04.22	-	5	05.04.22	5	07.04.22	Mar-22	1 small folder of filing - between both consultants
Dr McEneaney	-	-	-	-		-	13	01.04.22	3	07.04.22	Mar-22	
Dr Tweedie	-	-	-	-		15	15	Apr-22	11	Apr-22		outstanding results to be dictated and typed/all left to Jude's office on Friday. Currently working through DARO
Dr Mlodzianowski (CAH + DHH)	-	3	-	18	24-Feb	-	30	Mar-22	5	Apr-22	not recorded	outstanding results to be dictated and typed/emails/admin.
Dr Gray (CAH & DHH)	-	-	-	-		-	8	Mar-22			not recorded	Results/ECG/charts from clincis (typed by other secretaries to be filed).
Dr McClelland	-	2	-	-		-	6	Apr-22	10	Apr-22		Outstanding results to be dictated and typed/emails/admin.
Dr Campbell	-	-	-	46	Feb-22	-	35	Mar-22	50	18/02/2022	not recorded	
Dr Connolly	-	-	-	-		-	-	Jan-00	14	Feb-22	Mar-22	correspondence to be left in office and lift any if left out
Dr Menown	-		-	3	30.03.22	-	-		-		Mar-22	correspondence to be left in office and lift any if left out
Dr Flannery	-	-	-	-		10	8	Apr-22	24	Apr-22		Just todays post to be sent to Danny, currently working through DARO
Dr Moriarty												
AVS CL DR BRADY	-	-	7	-		-			-			
Arrithymia & other Associate Specialist clinics	-	-	-	4		-	35	Apr-22	1			NEIL ON LEAVE BEG APRIL X 2 W
Rapid Angina	-	-	-	5	31/03/2022	-			-			RAHFCt traige to be added to w/l
Heart Failure	-	-	-	5	31/03/2022	-			-			Clinics booked
	0	5	7	96		27	162		135			

RAAC /Arrithymia backlog is being typed by all staff

2022. 11. 04

Q23. 128. 2

Received from Anne McVey on 20/06/2022. Annotated by the Urology Services Inquiry.

Appendix Question 26

Southern Health and Social Care Trust
Quality Care - for you, with you

Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Personal Information redacted by the USI

[redacted]

2022 : 06 : 10

3

Southern Health and Social Care Trust
Quality Care - for you, with you

Objectives for Next Year:

Personal Information redacted by the USI

[redacted]

Reviewee Staff Name (Print) [redacted]

Reviewer Manager/Supervisor ([redacted]

Personal Information

Southern Health and Social Care Trust

Quality Care - for you, with you

ANNUAL PERSONAL DEVELOPMENT PLAN

Personal Information redacted by the USI

PLEASE SEND COMPLETED PART B TO: KSF DEPARTMENT, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ

OR EMAIL TO: - KAREN.MCSTAY(Personal Information redacted by the USI

Southern Health and Social Care Trust

Quality Care - for you, with you

Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Personal Information redacted by the USI

[redacted]

Southern Health and Social Care Trust

Quality Care - for you, with you

Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

Personal Information redacted by the USI

PLEASE SEND COMPLETED PART B TO: KSF DEI TMENT, HILL BUILDING, ST LUKES HOSPITAL, LI GHGALL ROAD, ARMAGH BT61 7NQ

OR EMAIL TO: - KAREN MCSTAY Personal Information redacted by the USI

Southern Health and Social Care Trust

Quality Care - for you, with you

Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Personal Information redacted by the USI

[redacted]

2021 06 28

Southern Health and Social Care Trust

Quality Care - for you, with you

Personal Information redacted by the USI

Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

Personal Information redacted by the USI

PLEASE SEND COMPLETED PART B TO: KSF DEPARTMENT, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ OR EMAIL TO: -

Appendix Question 27

Southern Health and Social Care Trust

Quality Care - for you, with you

Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Personal Information redacted by the USI

[redacted]

Personal Information redacted by the USI

[redacted]

Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

Staff Number: _____

Personal Information redacted by the USI

[redacted]

Personal Information redacted by the USI

[redacted]

PLEASE SEND COMPLETED PART B TO: KSF DEPARTMENT, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ OR EMAIL TO: -

Personal Information redacted by the USI

[redacted]

Reviewer Manager/Supervisor (Print) _____ Signature _____ Date _____

Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

Personal Information redacted by the USI

[redacted]

Southern Health and Social Care Trust

2012.09.01
Q27.144.2

Knowledge & Skills Framework (KSF)

Guidance Document

SEPTEMBER 2012

KSF Department
Hill Building
St Luke's Site
Loughgall Road
Armagh
BT61 7NQ

CONTENTS

Knowledge & Skills Framework (KSF) Guidance Document

1. What is the Knowledge and Skills Framework (KSF)?

The Knowledge and Skills Framework (KSF) is a developmental tool which is designed to provide the basis for career and pay progression within Agenda for Change Pay Bands.

The main purpose of the development review is to look at the way in which an individual member of staff is developing in relation to:

- The duties and responsibilities of their post and current agreed objectives
- The application of knowledge and skills within the workplace
- The consequent development needs of the individual member of staff

KSF was developed and is required to be implemented in partnership between management and trade union side. It defines and describes the knowledge and skills which staff (covered by Agenda for Change Terms and Conditions) need to apply in their work in order to deliver a quality service. It is a *knowledge and skills framework* and therefore, it is essentially a development tool, although KSF will also contribute to decisions about pay progression.

2. Personal Development Review (PDR)

The Trust is committed to the PDR process and regards this as an important component of the Trust's governance process. It contributes towards organisation and service development and provides opportunities for each member of staff to develop their potential. The Trust will ensure that each member of staff knows what is expected of them to ensure that they are clear about their role and responsibilities, their Knowledge and Skills Framework (KSF) Outline and the key aims of their ward/department and the Trust.

The development review is based on an analysis of the individual's application of their knowledge and skills and their development to meet the demands of the post as described in their KSF post outline. It brings together all of the discussions which have taken place throughout the year and enables reviewers and reviewees to reflect on these. It is expected that reviewers will have regular informal discussions with individual staff members throughout the year, providing constructive feedback on the individual's work and related development. The development review meeting is an opportunity to think about this in a structured way.

If any issues have been identified in the individual's work or development during the year, these should have been addressed at the time they arose; they should not be left until the review meeting. Any disciplinary issues must be dealt with via the normal channels. The guiding principle of the development review process is "no surprises".

Participation in an annual Personal Development Review meeting is mandatory under Agenda for Change. This takes the form of a face-to-face meeting between a manager or (person acting as their reviewer) and an employee (reviewer and reviewee). Normally the manager involved in the meeting will be the one who has most frequent managerial contact with the employee. The role of reviewer may be delegated to another member of staff, this staff member must be competent to carry out the review, must be familiar with the employee's work and normally hold a supervisory position. In cases of the role of reviewer being delegated the line manager must also sign off the PDR and PDP forms in their role of budget holder.

Personal Development Review (PDR) is a process by which a member of staff and their manager or designated professional manager can have a two way discussion about:-

- the duties and responsibilities of their post and current agreed objectives
- the application of knowledge and skills within the workplace
- the consequent development needs of the individual member of staff.

PDRs are completed on a 12 month period – the exact timeframe will depend upon the individual's incremental date. During the foundation period (the first year in post) all staff who have newly joined a payband will have at least two discussions with their reviewer to review progress against the KSF outline for their post. This includes newly appointed or promoted staff joining a payband and also those moving posts within the payband, particularly where this cuts across job families eg from Admin to Social Care.

3. PDR Process

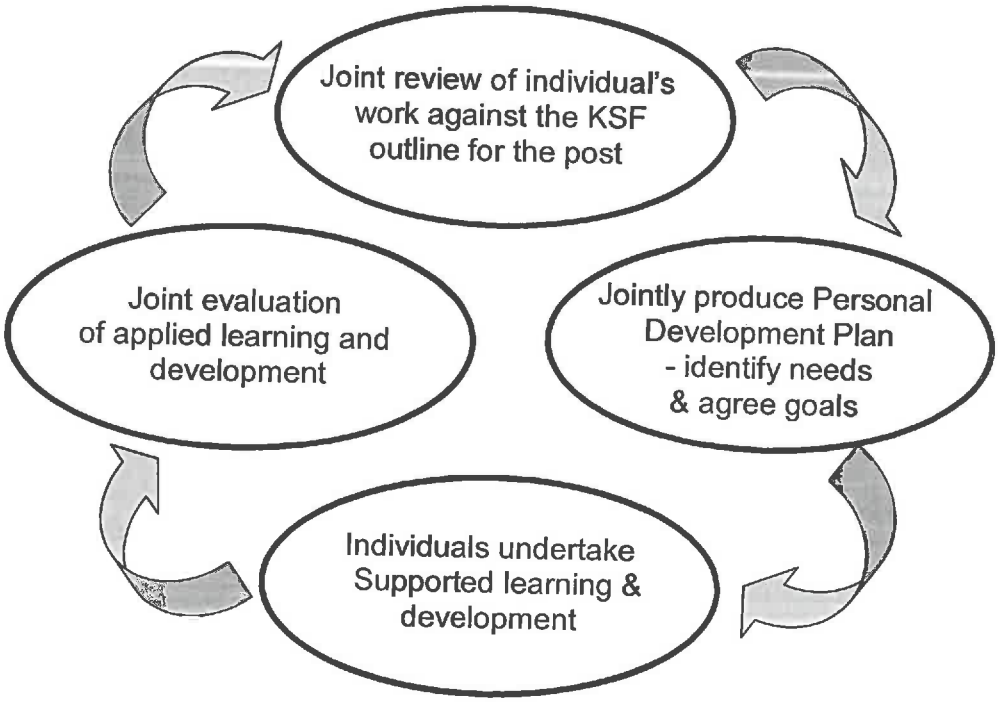
The PDR process is based on a cycle of learning and is repeated each year. It consists of:-

- a joint review between the individual and their reviewer of the individual's work against the demands of their post
- the production of a Personal Development Plan (PDP), which identifies the individual's learning and development needs and interests – the plan is jointly agreed between the individual and their reviewer

- learning and development undertaken by the individual, supported by their reviewer
- an evaluation of the learning and development that has taken place and how it has been applied by the individual in their work.

Evaluation of the learning and development undertaken is an important aspect of KSF as it will ensure that learning and development undertaken has been effective and applied to the workplace where benefits can be seen and potentially shared with other teams or team members. It will also ensure that learning and development undertaken has been beneficial and cost effective.

Please see the diagram below which illustrates the cycle.



The process of review begins with a focus on the review of an individual's work in relation to individual, service and organisational objectives. This provides an opportunity for individual staff members to receive feedback from the line manager on how they are working towards meeting the KSF post outline and roles and responsibilities of their post. In addition, objectives of a job role for the incoming period can be linked to KSF dimensions. However it should be noted that the KSF Outline looks at the knowledge and skills required to carry out the roles and responsibilities of the post, but the objectives are the key goals to be aimed for in order to achieve set targets. Therefore ways in which performance can be sustained or improved, can be laid out in the form of agreed individual/team/Trust objectives. There is a separate section on the PDR form for recording these objectives.

The PDR meeting will focus on helping individuals develop to meet the demands of

the KSF outline for the post in which they are currently employed.

Discussion should be honest, open and positive. An individual's strengths, successes and contribution to the service should be recognised explicitly alongside a consideration of areas in which they might need to develop or improve. Staff and managers will be most likely to get the best out of PDR if they go into the process with an open mind and are prepared to be positive about the experience.

The KSF post outline provided in the review documentation should be jointly considered. This should structure the discussion, enabling both parties to prepare for and contribute to the process.

The review evaluates the individual's application of knowledge and skills in their work, using the KSF outline for the post as the basis for the discussion. The process will involve consideration of information relevant to the post outline on the individual's work – this can be called 'evidence for the development review'.

This evidence can take a number of different forms, which might include:-

- verbal feedback from the individual, manager or other
- written work produced by the individual
- electronic work produced by the individual
- records of work (such as minutes / notes of meetings showing the individual's contribution)
- the individual's portfolio containing such items as reflection on learning / practice that they are prepared to share.

Newly appointed or promoted staff joining a pay band under the new system will serve an initial foundation period of up to 12 months. This includes newly appointed or promoted staff joining a payband and also those moving posts within the payband, particularly where this cuts across job families eg from Admin to Social Care.

Discussion and decisions made at the PDR meetings should be clearly recorded using the mandatory forms (see Appendix 1). Section three Personal Development Plan (PDP) forwarded to KSF Department after each review meeting.

4. Personal Development Plan (PDP)

The outcome of the PDR meeting should be recorded and a plan of action drawn up using the Personal Development Plan (PDP). This identifies the areas an individual needs to demonstrate more fully and the help they need to develop in order to achieve the required level for their post. This will include a discussion about the method of delivery for the learning and how the application of learning will be evaluated. The manager and employee are jointly responsible for doing this and both must then confirm they agree with the plan. Once completed a copy of the PDP should be forwarded to **KSF Department, Hill Building, St Luke's Site, Loughgall Road, Armagh. BT61 7NQ.**

The PDP will focus initially upon enabling an individual to meet the demands of their current post as described in the KSF outline. Once this has been achieved a PDP should enable an individual to maintain their knowledge and skills; developing them to meet any changing requirements, and facilitate an individual's further development within or beyond their current post, considering both individual and organisation needs and aspirations.

When thinking about learning and development needs the following three steps can be followed:-

CAN DO = the knowledge and skills that an individual already has and that seem to match the KSF job outline

WILL DO = the skills and knowledge that individuals think they ought to develop further because they haven't already achieved them or because they want to make them stronger

HOW TO = the learning opportunities or other activities that are likely to help individuals develop these skills and knowledge, or the people and agencies that can direct them towards their goals.

Remember that this should be done with the KSF post outline in mind.
Learning and development needs can arise for the following reasons, such as:-

- to meet an identified personal learning and development need to help an employee to meet the requirements of their post;
- to develop a skill identified as part of a job description; and
- to meet an organisational aim arising from the Trust's operational plans.

Managers must not rely on sending an employee on a course to meet all development needs. They should look at all possible methods of developing skills and widening the employee's experience. These might include some of the following options:

- Conferences
- Reading journals and research papers
- Carrying out a literature search
- Attending relevant meetings
- Attending relevant in-service lectures/ presentations
- Membership of relevant Professional Groups/Body
- Reflection on day to day practice with colleagues
- Visits to centres of excellence
- Work Shadowing
- Business in Community Initiatives
- Courses
- Learning from an experienced colleague
- Membership of a Special Interest Group
- Giving lectures/updates
- Appropriate job rotation/ opportunities in own work setting
- Participation in relevant multi-professional work group
- Self directed study/open learning
- Participation in project work
- Secondment within/outside Trust
- Mentoring
- Action learning

5. KSF Links with Pay (Gateways)

Staff will progress through the paypoints on their payband by applying the necessary knowledge and skills to the demands of their post. Although, at two defined points in a pay band – known as gateways – decisions are made about pay progression as well as development. There are two gateways in each pay band:

1. Foundation gateway – this takes place no later than 12 months after an individual is appointed to a pay band, regardless of the pay point to which the individual is appointed. During this initial period all staff will have at least two discussions with their manager (or the person acting as their reviewer) to review progress, guided by the KSF foundation outline for the post. The first of these discussions should normally be during the induction period. The aim of these discussions and any resulting support and development will be to help staff make a success of the new job and confirm as quickly as possible that they are applying the basic knowledge and skills needed for the job and can pass through the foundation gateway and commence progression up their pay band.

2. Second gateway – this is set at a fixed point towards the top of a pay band. The purpose of the second gateway is to confirm that individuals are applying their knowledge and skills to consistently meet the full demands of their post.

Position of Gateways

Pay Band	Position Of Gateway
Pay Band 1	Before final point
Pay Bands 2-4	Before 1st of last 2 points
Pay Bands 5-7	Before 1st of last 3 points
Pay Bands 8 A-D	Before final point
Pay Band 9	Before final point

The whole system is based on the principle of NO SURPRISES – if there are problems with individuals developing towards the full KSF outline for the post, or there are disciplinary issues, these must have been addressed separately by reviewers before the gateway reviews. This mirrors good management practice and should be no different from good appraisal practice. Therefore deferral of pay progression should be the exception rather than the rule.

There is an expectation that individuals will progress through the paypoints on a payband by applying the necessary knowledge and skills to the demands of the post. It is only at gateways, or if concerns have been raised about significant weaknesses in undertaking the current role, that the outcome of a review might lead to deferment of pay progression. In between gateways staff progress up the pay increments within their pay band on a yearly basis as they continue to learn and develop with the support of their manager through the participation in PDR meetings.

New Members of Staff who commence at the 2nd Gateway Point

In some instances a new member of staff may commence with the Trust and have sufficient length of service with another Trust that will mean they will commence at an increment which equates with their second gateway review. In this instance, during the Local Induction, the Line Manager should ensure that a one-to-one meeting takes place in which they explain the KSF Post Outline, discuss any transferred PDR information from their previous post and develops and together agree a PDP and Action Plan for the incoming Probationary Period of 6 months. The individual will automatically progress through their gateway and they will be reviewed at the end of the 6 month probationary period.

Preceptorship

Staff joining pay band 5 as new entrants on or after 1st October 2004, will have accelerated progression through the first two points (spine points 17 and 18) in six monthly steps (that is they will move up one pay point after six months and a further point after 12 months) providing those responsible for the relevant standards in the organisation are satisfied with their standard of practice. This twelve month period will be referred to as 'Preceptorship'.

Within the first 12 months of employment the individual will have two development reviews. The first review after 6 months will seek to establish whether the individual is on track in their development towards the foundation gateway, and if this is the case, they should receive an incremental point.

After 12 months, the second development review will focus on the KSF foundation outline for the post and this will form the foundation gateway. When the individual passes through this foundation gateway, they will move up to the next point on the pay band. Like all other staff they will only have one foundation gateway and only one foundation gateway review.

Accelerated Progression

Accelerated Progression relates to staff eligible under Agenda for Change Circular HSS (AFC)(12) 2008 ie there are groups of staff (such as midwives) who tend to move quickly to operate in roles that demand a level of autonomous decision making in the overall delivery of care that exceeds that normally associated with jobs allocated to pay band 5. Typically these roles operate without the influence of other professional groups. Where supervision operates, it is generally management supervision and does not normally impinge upon clinical practice. In such circumstances job size

should be reviewed no earlier than one year and no later than two years from the date of qualification, using the NHS Job Evaluation scheme. If the evaluation demonstrates that the post holder's job weight is of sufficient size to move to the next pay band (Pay Band 6) this should be affected without the need for application for a post at a higher level.

It is not expected that the review will be widespread practice as the majority of staff will work in circumstances in which there is regular clinical supervision and the delivery of care and treatment is subject to control or influence from other health care professionals There is no facility for this provision to operate in any other part of the pay structure. (Annex T, Terms and Conditions Handbook).

The process for handling such posts should be as follows:

- The post holder obtains a post with an agreed new entrant job description and person specification, which matches the band 5 profile
- 6 months post appointment, a first review will help to assess progress towards achieving what is required at the foundation gateway review for Band 5
- 12 months after appointment the foundation gateway review will take place. If the individual has achieved the necessary skills and competences for a band 5 they will then be awarded an increment.
- 12 months after appointment, an assessment should be made against the band 6 job description and person specification. If it can be demonstrated that the post holder has achieved the required standard, s/he is deemed ready to assume the responsibility and thereby work to the band 6 job at the level expected of a new recruit to that band.
- If this is agreed, the appropriate head of service is informed of the outcome. They will then authorise the progression to Band 6.

In the event where a practitioner is unable to attain the required level of knowledge and skill, this should be reassessed on a three monthly basis for a further 12 months.

If, following a further 12 month period (24 months post qualification) an individual is still unable to work at a level of a Band 6 post, the organisation concerned may wish to refer to its local capability procedures.

6. Dealing with Problems at Gateway Reviews

There may be times when staff are unable to achieve their full KSF outline and therefore not progress through the relevant gateway. Some examples of this may be:-

(a) KSF Outline not achieved due to organisational issues

If the employee is unable to demonstrate the application of the necessary skills and knowledge due to organisational issues such as:

- inadequate managerial support,
- not being released from the workplace due to staffing levels,
- financial constraints, etc – for example, continuation of pandemic for prolonged period.

In these cases the employee will progress through the gateway with an agreed action plan in place. Note that this list is not exhaustive.

(b) KSF Outline not achieved due to non-achievement of training and/or development agreements

In some instances staff may not have followed up or attended the necessary development opportunities as agreed with their manager through no fault of the Trust. In these circumstances staff will not progress to the next incremental point on their pay band until such times as they can demonstrate achievement of their KSF Outline. Pay progression cannot be deferred unless there has been prior discussion between the individual and the person undertaking their review, which should be recorded, about the knowledge and skills that the individual needs to develop and apply and that the member of staff has been given the opportunity to achieve the necessary development.

In the above circumstances a short term action plan should be agreed and put in place by both parties. The action plan should clearly outline:-

- the reason/s for deferment
- the KSF dimensions and levels which are still to be achieved,
- identified training and development opportunities
- an agreed review date (within 3 months of the previous review).

(c) KSF Outline not achieved as the Reviewee is unable / unwilling to apply their learning and development

On rare occasions the reviewee may be unable to apply their learning and development in order to achieve their KSF Outline. Good management practice and effective use of the annual review process will ensure that the staff member is aware of the issues as they arise. Problems with roles and responsibilities should be dealt with well in advance of the gateway reviews therefore allowing the individual adequate opportunity to work toward the standard required. If

issues still remain it may be necessary to refer to the Trust's Capability Procedure in the future. In these circumstances pay progression to the next incremental point on the pay scale will be deferred at the appropriate Gateway and this deferral will last until issues are resolved. The application of knowledge and skills cannot be backdated therefore the increment is not backdated.

7. Disagreements Regarding Gateway Decisions

If the member of staff and the reviewer fail to reach agreements regarding gateway decisions both parties can seek advise/support on an informal local basis from the Human Resources Department and Trade Union Side. If the informal process does not provide consensus, the member of staff can take their issue in writing to the Reviewer's Line Manager. The right to be accompanied by an employee representative will apply throughout the process.

Issues of disagreement should be the exception rather than the rule as one of the principles of the system is that it is based on "no surprises".

8. Extenuating Circumstances

8.1 Planned Long Term Sick Leave:

If a member of staff is on planned long-term sickness absence when an annual development review is due to take place, the reviewer and member of staff should agree when the review is to be scheduled. The review can take place either prior to the commencement of leave or within 3 months of returning to work or at a date that affords an equivalent timescale to the period missed prior to the review due date eg review due 10th August and sick leave commenced on 6th April the time period missed is 18 weeks. Therefore the annual review would be planned for 18 weeks following return to work.

8.2 Unplanned Long Term Sick Leave:

(a) If a member of staff is on unplanned long term sick leave absence when an annual development review is due to take place, the reviewer and member of staff should agree when the review is to be scheduled. The review can take place within 3 months of returning to work or at a date that affords an equivalent timescale to the period missed prior to the review due date eg review due 10th August and sick leave commenced on 6th April the time period missed is 18 weeks. Therefore the annual review would be planned

for 18 weeks following return to work.

If a gateway review is to take place and there has not previously been any significant weakness in performance or a skill gap identified, the member of staff will progress through the gateway while on sick leave. The reviewer must complete the first page of the PDR form and forward to the Trust's Payroll Department. It is important to note that where this form is not completed and sent to Payroll in time the individual will not receive their entitled increment.

In the event that Occupational Health guidance indicates that the member of staff is not able to undertake the full range of duties immediately on return to work, the foundation subset or full post outline requirements for second gateway may be modified for a period of time, if appropriate.

(b) If a significant weakness in performance or a skill gap has been previously identified, discussed and documented and has yet to be resolved, the member of staff will not progress through the gateway while on leave. The reviewer should meet with the member of staff on return to work to revisit the development action plan previously put in place. The gateway review should then take place at the earliest possible date, but no later than 3 months from the date the member of staff returned to work or an equivalent timescale to the period missed prior to the review due date eg review due 10th August and sick leave commenced on 6th April the time period missed is 18 weeks. Therefore the annual review would be planned for 18 weeks following return to work.

Once there is agreement that the individual meets the KSF post outline appropriate to the particular gateway then pay progression resumes from that date. The application of knowledge and skills cannot be backdated therefore the increment is not backdated.

8.3 Maternity Leave / Adoption Leave

(a) If a member of staff is on maternity leave/adoption leave when an annual development review is due to take place, he/she and the reviewer must agree that the review is to take place prior to the commencement of leave.

Where a gateway review is to take place and there has not previously been any significant weakness in performance or a skill gap identified, the member of staff will progress through the gateway while on leave. The

reviewer must complete the first page of the PDR form and forward to the Trust's Payroll Department. It is important to note that where this form is not completed and sent to Payroll in time the individual will not receive their entitled increment.

(b) If a significant weakness in performance or a skill gap has been previously identified, discussed and documented and has yet to be resolved, the member of staff will not progress through the gateway while on leave. The reviewer should meet with the member of staff on return to work to revisit the development action plan previously put in place. The gateway review should then take place at the earliest possible date, but no later than 3 months from the date the member of staff returned to work or an equivalent timescale to the period missed prior to the review due date eg review due 10th August and sick leave commenced on 6th April the time period missed is 18 weeks. Therefore the annual review would be planned for 18 weeks following return to work.

Once there is agreement that the member of staff can meet the KSF post outline appropriate to the particular gateway then pay progression resumes from that date. The application of knowledge and skills cannot be backdated therefore the increment is not backdated.

8.4 Unexpected long term leave / absence of reviewer

If the reviewer is on relatively short unplanned leave of any kind and this coincides with the date of a development or gateway development review, the date should be re-scheduled. Where the reviewer is likely to be absent on a long term basis and particularly where gateway progression will be affected by their absence, the review must be undertaken by an appropriate nominated reviewer in his/her absence who must be aware of any issues that have been highlighted at the previous development review or meetings that have taken place during the year.

8.5 Career Break

If a member of staff has opted to take a career break, incremental rises will be frozen until their return to work. On returning to work the member of staff and manager must have a meeting to discuss the KSF post outline, bearing in mind that the member of staff may have been on a career break for a number of years or may have returned to a different post; Map the current level of knowledge and skills against the outline and agree an initial Personal Development Plan.

The manager should meet with the member of staff on at least two occasions during the first 12 months of returning to work to ensure an appropriate level of support is provided.

8.6 Acting Up

Periods of acting up should not normally last any longer than 6 months except in instances of maternity leave or long-term sick leave where a longer period may be known at the outset. For development purposes, the member of staff and his/her manager should meet at the commencement of the period of acting up to discuss the KSF outline associated with the acting post.

If a gateway review associated with the member of staff's substantive post would have otherwise taken place except for the fact that he/she was acting up, on return to their substantive post the member of staff will be allocated the pay point that would have been awarded on successful gateway review except where there was a previously identified skill gap etc. The reviewer and member of staff should arrange to meet following his/her return to the substantive post to ensure that he/she has settled back into the job and to carry out the gateway review.

8.7 Movement to another post within the same pay band

If a member of staff moves to another post on the same payband after having passed through a foundation or final gateway then he/she will be expected to apply the necessary knowledge and skills described in the KSF outline. A foundation gateway will not apply for pay purposes if the individual has previously successfully passed through the gateway. However, the member of staff will still be reviewed against the KSF post outline subset and have a Personal Development Plan developed to meet the necessary knowledge and skills for the new post as described in the NHS KSF post outline. The reviewer and member of staff should meet at least twice during the first twelve months to ensure that the member of staff is adequately supported in their post.

If a member of staff moves to another post on the same payband when he/she has already passed through the second gateway, the final gateway will not apply for pay purposes. However, the member of staff will be reviewed against the full KSF outline and have a Personal Development Plan developed in order to meet the necessary knowledge and skills for the new post. The reviewer and member of staff need to decide and agree a realistic target within the first 12

months and ascertain when the full KSF post outline will be attained. Their Personal Development Plan will need to prioritise areas of development for the current post over any career progression.

In cases where a person moves to another post on the same payband but different job family eg from Admin to Social Care whilst their knowledge and skills may be transferable in relation to for example some of the Core Dimensions, they may not be for example the Health & Well Being Dimensions because they may not have been part of the person's previous Post Outline and therefore they will not have had the opportunity to demonstrate their application. These circumstances will be considered on an individual basis as part of the appointment process.

8.8 Temporary Staff

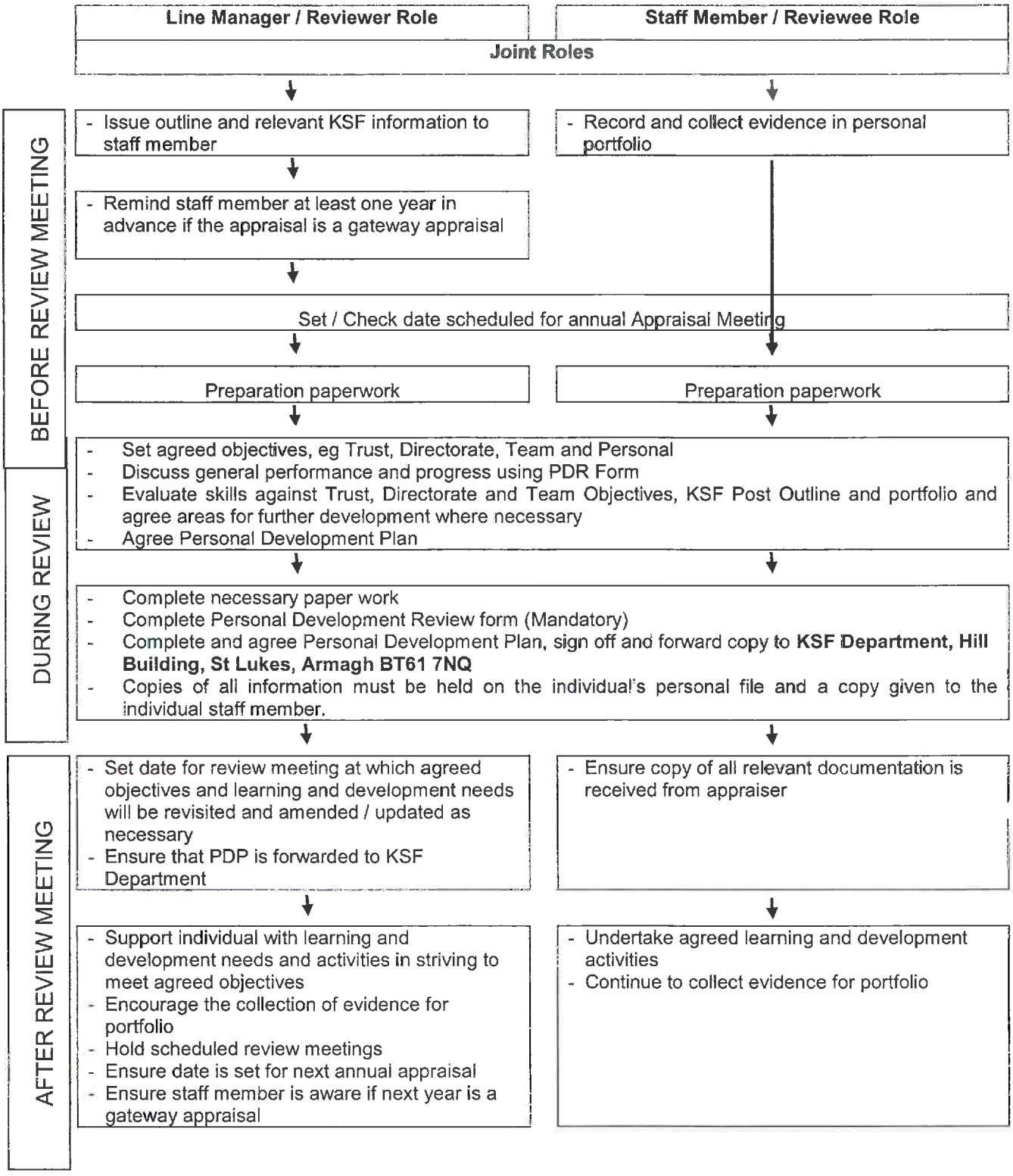
In accordance with employment law, temporary staff should be treated in the same way as permanent staff members.

Where an individual is employed on a temporary contract for a very short period of time, the manager and individual will agree the training needs as part of the induction. If the period of employment is for more than 6 months or the original temporary employment is extended to exceed 6 months it is expected that a Personal Development Plan will be developed for the member of staff based on the KSF outline.

8.9 Part-Time Working

Irrespective of the number of hours worked staff are required to have gateway reviews in order to pass through the paypoints. Personal Development Plan's and subset outlines should be realistic for the hours worked.

9. Flowchart for Personal Development Review



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Performance and Personal Development Review Policy Based on the Knowledge and Skills Framework (KSF)

Lead Policy Author & Job Title:	Anne Forsythe, Head of Workforce & Organisational Development
Directorate responsible for document:	HR & Organisational Development
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Working together Excellence Openness & Honesty Compassion

Policy Checklist

Policy name:	Performance and Personal Development Review Policy
Lead Policy Author & Job Title:	Anne Forsythe, Head of Workforce & Organisational Development)
Director responsible for Policy:	Vivienne Toal
Directorate responsible for Policy:	HR & Organisational Development
Equality Screened by:	Heather Clyde, Vocational Workforce and Assessment Centre
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Supersedes:	Legacy Policies for Craigavon and Banbridge, Craigavon Area Hospital, Newry & Mourne, and Armagh & Dungannon Trusts

Version History

Version	Notes on revisions/modifications and who document was circulated or presented to	Date	Lead Policy Author
Version 1.0	Contact Details, Introduction to Policy 1:7, Appendix 2 Revalidation incorporated.	01/12/2008	Assistant Director Human Resources / ELD – Mrs Heather Ellis
Version 2.0	Contact Details, Appendix 2 Revalidation Form Removed	22/03/2016	Director Human Resources Mrs Vivienne Toal
Version 3.0	Hyperlinks added at 3.8 and 3.12 and 8.0. Differentiation between Supervision and Appraisal added at 5.1. KSF PDP Form updated (Appendix 1). Contacted details updated (Appendix 3). 9.4 change in wording due to UK leaving EU – becomes - UK General Data Protection Regulations (UK GDPR) 2018.	15/02/2021	Anne Forsythe, Head of Workforce & Organisational Development

Contents

Appendices

1.0 Introduction

1.1 The Southern Health and Social Care Trust (hereafter referred to as "the Trust") is committed to ensuring that robust corporate governance arrangements are in place in the operation of its business.

1.2 The Trust is committed to performance review and personal development and regards this as an important component of the Trust's governance process. It contributes towards organisation and service development and provides opportunities for each of member of staff to develop their potential.

1.3 The Trust will ensure that each member of staff knows what is expected of them including standards of conduct and performance required of them, this will be done through personal feedback from their line manager and set in the context of objective setting and review.

1.4 In support of this, the performance review and personal development documentation has been based on the NHS Knowledge and Skills Framework (KSF). KSF defines and describes the knowledge and skills that Health and Social Care staff need to apply in order to deliver quality services. It provides a single consistent, comprehensive and explicit framework on which to base performance review and personal development for staff. KSF is used to develop outlines for individual jobs. These outlines provide links to gateways for pay progression.

1.5 As part of this process, Continued Professional Development (CPD) will be discussed. Each individual profession will have their own requirements for this and reference should be made to these guidelines as appropriate.

1.6 The Trust is committed to supporting staff in their CPD and expects all qualified staff to undertake the necessary amount/levels of CPD as required by their profession. CPD is a personal commitment to keeping your personal professional knowledge up to date and improving your capabilities throughout your working life. It is about knowing where you are today, where you want to be in the future and making sure you have formulated a direction in association with your line manager in order to help you get there.

1.7 Also with reference to management standards Health & Social Care in Northern Ireland have adopted The Healthcare Leadership Model which has been developed by the NHS Leadership Academy. It is an evidenced based research model that reflects the values of the NHS. It comprises of nine dimensions and the model provides NHS staff with a means of analysing their leadership roles and responsibilities.

1.8 Other agreed competency frameworks may also be used for reference.

2.0 *Purpose and Aims*

2.1 The Southern Trust, through this policy ensures that staff have a strong and effective performance review and personal development which has a very positive effect on the individual's performance, their development and that of the organisation and can therefore contribute greatly to the improvement and development of the services the Trust provides for its patients and clients.

2.2 Recognise achievements and provide help in overcoming obstacles to successful performance.

2.3 Through this policy the Trust will ensure the roll out of performance review and personal development using the KSF Framework across the organisation.

2.4 The Trust will ensure that all staff are clear about their responsibilities for staff development.

2.5 Provide the basis for future training and workforce development strategies and plans.

2.6 Encourage the development of a flexible learning culture across the organisation.

3.0 *Objectives of this Policy*

3.1 The process of performance review and personal development process begins with a focus on the review of an individual's work in relation to individual service and organisational objectives. This provides an opportunity to receive feedback from the line manager on work performance, ways in which performance can be sustained or improved, and have these laid out in the form of agreed objectives.

3.2 Discussion should be honest, open and positive. An individual's strengths, successes and contribution to the service should be recognised explicitly alongside a consideration of areas in which they might need to develop or improve.

3.3 The framework provided in the documentation should be jointly considered. This should structure the discussion, enabling both parties to prepare for and contribute to the process - Appendix 1.

3.4 A set of agreed objectives will be formulated from this discussion between the member of staff and the line manager. The action points supporting these objectives should be written using the SMARTER criteria (Specific, Measurable, Achievable, Relevant, Time-bound, Evaluated and Repeated).

3.5 The individual's objectives should reflect those of the Organisation, Directorate and Team. Where improvement is not required objectives may focus upon both maintenance and innovation.

3.6 The personal development review element of performance review focuses upon reviewing an individual's skills, knowledge and experience, and how they are applied in relation to the requirements of their post using the KSF outline. Training and development needs are identified; ways in which these needs can be

addressed are discussed and set out in the form of a Personal Development Plan (PDP).

3.7 Development review is a cyclical process that comprises of four stages:-

- A joint review between the individual and their line manager (or another person acting in that capacity) of the individual's work against the demands of their post, as set out in the KSF outline for that post.
- The formulation of an agreed PDP that identifies the individual's learning and development needs and interests.
- Learning and development by the individual, supported by their manager.
- Evaluation of the learning & development that has occurred and how the individual has applied it in their work.

3.8 Outlines developed for posts within the Trust are available from the Knowledge and Skills Framework link on share-point, (click here). It is only these outlines that should be used in the performance review. These outlines will be reviewed and further developed and are therefore liable to alteration. It is the responsibility of both parties to obtain the relevant and up to date outline as part of the preparation for a performance review. However, in the event of an outline not being available the KSF team within the Vocational Workforce Assessment Centre (VWAC) should be contacted for guidance (see Appendix 2).

3.9 The performance review evaluates the individual's application of knowledge and skills in their work, using the KSF outline for the post as the basis for the discussion. Demonstrable knowledge and skills evident in a person's work will be considered in relation to all the dimensions included in the outline.

3.10 A Personal Development Plan (PDP) is formulated from this performance review. This identifies the areas an individual needs to demonstrate more fully and the help they need to develop in order to achieve the required level for their post.

3.11 The PDP will focus initially upon enabling an individual to meet the demands of their current post as described in the KSF outline. Once this has been achieved a PDP should enable an individual to maintain their knowledge and skills; developing them to meet any changing requirements, and facilitate an individual's further development within or beyond their current post, considering both individual and organisation needs and aspirations.

3.12 PDP's need to be completed annually. Line Managers should record completion of a PDP directly on HRPTS (click here for guidance). Alternatively, completed PDP's can be forwarded to the Vocational Workforce Assessment Centre to be recorded centrally. .

3.13 Managers are required to monitor that the above policy is implemented and that regular follow up is in place to ensure performance review is completed for all staff groups. The policy will be monitored Trust Wide by the Vocational Workforce Assessment Centre. KSF reports are compiled on a regular basis and forwarded to

Directors. KSF is a standing item on the agenda of Senior Management Team (SMT) meetings.

4.0 *Policy Statement*

The Trust has an obligation to fully implement the Agenda for Change initiative. The Trust will ensure that there are effective systems in place to support the appraisal process and include ensuring that all supervisors have the appropriate knowledge and skills to completely undertake this role.

5.0 *Scope of Policy*

This policy applies to all permanent staff and those on a fixed term contract and long term agency staff (6 months) other than Medical, Dental staff, and Directors for which there are separate arrangements.

5.1 It is important to differentiate between supervision and appraisal. Whilst Supervision activities should inform, and are informed by, the KSF PDR process, neither activity should be substituted for the other, as each activity has a different purpose.

6.0 *Responsibilities*

In the Southern Trust there are key individuals with responsibility for ensuring KSF PDR process is implemented.

6.1 *Chief Executive*

The Chief Executive has overall responsibility and accountability for the quality of service provision. Appraisal plays an important role in ensuring the delivery of high quality, safe and effective care.

6.2 *Directors*

All Directors have responsibility for ensuring that arrangements are in place to implement and ensure compliance with this policy and that resources are available to support the process including that supervisors have the appropriate skills and knowledge to undertake appraisal. Directors also have responsibility to complete KSF reviews and PDP's for all those staff they manage.

6.3 *Assistant Directors*

Assistant Directors have responsibility for coordinating and facilitating implementation of the KSF process. They are responsible for agreeing the models to be employed within their area of responsibility and must ensure that appropriate resources are in place to meet the requirements of this policy. They are responsible for monitoring the level and quality of activity and supporting operational and professional Heads of Services and managers in the implementation of this policy. They also have responsibility to carryout KSF reviews and PDP's for all staff they manage.

6.4 *Head of Service / Line Managers*

The Head of Service/Line Manager has a responsibility to carryout KSF reviews for all those staff they manage. The Head of Service/Line Manager must also avail of KSF reviews and act as a supervisor for identified staff. S/he is also responsible for ensuring that arrangements are in place for the implementation and local monitoring of KSF activities.

6.5 *Supervisors*

Supervisors have a responsibility to maintain and develop their own skills and competencies relevant to KSF review in line with this policy. They have a responsibility to participate in and prepare for agreed KSF meetings. It is their responsibility to keep a record of the appraisal meeting and implement agreed action.

6.6 *Supervisees*

Supervisees have a responsibility to engage fully in the KSF process. They have a responsibility to participate in and where relevant, prepare for the agreed meeting. Where required supervisees should keep a record of appraisal and implement agreed actions.

7.0 *Evaluation & Review*

Managers are required to monitor that the above policy is implemented and that regular follow up is in place to ensure performance review is completed for all staff groups. The policy will be monitored Trust Wide by the Vocational Workforce Assessment Centre. KSF reports are compiled on a regular basis and forwarded to Directors. KSF is a standing item on the agenda of Senior Management Team (SMT) meetings.

8.0 *Legislative Compliance, Relevant Policies, Procedures and Guidance*

Policy on Professional and Operational Management Interface within the Integrated Care Teams – click here

9.0 *Equality & Human Rights Considerations*

9.1 This policy has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these.

9.2 Using the Equality Commission's screening criteria, no significant equality implications have been identified. The policy will therefore not be subject to equality impact assessment.

9.3 Similarly, this policy has been considered under the terms of the Human Rights Act 1998, and was deemed compatible with the European Convention

Rights contained in the Act.

This document can be made available on request in alternative formats, e.g. plain English, Braille, disc, audiocassette and in other languages to meet the needs of those who are not fluent in English.

9.4 Staff must comply with relevant legislation, professional standards and guidance and other DHSSPS publications as follows:-

UK General Data Protection Regulations (UK GDPR) 2018.

10.0 Sources of Advice & Further Information

Further information about the Performance and Personal Development Review Policy can be obtained from the: Vocational Workforce Assessment Centre, St Luke's Hospital, Hill Building, Armagh, BT61 7NQ.

Part A

Appendix

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: _____ **Staff Number:** _____

Is Professional Registration up to date? _____

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? **Post Outlines can be accessed via Trust Intranet (KSF link)** **YES** ☐ **NO** ☐ **Have Post Outline levels been achieved:** **YES** ☐ **NO** ☐ **If no, record below what action to be taken:**	**Staff members comments on his/her performance over past year:** **Line Manager's Feedback on staff members performance over past year:**
Objectives for Next Year:	

Reviewee Staff Name (Print) _____ Signature _____ Date _____

Reviewer Manager/Supervisor (Print) _____ Signature _____ Date _____

Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: _____

Training Type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction		
	Departmental Induction/Orientation		
	Equality, Good Relations and Human Rights – Making A Difference		
	Fire Safety		
	Infection Prevention Control		
	Information Governance Awareness		
	Cyber Security Awareness		
	Moving and Handling		
	Safeguarding People, Children & Vulnerable Adults		
Role Specific Essential Training	Basic ICT		
	Control of Substances Hazardous to Health (COSHH)		
	Food Safety		
	MAPA (level 3 or 4)		
	Professional Registration		
	Right Patient, Right Blood (Theory/Competency)		
	Waste Management		
Best practice/ Development (Relevant to current job role)	(eg Coaching)		

Reviewee Staff Name (Print) _____ Signature _____ Date _____

Reviewer Manager/Supervisor (Print) _____ Signature _____ Date _____

PLEASE SEND COMPLETED PART B TO:
VWAC, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ OR EMAIL: [redacted]

Appendix 2

Flowchart for completing KSF Personal Development Review and Plan

	Line Manager	Staff Member
BEFORE MEETING	Read post outline and job description for staff member	Read post outline and job description Reflect on how you have achieved the levels
DURING MEETING	Discuss general performance and progress Evaluate skills against post-outline and job description Agree areas for further development where necessary Discuss career development Complete PART A of form including staff member's comments and line manager's feedback from discussion	
AFTER MEETING	Keep a copy of completed form Set an annual review date (or sooner if actions identified in Part A require on-going meetings)	Keep a copy of completed form Undertake any actions identified in Part A Undertake agreed learning and development activities

FORWARD PART B TO VWAC TEAM

Contacts for KSF (Knowledge & Skills Framework)

Lynn Irwin **Senior HR Manager (Vocational Workforce Development)**	Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI E Mail – Personal Information redacted by the USI
Margretta Chambers **Union Representative KSF Advisor**	Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI E Mail – Personal Information redacted by the USI
Ann McCann **KSF Support**	Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI E Mail – Personal Information redacted by the USI
Gemma Cunningham **KSF Support**	Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI E Mail – Personal Information redacted by the USI
Tara Davison **KSF Support**	Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI E Mail – Personal Information redacted by the USI
Carol McGreevy **KSF Support**	Tel: Personal Information redacted by the USI Mob Personal Information redacted by the USI E Mail – Personal Information redacted by the USI
Heather Clyde **KSF Support**	Tel: Personal Information redacted by the USI Mob: Personal Information redacted by the USI E Mail - Personal Information redacted by the USI
Forward PDPs to	Tel: Personal Information redacted by the USI E Mail - Personal Information redacted by the USI

Flowchart for completing KSF Personal Development Review and Plan

	Line Manager	Staff Member
BEFORE MEETING	Read post outline and job description for staff member Reflect on achievement of levels Refer to previous years KSF form	Read post outline and job description Reflect on how you have achieved the levels Complete Part B of the KSF form for mandatory training only Refer to previous years KSF form
DURING MEETING	Discuss general performance and progress Evaluate skills against post-outline and job description Agree areas for further development where necessary Discuss career development Complete PART A of form including staff member's comments and line manager's feedback from discussion Complete PART B sections on essential for post and best practice training Manager and staff member to sign and date PARTS A and B	
AFTER MEETING	Keep a copy of completed form Set an annual review date (or sooner if actions identified in Part A require on-going meetings) Forward a copy of PART B to the KSF department to ensure staff members Personal Development Plan is recorded annually on HRPTS	Keep a copy of completed form Undertake any actions identified in Part A Undertake agreed learning and development activities Refer to KSF form (parts A & B) during supervision throughout the year

FORWARD PART B TO KSF DEPARTMENT

Appendix Question 33

Southern Health and Social Care Trust

Name of Meeting: Acute Services SMT Performance Meeting **DRAFT NOTES**

Date of Meeting: Tuesday, 23 February 2021 at 11.30am

Venue: Videoconference – Ronan Carroll's Meeting Space

Attendees: Melanie McClements; Mary Burke; Ronan Carroll (**Chair**); Barry Conway; Anne McVey; Tracey Boyce; Anita Carroll; Lynn Lappin; Julie Brodison; Joanne Hughes

Apologies: Lesley Leeman

Agenda Item	Discussion	Action
1. Apologies	• Apologies received from Lesley.	
2. Chair's Business	• Melanie welcomed everyone to the meeting. No Chair's business to be discussed, other than listed on the agenda.	
3. Matters Arising	• Actions notes from the meeting on 26 January 2021 are agreed as an accurate reflection. • Contracts – Lynn advised that Sue-Ann Collins is aiming to have the Band 6 and Band 7 job descriptions with the teams by 16th March.	**Sue-Ann Collins to draft job descriptions**
4 lective Additionality 2020/21	• Lynn advised that elective additionality was ongoing with no underspend / risk identified by the Teams at this time. • Lynn gave an update to the meeting on Orthopaedics plan with the Hermitage, Dublin. Work is ongoing with Hermitage to get agreement finalised.	
5. Elective Additionality 2021/22	• Ronan suggested that opportunities for IHA would be limited in 2021/2022 as theatre staffing continues to remain an issue. Lynn noted that Q1 bids would be required for red flag / urgents. • Lynn queried with Ronan if the Nurse Endoscopist post, which had been recruited at risk, still required recurrent funding. Ronan to confirm and Lynn to submit to HSCB if required. • Anne raised the vacant Nurse Endoscopist post advising that one of the Consultants had sought the redirection of this funding to consultant sessions. Ronan advised that they would be seeking to	**Ronan to confirm if NE still funded at risk** **Lynn to notify HSCB of cost**

Agenda Item	Discussion	Action
	replace this post with another Nurse Endoscopist and that they believed that this recruitment would be successful. Melanie queried the sessional throughput from a Consultant versus a Nurse Endoscopist. Melanie was advised that a Nurse Endoscopist would have 5 sessions of endoscopy a week versus 1 – 2 for a Consultant.	
6. Regional Elective Prioritisation Process	• Ronan stated that the elective rebuild will be a slow process and that ICU beds are still at 14, therefore, April will not demonstrate a lot more theatre activity. Ronan further indicated that CCANI wished to keep the existing arrangements in place until May. • It was noted that the Regional prioritisation process for IS and elective theatre capacity has worked well. • NOUS being undertaken by the Northern Trust due to extra capacity which is also working well and SET have offered capacity for Echos with Kay working to send patients. • Lynn asked for any issues that needed to be raised at the next HSCB performance meeting: o Anne asked that Cardiology Cath Lab pressures to be raised with Team concerns / frustrations around only have one Lab and lack of back up should the machine break down. o Red Flag waiting time information to be raised at HSCB Cancer Performance Meeting as lack of Regional approach to sharing this information. o Ronan noted daily queries from MLAs regarding waiting times and the time required to answer these queries along with the raised expectations from the patients. Melanie to raise at SMT and Lynn to add to HSCB/Trust Service Issues/Performance meeting agenda.	**Melanie to raise MLA queries regarding elective wait times at SMT** **Lynn to add MLA queries and communication of waiting times to HSCB/Trust meeting agenda**
7. Performance Issues/Update	• Cancer Performance – Barry gave an update from the fortnightly Cancer Performance meeting. The 62 day target is now at 44% reflecting the decline in performance that the Trust has advised would occur as the patients begin to close off their pathway; 14 day target for Breast has shown some improvement. The Cancer Tracking Team continues to track double the normal amount of patients on the cancer pathways. Barry further noted work via the Fortnightly Cancer Checkpoint	

Agenda Item	Discussion	Action
	meetings to start and gather information per tumour site on their pre and post-Covid issues / performance and what their key barriers are now to improve this position. • Review Backlog – approximately 35,000 on list at present. The longest waits are from 2012/13 and if stragglers could be cleared it would make a big difference. Lynn suggested a line by line review of these outlying patients with the patients then being seen or discharged. • Cath Lab – Anne again noted the concern around only having one Cath Lab and the risk involved with this. Melanie asked if we were the only Trust in this situation? Melanie further asked if we had contingency arrangements in place in case of breakdown? • Imaging – Barry suggested that our infrastructure issues need to be flagged up to the new Imaging Board, being managed by Maria Wright. Capital investment and new equipment is needed.	**Lynn to check if any non-recurrent funding available for this** **Lynn to discuss with Regional Performance colleagues** **Anne to advise on contingency arrangements**
8. No More Silos	• Work Stream 2 – Lynn noted that the Interim Directory of Services would be completed by April. Melanie advised that the A/Ds were testing the numbers etc and would feed back to Elaine. Lynn noted the importance of the key Trust numbers being included, kept up to date and not staff's personal numbers as this is a public document. • Ambulatory Developments – Lynn noted the updates that had been submitted to Lesley with the Gynae proposal being finalised and the Surgical proposal still outstanding. Ronan advised that the Surgical Hotline was not being used well. Lynn advised that Lesley queried if space for this service had been requested from the Strategic Accommodation Group? Anita advised that it has not. Anita noted that a list of the vacant spaces has been drawn up which includes the booking centre areas. Anita further advised that there are two other Directorates looking at these spaces. Melanie asked Ronan could the Surgical service be run without current staffing levels if they were allocated accommodation? Ronan confirmed that yes, they could run the service if accommodation was available. Melanie voiced concern that she did not have one compiled document to evidence what space is required for Acute Services and what the justifications / need for it are. A/Ds to urgently meet to complete this and return to Melanie. This document should also include the requirements for the DCC which is currently located in STH theatres	**A/Ds to send any corrections or additions to Vicki this week** **A/Ds to draft detailed proposal and send to Melanie.**

Agenda Item	Discussion	Action
	and should be a 'black & white' solution for the provision of safe medical cover. This will enable Anita to raise at Strategic Accommodation Group. • Urgent Care Centre – Melanie voiced concern that that there are only 2 x 8A's using the allocated area in Ramone and feels that this space could be better utilised. • Work Stream 5 – Lynn provided an update from Elaine Murphy. The Patient Discharge Leaflet has been uploaded onto SharePoint and is out for printing. The Red Cross assisted discharge scheme commenced in January and seems to be working better in DHH than in CAH. In respect of the Dementia & Delirium sub-group Lynn advised that Claire Kelly would be assisting with this. Melanie noted concern and asked that this sub-group does not drag on like the Frailty one did. Anne advised that Patricia Loughran has been appointed as Head of Service for Stroke/Frailty.	
9. AoB	• Mary queried if the Emergency Department 4 hour performance should be added as a standard item to this agenda. Melanie agreed. • Tracey discussed the issue of vaccines for in-patients with the group and the importance of having an up to date list so vaccines are not wasted. It was agreed that a list of patients, that were fit and able to be vaccinated, was needed every morning. Tracey further noted that Edith Doyle was working on a template to send to GP's to inform them that patient has had the vaccine in hospital. • Melanie raised the topic of complaints from in-patients and their relatives that seem to be coming through the Chief Executive's office / other routes and queried where these should be going to / who should be dealing with? It was noted that within the Mental Health Directorate the A/D of the Week is the key link. ? no agreement was reached on how this should proceed.	**ED 4-hour performance to be added to agenda as standing item** **All to consider the appropriate route for complaints from in-patients/relatives**
10. Date of Next Meeting	• **Tuesday, 23 March 2021 @ 10.30am**	

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Melanie McClement

Tel: Personal Information redacted by the USI

2020 · 08 · 01

Q 33 · 156 · 2

ACUTE CLINICAL GOVERNANCE

Date: Friday 12 February 2021

8am Melanie's meeting space. Personal Information redacted by the USI

Meeting will not go ahead in view of covid pressures. One report sent to team for response and approval.

1.0	**Apologies**: S Tariq	
2.0	**Notes from last meeting** Action Notes 08.01.2021 Acute Cli	
3.0	**Chairs business**	
4.0	**Electronic Sign off** SIGNOFF_2020_12_ SHSCT.pdf	
5.0	**SAIs** Personal Information redacted by report for ACG.docx Ronan/ Ted/Mark Report send for comments- Ted, Shahid and Seamus replied saying they were happy with the report and added not comments.	AMDs/ CD
6.0	**Effectiveness and Evaluation** 2) Clinical audit summary for Acute Cl **Patient Safety Report** Acute Governance Report Feb21.doc	ADs and AMDs
7.0	**Monthly Acute Governance report**	

	copy December 2020 Acute SMT Governan	
7.1	**Complaints Position** – (communication and staff attitudes main complaints) • Current Complaints Current Complaints.xlsx • Weekly reopened complaints Reopened Complaints Report 08 • **Open 72 (27 overdue)** **Reopened- 27** **Ombudsman- 11** Ombudsman 07.01.2021.xlsx	
8.0	**Medicine Incidents/ Incident Management Position** Copy of December 2020 Acute.xlsx	
9.0	**Risk Registers** – additions, amendments and closures to the governance team. Corporate Risk Register August 202(Directorate RR December 2020.xlsx CCS Div.HOS.TEAM RR December 2020.x FSS Div.HOS.Team RR December 2020.x IMWH Div.HOS.Team RR December 2020.x Emergency Medicine Div.HOS.Team RR Au Pharmacy Div.HOS.Team RR De SEC.ATICS Div.HOS.Team RR De	ADs & AMDs
10.0	**Mandatory training**	

	Copy of Trustwide CMT Compliance Sum	
11.0	**Any Other Business**	
12.0	**Date of Next Meeting:** **8.00 am Friday 12 March 2021** **Via zoom link**	

CORPORATE OBJECTIVE: 1 – PROMOTING SAFE, HIGH QUALITY CARE				
Likelihood: Likely (4) **Impact: Major (4)** **Total Score: 16** **Risk Rating: HIGH** **Previous score: 16**		**RISK OWNERS: Director of Acute Services; Director of Children & Young People's Services; Director of Mental Health and Disability Services** **DATE RISK ADDED: November 2010** **Reworded: August 2017** **TIMESCALE FOR REVIEW OF CONTROLS: Monthly**		
Risk No.	**Risk Description**	**Key Current Controls**	**Who monitors the control?**	**How is it evidenced?**
12	**Clinical risk associated with inability to manage patient care within clinically indicated timescales.** Impact of COVID-19 has and is likely to increase this risk further due to downturn in activity and impact of social distancing restrictions.	Assistant Director and Heads of Service meetings Monthly Directorate SMT Performance and Governance meetings for escalation and review of risk management Quarterly External Performance meetings with Health and Social Care Board to account for performance and highlight risks in relation to patient safety and long waits	Heads of Service/ Assistant Directors Director and Assistant Directors Director and Assistant Directors	Notes and actions from meetings Reports, minutes and actions from meetings "
	Risk associated with: i) **inability to diagnose/assess/treat new red flag and new urgent patients within clinically indicated timescales**	1. Prioritisation of capacity to red flag and urgent demand in the first instance 2. Mechanism in place for triage and identification of red flag and urgent new patients	Assistant Directors Heads of Service	Recorded in notes of SMT performance meeting and Trust Board performance report SMT challenge Triage outcomes recorded on Clinical system and hard copy

		3. There are mechanisms to monitor at patient tracking level, red flag referrals and agreed process for escalation	Operational Service Leads/Heads of Service	Cancer tracking team escalates via email to Operational Service Leads/Heads of Service at each stage of the 62day cancer pathway for those patients who are not progressing and may breach. Each breach is discussed at the monthly cancer performance meeting
		4. Monthly Assistant Director Cancer and Divisional Performance meetings to review/escalate situations where risk presents in managing patients within their clinically indicated timescales. Risk Assessments completed as appropriate and options developed for management of same.	Heads of Service/Assistant Director	Divisions have submitted non recurrent bids to address these backlogs. It is discussed on a monthly basis with the each division and the performance team.
		5. There are mechanisms to monitor the waiting times for new urgent patients.	Operational Service Leads/Heads of Service	Weekly/monthly waiting list reports circulated Operational Service Leads for review
		6. There is a mechanism in place to ensure that a risk assessment is undertaken prior to cancellation of urgent or red flag patients. Cancellation avoidance is the first consideration.	Assistant Director	There is Acute Guidance for the cancellation of patients. Daily process for managing elective activity in the context of unscheduled care pressures - including framework for

				considering cancellation of elective activity and "Code Black" Process Flow for cancelling Elective activity Monday-Friday. Email communication of decisions re cancellation and rescheduled. All cancellations maintained on database
		7. Monitoring of cancellations of urgent or red flag patients – inpatient and day cases	Assistant Director	Live database tracking cancellations and rescheduled date
	ii) **Review or planned assessment/treatment waiting beyond the clinically indicated timescales** Impact of COVID-19 has and is~~will~~ likely ~~continue~~ to increase this risk due to downturn in activity and social distancing restrictions.	1. There are mechanisms in place to allow clinicians to categorise reviews into urgent and non urgent for assignment to appropriate waiting lists to facilitate booking those who most need their review	Individual clinicians	Separate waiting lists on PAS for routine and urgent. Clinical outcome sheet in place.
		2. There is monthly monitoring information in place to assist with oversight and identify and escalate those requiring prioritis~~z~~ation	Operational Service Leads/Heads of Service	Report produced by Operational Service Leads for Head of Service review and circulated to individual clinicians as appropriate
		3. Monthly Head of Service Specialty meetings to review/escalate situations where risk presents in managing patients within their clinically indicated timescales. Risk assessments undertaken as appropriate. Additional capacity prioritised as available.	Head of Service/Assistant Directors	Minutes of Head of Service meetings

		4. Action Plan being developed to consider improvements which can be made and need to consider alternative models of care delivery e.g. teleconference/ videoconferencing to facilitate patient assessment & review and associated policies will need to be updated to reflect this change **CHILDREN AND YOUNG PEOPLE'S SERVICES** 5. Review of clinical templates to seek to re-balance demand for review and new patients to manage risk 6. Analysis of new to review ratios and current review practice to assure best practice	Head of Service/Assistant Directors Head of Service/Assistant Director (CYP) Head of Service/Assistant Director (CYP)	Acute SMT Performance Minutes Project work ongoing Project work ongoing
	iii) Reporting of diagnostic testing beyond the clinically indicated timescales	1. Prioritisation of capacity to accommodate red flag and urgent reporting in the first instance 2. There is a mechanism in place for identification of red flag and urgent new patients 3. Additional contracted capacity for reporting in place - imaging 4. There is weekly and monthly monitoring information in place to assist with oversight and identify key areas where diagnostics	Head of Service/Assistant Director/Clinical Director/Associate Medical Director/ Operational Service Lead	Minutes of Radiology Thursday afternoon meeting IS contracts are used to manage the scanning and reporting times and where necessary we can access this to manage investigation and reporting time. Minutes of Radiology Thursday afternoon meeting Minutes of Radiology Thursday afternoon meeting

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		remain unreported and escalate those requiring prioritization		

Additional Actions Planned and Timescale

Non-recurrent funding as available will be allocated to provide additional in house and Independent Sector activity to areas to address the risk associated with inability to manage patient care within clinically indicated timescales. Areas of risk will be escalated to SMT with a view to increasing capacity at financial risk.

The Trust will continue to re-direct any available internal resources to areas of greatest risk

Ongoing engagement with clinicians in respect to what is a clinically acceptable wait for red flag/urgent patients

Acute SMT performance meetings are utilized to discuss escalations from divisional meetings and to review actions required.

Work ongoing to implement ~~finalise~~ an action plan to address those waiting longer than clinically indicated timescale for review~~—anticipated February 2020.~~

COVID factors:

- Impact of COVID has further reduced total capacity for elective activity
- All services have taken steps to maintain as much urgent and red flag activity as possible. This has included some face to face consultations, virtual consultations and video consultations. A significant amount of validation work continues to be done - both clinical and admin focussed
- Clinical teams have worked closely with regional Clinical Reference Groups to ensure a consistent approach to prioritisation of cancer work across tumour sites with cancer surgery being focussed in DHH and also with links to IS (mainly for Breast, Urology and Gynae to date). Information is being shared regularly with the clinical team to support this work including, for example a weekly meeting with a cancer focus.
- Diagnostic services have been maintained for urgent and red flag cases where possible. ~~, however this~~ There has been ~~an~~ impact ~~for example~~ on CT whereby one of the CT scanners in CAH has been dedicated as the COVID19 scanner. Throughput has also been reduced to support cleaning between patients and social distancing.

Appendix Question 40

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Director: Mrs Esther Gishkori

Tel: Personal Information redacted by the USI

2019.04.12

Q40.191.1

ACUTE CLINICAL GOVERNANCE

Date: Friday, 12th April 2019
8am, Board Room (beside the Canteen), CAH

1.0	**Apologies**: Neville Rutherford Jones, Ronan Carroll, Damian Scullion **Attendances – Tracey Boyce, Esther Gishkori, Anne McVey, Una Bradly, Martina Hogan, Chris Clarke, Philip Murphy Kathryn Boyd, Barry Conway, Aoife Currie, Ted McNaboe Patricia Kingsnorth, Mark Haynes.**	
2.0	**Matters Arising/Actions** ask Caroline Beattie will link with Aoife and Ronan re: ;learning.	
3.0	**Standards and Guidelines** papers provided for review	Caroline Beattie
4.0	**Audit** **Papers provided for review**	ADs and AMDs
5.0	**Dr Murphy shared the SAI reports for** Personal Information redacted by the USI **learning re: NEWS score training should be mandatory for all medical and nursing staff. A discussion took place re: the escalation of a deteriorating patient. Particularly for agency and bank staff. This should be included in a staff induction – progress with training teams.** Personal Information redacted by the USI **learning shared Dr Haynes advised there is a pathway for the stable fractured – under age of 65 they go to T+O and over 65 go to medical. Unstable fractures should go to the spinal team. A discussion took place around this process. Chest injury also occurred in this case. Repatriation also was a problem in this case. There is a need for clearer guidance. Esther advised there is a process in place for major trauma patients to be managed in Belfast. Expectation would be consultant to consultant for repatriation. There are issues with the Belfast Trust to provide capacity to care for trauma patients. This case should be fed back to the regional group. Spinal injuries have never been admitted to Southern Trust. Duncan Redmill is leading on the regional trauma**	Patricia Patricia

group.

This report will be shared with the HSCB for shared learning regionally in and JC – issues around reading notes and reports. Escalation of red flag reports. There needs to be a clear process. Verbal communication is not sufficient to speak to a person. There is an need for electronic sign off. Patricia to bring back this report.
The WHO checklist recommends all scans and reports to be reviewed prior to surgery. Trudy had been working on a policy for follow up of radiology results. Currently email are sent to consultants and secretaries.
What happens when preliminary reports are signed off and then the report is changed? Barry will follow up with Dr Yousouf.

Tracey to action Barry to follow up with Imran

- **SAIs:**

Appendix 4 - SEA [redacted].docx

- SEA Interna[redacted] 10.4.19.docx

SAI level 1 [redacted]-Final 11.4.19.docx

Gareth Hampton + Anne McVey

Report draft - SEA [redacted].docx

Draft report as at 6.2.19 SEA Including

Mark Haynes + Ronan Carroll

Personal information redacted by was discussed the questioned from the family appear to be defensive the SMT would recommend a more forthright answer. Talk to Dr Polley. Change may have to likely have caused the cardiac arrest.
There are issues having a GA MRI as no process for monitoring patients appropriately. There is a need for designated slots for GA MRIs.
There is should be a facility for Adult for GA MRI added as a recommendation.

Personal Information redacted by the USI – Personal Infor[redacted] is not for prevention of aspiration. Report not approved.

Internal reviews discussed and advised that the governance team will be conducting more SEA with staff directly involved in incidents as there is direct learning promptly.

SEA Level 1 - [redacted].docx

SEA Debrief [redacted].docx

SAI position
22 in total
14 reports to be started – problems with arranging meetings due to availability.
The team were advised to read the reports provided.

6.0	**Complaints Position –**	Patricia

	Current Complaints 01.04.19..xlsx Ombudsman complaints Ombudsman weekly 01.04.19..xlsx Re-opened complaints Weekly Re-Opened Report 01.04.19..xls:	
7.0	**Incident Management Position - for review** February 2019 Acute SMT Governance Rep • Majors and above for Feb 2019 Major and Catastrophic Incident • Other Incident Reports Acute Incidents - February 2019.xlsx Incident Review Position as at 01.04.1 • Medicines incidents Acute Services Directorate 28th Mar Learning from Medication Incidents .	Patricia
8.0	**Risk Registers** – additions, amendments and closures to the governance team. IMWH Div.HOS.Team RR Mar19.xlsx MUC Dir.Div.HOS.Team RR SEC.ATICS Div.HOS.Team RR ma CCS Div.HOS.Team RR mar19.xlsx FSS Div.HOS.Team RR Mar19.xlsx Directorate RR Mar19.xlsx Corporate Risk Register to Governan	ADs & AMDs
9.0 SI	**Management of Trust Clinical Guidelines** Clinical Guidelines – processes for adding guidelines to the side including Acute Consultation processes.	

13.0	**Any Other Business**	
14.0	**Date of Next Meeting:** 10th May 2019 at 8.00 am in the Board Room, CAH	

Surgery and Elective Care Division
Divisional, HOS and Team Risk Register - 1 March 2019

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
	15/10/2016	Provide safe, high quality care	ATICS/SEC	Inpatient / Daycase Planned Backlog Planned procedures beyond clinically indicated Timescales	Delay in review of patients for planned screening/repeat procedures presenting adverse clinical risk	INDC planned backlog in the following surgical specialities: Urology, General Surgery, Ortho and Chronic Pain	6/2/19 - Continue monitoring and discussed at HOS meetings 20/11/18 - IPDC planned backlog continues to be high risk to the Trust. Monthly monitoring continues and discussed at HOS performance meeting and monthly Director performance meeting 15/10/18 - Risk assessment paper written and submitted to Director for discussion at SMT. Validation of long waiters being undertaken in Gen Surgery and Ortho		
	15/10/2016	Provide safe, high quality care	ATICS/SEC	Inpatient / Daycase Planned Backlog for Endoscopy Planned procedures beyond clinically indicated Timescales	Delay in review of patients for planned screening/repeat procedures presenting adverse clinical risk	Encdoscopy planned backlog. Papers written and submitted to Director re risk. Requested HSCB funding for planned backlog clearance	6/2/19 - Ongoing validation. IS contract with medinet for 822 routine planned scope patients, however, only 350 colons. Routine planned continues high risk. 20/11/18 - Endoscopy planned validation continues by the NE. Funding secured to transfer routine planned patients to SET mobile for Q4 of 2018/19. 15/10/18 - Risk assessment paper written and submitted to Director for discussion at SMT. Validation to be undertaken of planned long waiters by Nurse Endoscopists		
	15/10/2016	Provide safe, high quality care	ATICS/SEC	OP Reviews beyond clinically indicated timescales	Delay in review of patients for planned screening/repeat procedures presenting adverse clinical risk	Delays in review of patient presenting adverse clinical ris	6j/2/19 - non-recurrent funding received to end of March 19 for Gen Surgery and chronic pain. To request funding from April 19 to continue with additonality on RBL. RBL discussed at HOS 20/11/18 - Ongoing review backlog clinics in general surgery, chronic pain and urology to the end of March 19. RBL remains high risk 15/10/2018 - HSCB funding requested for review backlog clinics in geneal surgery, chronic pain and urology. Clinical validation being undertaken in general surgery		
	15/10/2016	Provide safe, high quality care	ATICS/SEC	Access Time (Outpatients) - General (not inclusive of visiting specialties)	Increase in access times associated with capacity gaps and emergent demand - Capacity gapin RF, urgent and routine	ATICs/SEC specialities with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain	6/2/19 - Waiting times are monitored by OSL and HOS, and discussed at HOS weekly meetings. Risks highlighted at monthly performance meetings 20/11/18 - new outpatient waits continue to grow on a monthly basis. Additionality secured for general surgery and chronic pain. high risk of incidental cancers from long new waiters 15/10/18 - Clear capacity gap. Request for HSCB funding when IHA capacity available to do additional sessions. Ongoing RF capacity issues discussed at monthly cancer performance meeting		
	15/10/2016	Provide safe, high quality care	ATICS/SEC	Access Times (In-patient/Day Case) - General	Increase in access times associated with capacity gaps and emergent demand	ATICs/SEC specialities with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain	6/2/19 - IPDC waiting times continue to grow. Winter plan in place from Dec 18 to March 19 with 30% reduced theatre capacity. No routines to be scheduled on CAH site, capacity for RF and urgent only 20/11/18 - IPDC waiting times continue to grow. Winter plan in place from Dec 18 to March 19 with 30% reduced theatre capacity. No routines to be scheduled on CAH site, capacity for RF and urgent only 15/10/18 - Clear capacity gap. Request for HSCB funding when IHA capacity available to do additional sessions. Ongoing RF capacity issues discussed at monthly cancer performance meeting		

2019.04.12
Q40.191.2

Cancer and Clinical Services Division
Divisional, Head of Service and Team Risk Register - 1 March 2019

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3191	03/09/2012	Safe, High Quality and Effective Care		62 Day Cancer Performance	Trust fails to meet performance standard due to increase in red flag, capacity issues, inability to downgrade and Regional issues.	Daily monitoring of referrals of patients on the 62 day pathway. Escalations to HoS/AD when patients do not meet milestone on pathway. Continuous communication with Regional with regard to patients who require PET and ITT patients for Thoracic Surgery, 1st oncology appointment. Monthly performance meetings with AD/HoS and escalations of all late triaging	14.11.17 Cancer work plan under development, Cancer trajectories in place, Weekly monitoring continues 6.6.17 Difficulty achieving 62 day performance due to delay in 1st apt, investigation and external pressures including PET scan lung/cru oncology 28/06/2016-achievement of the 62 day pathway continues to be a risk due to external factors and internal factors such as delay in first appointments, increase in red flag referrals from GPs, Reporting of diagnostics . May performance 76%. • Breast screening and assessment, Breast 2ww - currently unable to achieve this target due to increase in demand and reduction in Radiologists and Surgeons to cover this service. Routine symptomatic breast service.	MOD	DIV

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Appendix Question 44

2009. 11. 25
Q 44 · 201

Southern Health and Social Care Trust

Consultant Job Planning Steering Group Meeting

Meeting of the Steering Group held on the 25 November 2009 in the Boardroom, Trust Headquarters

Present:

CHAIR – Mrs M McAlinden, Chief Executive
Dr P Loughran, Medical Director
Dr G Rankin, Interim Director Acute Services
Mr F Rice, Director MH&D
Mr S McNally, Director of Finance
Mr K Donaghy, Director HROD
Mrs A McVeigh, Acting Director OPPC
Mr P Morgan, Acting Director, CYPS
Mrs P Clarke, Director of Performance & Reform
Dr J Simpson, AMD, MH&D
Dr M Hogan, AMD, M&WH
Dr C McAllister, CD C&CS
Mr S O'Reilly, CD Unscheduled Care
Mr L Stead, AD, Medicine & Unscheduled Care
Mr R Carroll, AD, Cancer & Clinical Services
Mrs A McVey, AD, Maternity & Women's Health
Mrs D Burns, AD Performance and Reform
Mrs S Rowe, Finance Rep, Core Working Group
Mrs T Cunningham, MD Rep, Core Working Group
Mrs J Morton, P&R Rep, Core Working Group
Mrs L Lappin, P&R Rep, Core Working Group
Mr M Clegg, HR Rep, Core Working Group
Mrs Z Parks, HR Rep, Core Working Group

Apologies:

Dr P Murphy, AMD M&UC
Mr E Mackle, AMD S&EC
Dr S Hall, AMD, C&CS
Dr B Aljarad, AMD CYPS
Mr R Brown, S&EC

Notes of Decisions and Actions Agreed:

1 Job Planning Steering Group – Terms of Reference

The terms of reference document was tabled for discussion. It was confirmed that the Job Planning Steering Group would consist of the Chief Executive, all members of the Senior Management Team, Associate Medical Directors and/or Clinical Directors responsible for job planning and Assistant Directors. The above group would also be attended by those in acting or interim positions in the above categories.

Decision:

- The group was content to approve the Terms of Reference document

2 Core Working Group – Proposed Framework

The core working group framework document was discussed. The core team will consist of Zoe Parks (HR), Sinead Rowe (Finance), Teresa Cunningham (MD office) and Debbie Burns, Jacqueline Morton, or Lynn Lappin (Performance & Reform).

Decision:

- The group was content to approve the Core Working Group Framework and indicative timeframes.

3 Supporting Professional Activities

The group considered the paper setting out further management guidance on supporting professional activities. It was agreed that Mrs Z Parks would amend the paper slightly to reflect the actions discussed and agreed, as set out below:

Actions:

- Associate Medical Directors and Directors should ensure in all prospective job plans SPA allocations over and above 1.5PA's are approved by them. This additional work should be timetabled into the job plan along with clear specific objectives for this work, detailing the output expected from this work.

- Associate Medical Directors and Directors should ensure that in all prospective job plans where SPA allocations exceed 2 PA's, this should be brought to the monthly Job Planning Steering Group for discussion prior to approval. Again clear specific objectives for this additional work should be clarified.

- The group also advised that the minimum SPA allocation i.e. 1.5 PA's should normally be undertaken on-site, unless agreed by the AMD/CD and the Director in specific circumstances or for a defined period of time. There

would however be more flexibility with SPA's agreed in excess of 1.5 to be worked off site where appropriate as agreed by the AMD/CD and Director.

4 External Duties & Additional HPSS Responsibilities

The group discussed the above roles and the approval mechanism required. Consideration was given to those roles that currently exist within the Trust and how these should be reviewed and approved on an annual basis. The following actions were agreed:

Actions:

- Associate Medical Directors and/or Clinical Directors should ensure that where an individual undertakes External Duties or Additional HPSS responsibilities, the approval request form is completed and approved by the Director and Medical Director. The completed form must be attached to the job plan template.

- The Director/AD in consultation with the AMD/CD should ensure a review date is agreed for all external duties/additional HPSS responsibilities to ensure there is no automatic assumption that approval to undertake these posts will run on from one year to the next.

- It was agreed that the approval proforma should be completed for all consultants undertaking external duties/additional HPSS responsibilities regardless of when these commenced – therefore all existing arrangements will need to be reviewed when reviewing job plans.

5 Clinical Lead Roles with Southern Trust & Sub Specialties

Informal clinical lead roles were discussed in the context of additional SPA responsibilities. It was recognised that there is potential for numerous clinical lead roles in every specialty. The group agreed these roles would fall in under the Additional HPSS responsibilities or SPA and as such should be approved in the same way – using the request for approval proforma for external duties / additional HPSS responsibilities. Approval would therefore be required from the Associate Medical Director/CD and the Director/AD. It will be necessary for the Director to consider the cost/benefit analysis of facilitating such roles and this may for example result in agreements being reached for a time limited period.

Action:

- Director of Human Resources in consultation with the Medical Director to circulate a paper summarising existing informal clinical lead roles currently undertaken within the Trust to AMD's and Directors, with a view to the Steering Group deciding which roles would be formalised and recognised/supported by the Trust in the future. The Associate Medical Directors and Directors should consider this document and identify the anticipated or expected time requirements for each role. The Steering Group to consider at next meeting which roles would be recognised and

supported in the Trust as these would require a formalised expression of interest process through the Medical Director/HR office for appointment in the future.

6 Legacy On-call Allocations

In confidence, information in relation to the legacy on-call allocations was shared with the group. This set out the various on-call PA's that are currently paid to consultants in various specialties. It was highlighted that this information was based on the consultant diary card exercise that was undertaken in 2004 and therefore may need to be updated in some specialties, particularly in those teams where there has been an increase in consultant numbers or extra junior medical staff.

Action:

- The Core Working Group (Z Parks) will liaise with Associate Medical Directors and the Medical Director to determine if the existing weekly on-call hours allocated for the specialty is reasonable or if there is a requirement to undertake a further on-call diary exercise to update the on-call allocations. This would also have to accurately reflect the correct number of consultants on the on-call rota.

7 Waiting List Initiative Rates and Claim Form

The final waiting list claim form was circulated. The claim form was approved and it was agreed that this should be implemented with immediate effect.

Action:

- The Core Working Group (Z Parks) to liaise with Directors to ensure this claim form is implemented within each service area as soon as possible. Communication to be made with the Finance Department to ensure the new rates are payable from 1 April 2008 and no further claims are processed until submitted on the new claim form.

8 Updates from Associate Medical Directors / CD's

Dr M Hogan advised that the demand and capacity modelling exercise had commenced for obstetrics and gynaecology and that she had been working with the core working group to develop team PA allocations for both sites. This is based on a 48 week service model – as the consultants work in teams over the 42 working weeks. SPA's remain an issue on both sites and she is currently working on a draft document detailing the SPA commitments which can then be discussed as per the process agreed at this meeting.

Mrs Z Parks provided an update on behalf of Dr B Aljarad. In relation to direct patient care, until recently there has been no reliable way of measuring productivity, however following the "Changing for Children review", they now have a better idea of the workload and capacity. In relation to SPA's, Dr

Aljarad recognises that in most cases (particularly in acute) most consultants still have 2.5 SPA's. This has been down to legacy allocations for undergraduate tutor, postgraduate/college tutor and clinical governance co-ordinator. There have also bee increased demands in the above roles and to date management responsibilities have been absorbed in SPA time. Dr Aljarad does however recognise that these allocations will need to be reviewed in the prospective job plans. Dr Aljarad also identified that consultants had previously been allocated 2 PA's for on-call and there may be potential to decrease this however this would have to be considered in light of the less experienced junior staff and recent shortages which have resulted in more call out time for consultants.

Dr J Simpson provided an update on Mental Health/Disability. All the job plans have been reviewed for 09/10 with the average direct patient care PA's appropriately 8.6PA's, 2.3 SPA's and total PA's 10.3. These averages are subject to change however as a few of the 09/10 job plans have yet to be forwarded to HR for processing. Dr Simpson advised that those SPA's in excess of 1.5 are for specific requirements. He also indicated that in the past he would have included higher SPA's in job plans but that some of this activity could be realigned to direct patient care.

Mrs Z Parks provided an update on behalf of Dr S Hall. He had advised in advance of the meeting that all job plans had been completed for Radiology however he was holding these in the specialty before sending to HR for processing until the new consultant commences and signs up to her job plan in December. Dr Hall had advised that he had looked at overall workload in devising these job plans. The principle of ensuring a minimum of 1.5 SPA's has been applied with any additional being detailed and agreed with Dr Hall. Dr Hall felt it was important there was consistency in how job plans were agreed in the Trust in relation to specific issues, such as SPA's and clinical lead roles and in particular how PA allocations linked into clinical excellence awards. Pathology job plans are being completed by Dr G McCusker and these have all been completed. Dr C McAllister will be undertaking job plans in Anaesthetics who has undertaken significant work on this to date. A meeting with the Core Working Group has been arranged for 5 January 2010 to take this forward.

Mrs Z Parks provided an update on behalf of Dr P Murphy. He had advised in advance of the meeting that job planning has been taking place in Medicine however progress had been slow recently, due to the resignation of the CD. He did advise however that Dr O'Brien had informed him that the DHH Medicine job plans had been completed but at the time of this update, he hadn't had sight of these. Dr Murphy also advised that he had previously given some thought to teaming some elements of the acute physician work in job plans. This would result in a weekly PA allocation being awarded to each consultant to reflect all acute physician work such as ward rounds, pick up ward rounds, discussions with relatives and administration. This would then need to be added to PA's to reflect sub specialty work, on-call, SPA's etc. Dr

Murphy acknowledged this is something that could be explored in the core working group job planning discussions. Dr Murphy advised one of the barriers to job planning is the time associated with setting up job planning meetings and typing up the actual job plans. He felt it would be helpful if someone was identified to support with this process. A job planning meeting with the core working group has been arranged for 13 January 2010 to commence the demand/capacity modelling exercise for Gastroenterology.

Debbie Burns and Jacqueline Morton provided an update on the ENT and Urology demand and capacity modelling exercise which has been ongoing. An ENT team PA model has been almost agreed and will be shared with the Associate Medical Director shortly with a view of implementation when the new consultants have been appointed. To date there has been no agreement in terms of DCC sessions for Urology and a further meeting with the Director has been arranged.

9 **Any Other Business**

- The next Steering Group meeting will be scheduled for mid January 2010.

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Southern Health and Social Care Trust

Consultant Job Planning Steering Group Meeting

Meeting of the Steering Group held on the 24 March 2010 in the Boardroom, Trust Headquarters

Present:
CHAIR – Mrs. M McAlinden, Chief Executive
Mr. K Donaghy, Director HR & Organisational Development
Dr. P Loughran, Medical Director
Mrs. P Clarke, Acting Director of Performance & Reform
Mr. S McNally, Acting Director of Finance & Procurement
Mrs. A McVeigh, Acting Director OPPC
Dr. G Rankin, Interim Director Acute Services
Mr. F Rice, Director MH&D
Dr. B Aljarad, AMD CYPS
Dr M Smith, CD Acute Paediatrics
Dr. M Hogan, AMD, M&WH
Mr. N Heasley, CD Obstetrics & Gynaecology
Mr. E Mackle, AMD S&EC
Dr. P Murphy, AMD M&UC
Mr. S O'Reilly, CD Unscheduled Care
Dr. C McAllister, CD Anaesthetics, Theatres & ICU
Mr. R Carroll, CD C&CS
Mr. B Conway, AD M&UC
Mrs. H Trouton, AD S&EC
Mrs. G Maguire, AD of Specialist Child Health & Disabilities
Mrs. S Rowe, Finance Rep, Core Working Group
Mrs. T Cunningham, Medical Directorate Rep, Core Working Group
Mrs. D Burns, P&R Rep, Core Working Group
Mrs. L Lappin, P&R Rep, Core Working Group
Mrs. J Morton, P&R Rep, Core Working Group
Mr. M Clegg, HR Rep, Core Working Group

Note Taker: Mrs. H Mallagh-Cassells, Senior Medical Staffing Officer

1. Welcome and note of any apologies

Apologies were noted as follows:

Dr. S Hall, AMD, C&CS
Dr. J Simpson, AMD, MH&D
Mrs. A McVey, AD, Integrated Maternity & Women's Health
Dr. P McCaffrey, CD Medicine for Older People

Mrs. McAlinden opened the meeting and advised that during the meeting she would like to revisit the job planning process and obtain an update on where the process is to date.

With regard to the additional SPA activity, Mrs. McAlinden reported the majority, but not all, of the divisions had returned proposed additional SPA activities which are above the 1.5 core for each consultant. She explained that the information provided is not consistent across divisions, and it would be very challenging to make any fair decisions without further discussions. Mrs. McAlinden indicated that she has asked Dr. Loughran, Mr. Donaghy and the Lead Director/Assistant Directors for each division to meet with Associate Medical Directors individually to discuss these proposed additional SPAs and bring a resolved position to the next meeting of the Steering Group. She added that each Director would set up these meetings as a matter of urgency.

Action: Dr. Loughran, Mr. Donaghy and the Lead Director/Assistant Directors for each division to meet with Associate Medical Directors individually to discuss the proposed additional SPAs and bring a resolved position to the next meeting of the Steering Group.

Mrs. McAlinden circulated a paper entitled "Job Planning Process Core Working Group" and Dr. Loughran gave a presentation on the job planning process. He added that the presentation had previously been made at the Medical Forum in October 2009.

Mrs. McAlinden re-iterated the importance of ensuring a clear understanding regarding the stages in the process and the capacity and demand issues in order to be able to ensure the Trust provides the service needs. She added that the additional SPA activities above the 1.5 core are a separate issue.

Mr. Mackle asked for views with regard to waiting list payments for junior staff who do a Saturday clinic but there are no extra patients – therefore not a waiting list initiative but should be paid as locums.

Action: **Mr. Donaghy** to look at the policy guidance.

Dr. Aljarad enquired if there was any guidance for admin staff who are typing waiting list initiative letters since there are additional payments for other staff and also with regard to what applies to external duties and HPSS responsibilities. Dr. Loughran indicated that when the job plan review is being undertaken it will be necessary to reconsider any external duties and additional HPSS responsibilities at that stage.

Dr. McAllister attended at this point ...

2. Update by Associate Medical Directors and Directors

Each of the Associate Medical Directors took it in turn to provide an update in respect of their Programme of Care:

- **Surgery & Elective Care**

  Mr. Mackle reported that capacity and demand was currently being undertaken for General Surgery, T&O hoped to have 6 full time consultants by the summer, ENT was complete and Urology ongoing with progress.

- **Mental Health & Disability**

  Mr. Rice explained that the MH&D Directorate have had a workshop to look at SPA activity, which would be incorporated into job planning process.

  Action: Mr. Rice to forward details of the SPA activity.

- **Medicine & Unscheduled Care**

  Mr. Conway advised that broad principles of service had been agreed for A&E and that a draft job plan was being developed, a meeting had taken place to look at the service model for Respiratory and that the first meeting in terms of work in respect of Cardiology and Gastro was scheduled.

Dr. Loughran enquired if Associate Specialists were being considered in terms of demand and capacity. Mrs. Burns confirmed that there are variations in specialists and as to whether Associate Specialists are competent in their role. Mrs. McAlinden asked Dr. Loughran to define the role of the Associate Specialists and take forward in conjunction with Mr. Donaghy.

Action: **Dr. Loughran** to take forward in conjunction with **Mr. Donaghy** – to define the role of Associate Specialists.

- **Integrated Maternity & Women's Health**

  Dr. Hogan reported that work had taken place in Daisy Hill Hospital with regard to team planning. There are 3 teams of 2 with funding awaited for another consultant. Dr. Hogan indicated that it would be necessary to look at middle tier staffing and agreed to meet with regard to the additional SPA activity proposals. Mrs. Clarke advised that confirmation regarding the funding for the other consultant was expected within 24 hours.

  Mr. Heasley indicated that an additional consultant was needed and a few job plans up to 11 PA. He advised that one consultant had resigned and that this post would need to be replaced.

- **Children & Young People**

  Dr. Aljarad advised that work has been done on the on-call supplement to which he indicated that he felt could be reduced. With regard to demand and capacity, Dr. Aljarad indicated that more capacity would be needed and that a nurse led clinic and role of the Associate Specialist would be looked at. He indicated that work could not be moved forward without approval for additional SPA. Mrs. McAlinden referred to the process to take place with regard to this issue.

- **Cancer & Clinical Services**

  Dr. McAlister advised that information had been provided with regard to proposed additional SPA activity and that he had met with 3 Consultants and expected job plans to be agreed.

  Mr. Carroll indicated that the first meeting with regard to demand and capacity for Radiology was scheduled. He was unable to comment with regard to Laboratory.

In response to a question from Mrs. McAlinden, Dr. Loughran advised that there was no regional timescale set to be adhered to in respect of completion of the process.

Dr. McAllister indicated that there would be a number of Anaesthetists willing to work more than 12 PA. Mrs. McAlinden advised that this would be dependent if the demand and capacity indicated a need. Dr. Rankin suggested a business case should be produced to identify the demand. Mrs. Burns indicated that it would be necessary to ensure that equity is applied and fed through in terms of modernisation. Mr. Donaghy reiterated the need to ensure that any job plan above 12 PA must come back to the Steering Group and that EWTD opt out needs to be looked at.

Action: EWTD Opt Out to be discussed at the next meeting.

Dr Murphy attended at this point …

3. Update from Core Working Group

On behalf of the Core Working Group, Mrs. Lappin provided the following update:

1. ENT: Team model agreed, with service delivery provided over 48 week using a backfill model. This will meet both the access targets and demand. Some minor amendments are required before final sign off.

2. Gynaecology: Proposal of 2 different models - DHH service delivery provided over 48 week using a backfill model, CAH service delivery 52 weeks through additional PA's each week. Some minor amendments are required before final sign off.

3. Gastroenterology: Initial meetings held and demand and capacity analysis discussed. Demand and capacity re-examined following discussions and re-forwarded to clinicians for consideration. Job plan templates are being developed to assist the AMD review options.

4. Anaesthetics: Service demand agreed to be delivered over 52 weeks. Job planning has now been taken forward by the CD.

5. A&E: Job plans have been drafted by the CD taking account of demand analysis. These are currently with the Assistant Director for discussion.

6. Paediatrics: Demand and capacity analysis completed for acute paediatrics. Job plan templates being developed to assist the AMD.

7. Radiology: Demand and capacity analysis in progress.

8. General Surgery: Initial meeting undertaken to Q/A the demand and capacity analysis. Demand and capacity re-examined following discussions. Second meeting agreed for 31st March 2010. Job plan templates are being developed to assist the AMD.

9. Respiratory: Demand and capacity analysis completed. Initial job planning core working group meeting scheduled for 25th March 2010. Job plan templates are being developed to assist the AMD.

10. Cardiology: Demand and capacity analysis completed. Initial job planning core working group meeting scheduled for 24th March 2010. Job plan templates are being developed to assist the AMD.

11. Urology: Demand and capacity analysis completed. Draft Job plan templates have been developed to assist the AMD. Meeting to be organised with Team to discuss.

4. Supporting Professional Activity (SPA Proforma) – Way Forward

Mrs. McAlinden advised, as previously indicated in earlier discussions, this matter would be taken forward within a small group consisting of Dr. Loughran, Mr. Donaghy, Service Director and Associate Medical Director.

5. Any other business

5.1 Dual Role of College Tutor and Associate Medical Director/Clinical Director

Dr. Loughran indicated that he had written to Consultants regarding the need to identify if there is anyone in such a dual role and to try to avoid due to the potential conflict of interest. While Dr. Loughran advised that he would prefer not for this practice to take place he would re-consider if there were issues within a small area. He advised that if there were any difficulties he would be happy to speak with those concerned. Further discussion took place with regard to this issue and origin of the query.

5.2 Study Leave

Mrs. McAlinden reported that Dr. Loughran and Directors have been receiving appeals for study leave due to the embargo on study leave as part of the Trust's financial contingency arrangements. She advised that the Trust would hope to implement a 3-year rolling budget but as it is necessary to ensure equity within budgets, Mr. McNally would be taking forward recommendations as to budget setting. Mrs. McAlinden added that while LNC would appear to be happy with the suggestion, a consultation document would be finalised and issued for comment by Dr. Loughran and Mr. Donaghy.

Mr. Mackle indicated that in the past International Meetings would have been funded by Drug Committees but that this was no longer the case.

Dr. Aljarad advised that the Northern Trust currently have a system in place. Mrs. McAlinden responded by indicating that it would be useful to have a comparative rate.

Action: Trust to set 3-year rolling budget for study leave.
Mr. McNally to recommend budget setting.
Dr. Loughran and Mr. Donaghy to issue consultation document on a Study Leave Policy for comment.

5.3 Medical Staff Annual Leave Guidance

Mrs. McAlinden advise that she was aware that this guidance was not being observed and gave examples as late cancellation of clinics or medical staff leaving the clinic early. She asked that Associate Medical Directors re-iterate adherence to the guidance within their Divisions. Dr. Rankin also advised that it is necessary to have knowledge of annual leave commitments of Associate Specialists and Staff Grade doctors.

Action: Associate Medical Directors to re-iterate adherence to the guidance within their divisions.

6. Date of Next Meeting

Wednesday 28 April 2010 at 5.00 pm in the Boardroom, Trust HQ

2011.03.02
Q49.202.2

Southern Health and Social Care Trust

Consultant Job Planning Steering Group Meeting

Meeting of the Steering Group held on the 2 March 2011 in the Boardroom, Trust Headquarters

Present:
CHAIR – Mrs. M McAlinden, Chief Executive
Mr. K Donaghy, Director HR & Organisational Development
Dr. P Loughran, Medical Director
Dr. G Rankin, Director Acute Services
Mrs P Clarke, Director of P&R
Mr. S McNally, Director of Finance & Procurement
Mrs. A McVeigh, Director OPPC
Dr. M Hogan, AMD, IM&WH
Mr. N Heasley, CD Obstetrics & Gynaecology
Mr. E Mackle, AMD S&EC
Dr. P Murphy, AMD M&UC
Dr. P McCaffrey, CD Medicine for Older People
Dr. C McAllister, AMD Anaesthetics, Theatres & ICU
Dr. S Hall, AMD, C&CS
Dr. J Simpson, AMD, MH&D
Mr. R Carroll, CD C&CS
Mr. B Conway, AD M&UC
Mrs. A McVey, AD IMWH
Mrs. A Magwood, AD P&R
Ms. R Toner, Acting AD OPPC
Mrs. J Morton, P&R Rep, Core Working Group
Mrs. L Lappin, P&R Rep, Core Working Group
Mrs. Z Parks, HR Rep, Core Working Group
Mr. M Clegg, HR Rep, Core Working Group

Note Taker: Mrs. H Mallagh-Cassells,
PA to Director of Human Resources & Organisational Development

1. Welcome and note of any apologies

Apologies were noted as follows:

Dr. B Aljarad, AMD, C&YPS

Mrs. McAlinden welcomed everyone to the meeting and indicated that Agenda Item 3 would be discussed at the end of the meeting as there were some assumptions that required clarification.

The notes of the previous meeting were agreed and Mrs. McAlinden suggested that the Group should meet every 3 months.

2. Matters Arising

2.1 Update from Medical Director regarding AMD job plan reviews

Dr. Loughran reported that he had met with all AMDs. He advised that some AMDs had been able to identify time in their job plan for AMD duties which also allowed for clinical duties and SPA time. However, he indicated that for some AMDs it had not been possible to secure such time as this would mean reducing clinical time and there was not enough backfill available to cover the time.

Mrs. McAlinden indicated that the work being undertaken by Pat Kilpatrick and SABA work is closely linked and in order to be able to inform such work – it would be necessary to complete job planning. Mrs. McAlinden asked the Operational Directors to consider short term measures to allow job planning to be completed.

ACTION: Operational Directors in conjunction with AMDs.

Mrs. McAlinden advised that it would also be necessary to look at remuneration for Clinical Directors and given the tax changes due in April, this should be taken forward as a matter of urgency. In response to a question from Mr. Heasley, Mr. Donaghy explained the proposed remuneration package. Dr. McCaffrey indicated that consideration should be taken into account in respect of complexity, workload and number of staff in the Directorate. Mrs. McAlinden asked that feedback be given to Dr. Loughran and Mr. Donaghy in relation to this issue.

ACTION: AMDs and CDs

Mrs. McAlinden requested that Dr. Loughran and Mr. Donaghy circulate a discussion paper on this issue for comment and agreement in advance of the 1st April 2011.

ACTION: Dr. Loughran and Mr. Donaghy

2.2 Guidance on study leave v external duties

Dr. Loughran advised that guidance on external duties had originally been provided within the Study Leave Policy – 10 days per year, i.e. 30 days over 3 years but LNC had asked for such to be removed from the policy.

Discussion took place with regard to how to record time as an examiner, problems in terms of requests for attending multiple courses, the need to consider that there is no double counting in records, the need to ensure that there is some discretion to balance attendance and possibly setting limits within specialties. It was suggested

that a set of standards should be agreed. Dr. Loughran undertook to reconsider based on the discussions and discuss further with the AMDs and CDs.

ACTION: Dr. Loughran

Mrs. McAlinden enquired as to the Trust's position if LNC did not agree to any amendments. Mr. Donaghy advised that the Trust could still implement the policy without LNC agreement and continue to discussed and negotiate with LNC to attempt to reach an agreement.

3. Presentation and Group Discussion on review of principles for extra contractual work and the link to consultant job planning

Agenda Item deferred until the end of the meeting.

4. Update from Associate Medical Directors towards completion of 2011/12 job planning by 1 April 2011

Mrs. McAlinden asked each AMD to provide an update on progress, barriers to completion and what assistance they would need to complete the job plans.

i. **Surgery & Elective Care**
General Surgery - Prospective plans drawn up but would need further developed due to long term work.
ENT – Job Plans to be modified due to changes to all day lists which will make the service more efficient.
T&O – 50% of Consultants content with job plans.
Urology – draft job plans in place for when there is a full compliment of staff.

ii. **Medicine & Unscheduled Care**
Templates are in place but have been unable to move forward due to time constraints together with no CD in Medicine in Craigavon and in Emergency Medicine. Dr. Murphy indicated that he had 30 job plans to undertake, which would require 3/4 sessions per week for one month to be replaced to complete these.

iii. **Cancer & Clinical Services**
Laboratory – team job plan does not match capacity and demand but would hope could be resolved by mid April.
Haematology – Completion expected within 4 weeks.
Radiology – prospective job plan written up but it doesn't match capacity and demand including difficulties with time allocations for internal and regional meetings. Dr. Hall indicated that he would anticipate completion by the end of April.

iv. **Anaesthetics, Theatres & Intensive Care Services (ATICS)**
Dr. McAllister advised that there had been no progress in the last few months due to time constraints.

v. **Integrated Maternity & Women's Health**
DHH – job plan agreed and would anticipate in place by the end of March.
CAH – productive meetings have taken place. Consultants not keen to have team job plan but rather backfill model. Day case work to be reviewed to measure activity. Diary exercise completed in Labour Ward which indicates a slight increase in activity. Consultant of the Week cover in Labour Ward at 1PA. Job plans should be completed within 1 month at 11/12 PA.

vi. **Mental Health & Disability Services**
Dr. Simpson advised that due to some re-organisation this would mean significant changes and he would anticipate completion by June.

vii. **Children & Young People**
As Dr. Aljarad was unable to attend – there was no update provided.

In response to a question from Dr. McCaffrey, Dr. Loughran advised that Mae McConnell and Anne Brennan had almost completed the work in terms of teaching allocations.

Mr. Macke raised the issue of displaced time by Lead Clinicians in order to carry out certain initiatives and how to manage if not delivered upon. Mrs. McAlinden suggested that the work in respect of Additional SPA had an element for service development initiatives and suggested that such work should be revisited by Mr. Mackle with Dr. Rankin and Dr. Loughran

ACTION: Mr. Mackle in conjunction with Dr. Rankin and Dr. Loughran.

Mr. Carroll suggested the need for a Clinical Lead in ATICS.

5. Communication and Distribution of Notes of Steering Group

Mrs. McAlinden explained that LNC had raised the issue that the consultants not involved in management issues are not aware of discussions at this meeting and asked if members would be happy for a high level summary of the notes of the meeting to be circulated to all consultants. The members agreed to this request.

ACTION: A high level summary of the notes of Meeting to be made available to all consultants.

Medical Staffing Manager to take this forward and identify if it would be possible to place summaries on the intranet and signpost all consultants.

6. Any other business - None

7. Date of Next Meeting

Wednesday 8 June 2011 at 5.00 pm in the Boardroom, Trust HQ

2011 · 09 · 28
Q 44 · 202 · 3

Southern Health and Social Care Trust

Consultant Job Planning Steering Group Meeting

Meeting of the Steering Group held on the 28 September 2011 in the Boardroom, Trust Headquarters

Present:
CHAIR – Mrs. M McAlinden, Chief Executive
Mr. K Donaghy, Director HR & Organisational Development
Dr. J Simpson, Medical Director
Dr. G Rankin, Director Acute Services
Mr Paul Morgan, Director Children & Young People
Mrs P Clarke, Director of P&R
Mrs L Leeman, AD Performance
Mrs. A McVeigh, Director OPPC
Dr. M Hogan, AMD, IM&WH
Mr. E Mackle, AMD S&EC
Dr. P Murphy, AMD M&UC
Dr. C McAllister, AMD Anaesthetics, Theatres & ICU
Dr. S Hall, AMD, C&CS
Mr. R Carroll, CD C&CS
Mr. B Conway, AD M&UC
Mrs. A McVey, AD IMWH
Mrs H Trouton, AD SEC
Mrs. J Morton, head of Reform/ Core Working Group
Mrs. L Lappin, Head of Reform/ Core Working Group
Mrs. Z Parks, Medical Staffing Manager / Core Working Group
Mr. M Clegg, Assistant Medical Staffing Mgr/ Core Working Group

1. Welcome and note of any apologies

Apologies were noted as follows:
Dr. B Aljarad, AMD, C&YPS

2. Matters Arising

2.1 Actions arising from the previous meeting:

- *Directors to arrange short term measures to release AMD's from some commitments to complete job planning.*
  i. Confirmation was given by Directors and AMD's that this had taken place, however in some areas this was not adequate to complete the process.

- *AMD's and CD's were to raise any concerns about the Clinical Director remuneration to Mr Donaghy and Medical Director*
    i. All CD's have since accepted their contract and responsibility allowance (with the exception of one outstanding issue) so it was concluded no further action was necessary.

- *Medical Director was to discuss the issue of how to record time as an external examiner and possibly consider setting limits within specialties.*
    i. Some discussion took place regarding how external examiner roles should be recorded in the job plan. It was concluded that no further guidance was required but that the matter should be addressed again at the next AMD Governance meeting.

- *Medical Director and AMD Surgery to review the allocations for service development within their additional SPA's to consider requirements for Lead Clinician role.*
    i. Discussion took place regarding the Additional SPA templates that had been agreed for each specialty. Dr Hall felt that it was important all areas held the line as there would be lead clinicians in all specialties. It was confirmed that the total additional SPA's that can be allocated cannot exceed the agreed templates otherwise allocations would have to come back to the Steering Group for approval.

- Communication was to be issued to all consultants to inform them of the action that had been agreed at the Steering Group meeting
    i. A high level summary had been issued to all consultants and can be downloaded from the Trust intranet website at http://shsctintranet.hpss.n-i.nhs.uk/HTML/HR/Information.html

- *Following the audit of the Waiting List initiatives, the principles and claim form was to be revised and reissued.*
    i. The document has been revised and can be downloaded from the intranet by following the link above. Dr Simpson has also recently written to all consultants attaching a copy of the revised documents.

Actions Required: None

3. Update from Paul Clarke regarding Capacity Planning

An update was given regarding the SBA Acute Capacity Exercise. (See handout attached) The current in year position was outlined highlighting the ongoing issues, challenges and opportunities. It was emphasized that in the future the new SBA will be much more closely linked with the direct face to face patient sessions in consultant job plans.

4. Update from Associate Medical Directors regarding AMD job plan reviews

Dr Hall (CCS) confirmed that the majority of job plans had been completed in his directorate and this was confirmed by Medical Staffing. 2 job plans for Haematology are outstanding are currently at stage 3. (With individual consultant for agreement) 5/7 Histo

Cyto job plans had been completed and of the two outstanding, one had just returned from an extended career break and the other has a few issues with time for SPA linked activity. The two microbiologists were completed at beginning of the job planning round. (May 2010) There are only 3 out of 15 job plans in Radiology outstanding. 1 may be difficult and may go to facilitation and 1 is CD which should progress now following clarification around time for this role.

Dr Murphy (MUC) confirmed that of the 20 consultants in general medicine 5 are outstanding - Dr Gibbons (who I am meeting this week), Dr S Murphy (Dr O'Brien is chasing up), myself, Dr Ritchie and Dr McConnell. The last two (endocrine) have been delayed due some health issues. The AMD job plan is not completed but a meeting took place with Dr Loughran before he left and agreement was reached – Anne Brennan is chasing up the paperwork. The remaining four are either vacant or very recently appointed (elderly care DHH, endocrine DHH, rheumatology CAH and GI CAH) so would not be included in the job plan review process this time round. However it was confirmed after some questions that the Trust would be aware of the indicative sessions for service planning. Dermatology job plans are complete. Cardiology are just in the early phases but there are active discussions on-going and it is anticipated this will move forward quite quickly. Geriatrics are all signed off (other than orthogeriatrics which should be agreed and signed next week.) It had been decided to postpone completing A&E as there have been several new consultants appointed within the last few weeks and all job plans will change when they start in the near future. Draft renal job plans have been produced but negotiations are in progress as there are some issues with the PA's. Dr Murphy confirmed that he had liaised closely with Barry on the job plans in terms of the operational requirements including demand/capacity.

Dr Hogan (IMWH) advised that within the last few days, 5 job plans had been signed off. In Daisy Hill Hospital, 2 have been signed off and completed (Stage 4) and the remaining 3 are at stage 3. The process as set out in the template document has been followed and all job plans have been agreed by Anne McVey in advance of the individual job plans to match the activity to demand/capacity information which did lead to some changes.

Dr Simpson (MH) confirmed on behalf of Mental Health that 19/23 job plans had been completed. The remaining 4 represented two temporary consultant posts, his own job plan and one other which had just been agreed.

Mr Mackle (SEC) advised that 6 General Surgery job plans had been completed. Of the remaining 6, 3 were at stage 2b (AMD to meet and agree with Director to match demand/capacity) and 3 were at stage three (Job Plan with consultant for agreement). The consultant in orthodontics was still to be done. 2/3 Urology job plans have been completed with the third going to facilitation. The 5 permanent ENT consultant job plans are at stage 3 (job plans with consultants for agreement) The 6 consultants in T&O are currently at stage 2b (AMD to meet and agree with Director to match demand/capacity). Dr Rankin confirmed the job plans had been developed in line with SBA requirements.

Mr P Morgan provided an update on behalf of CYP. He confirmed that 10/12 Paediatric job plans had been completed however there were still a number of issues ongoing regarding the demand/capacity. The one outstanding job plan in Paediatrics related to a consultant who has just recently retired on health grounds. There is one job plan outstanding in CAMHS.

Action Required: Mairead asked all Associate Medical Directors to make the final effort to ensure all remaining job plans were completed and she would like an update on this position at the end of October. **All AMD's to work with Directors to complete all job plans and provide update on progress to the Medical Staffing Manager by 31 October 2011**

5. Electronic Job Planning

Kieran confirmed that Zoe had been liaising with the Associate Medical Directors to agree the job planning language that will be used in the electronic job planning system. He also advised that there may be some issues with paying the fee required by Zircadian to input our prospective job plans and this may have to be completed by Trust staff. However Kieran advised he would look at bringing in temporary staff to complete.

6. Any other business

- Mairead asked if the next Medical Forum meeting could be used to talk about the key messages to go into the [Personal Information redacted by the USI] review and if there would be agreement to invite a small number of GPs to augment Dr Beckett's input. AMD's were content with this request.
- Kieran advised the group regarding the forthcoming Industrial action planned for next Wednesday. Further discussions would take place with Directors and AMD's regarding the Critical Care areas that will need to be protected.

7. **Date of Next Meeting** – position to be reviewed at the end of October.

Appendix

Question 48b

NHS
National Clinical Assessment Service

Handling concerns about a practitioner's behaviour and conduct

An NCAS good practice guide

Version 1 – June 2012

Contents

1. Introduction

1.1 Background

The National Clinical Assessment Service (NCAS) was established in 2001. It advises healthcare managers where they have a performance management concern about the practice of a doctor, dentist or pharmacist. As part of its work NCAS has identified that a significant proportion of the concerns it sees (59%)[1] contain a behavioural or conduct component. Even where clinical concerns about an individual's practice are not present, behavioural and conduct issues can nevertheless have a significant and detrimental impact on team relationships and patient care. We therefore dedicated our 2011 Annual Conference to understanding and tackling behaviours that can give rise to conduct problems in the workplace. Recognising these types of concerns can be complex; behavioural concerns should be considered in the individual circumstances of the case. This guide distils some of the feedback and learning from the conference as well as our practical experience of over 10 years of supporting healthcare managers. It is a "lessons learned" document drawing on NCAS experiences from referrals.

1.2 What constitutes poor behaviour and conduct?

There is no standard definition of behavioural concerns in clinicians in the UK. The College of Physicians and Surgeons of Ontario, Canada and the Ontario Hospital Association have for a number of years been collecting evidence about issues of poorly behaving practitioners and about how difficult it can be to resolve behavioural concerns. Their 2008 guidance, *Guidebook for managing disruptive physician behaviour*,[2] defines behavioural concerns (here called disruptive behaviour) as follows:

> *Disruptive behaviour occurs when the use of inappropriate words, actions or inactions by a physician interferes with his or her ability to function well with others to the extent that the behaviour interferes with, or is likely to interfere with, quality health care delivery.*

Behavioural concerns can manifest themselves in practitioners who are otherwise clinically sound, often when there has been some change in their personal life or to their working environment. An analysis of 1472 cases handled by NCAS between December 2007 and March 2009 showed that work environment influences were a factor in 11% of cases. Issues included problems with team working, systems and support and resource issues.[3]

The guide refers to behaviour and conduct. It is important not to disregard poor behaviour even if the practitioner is clinically sound. Poor behaviour, which can include unpredictability, irritability, aggression, arrogance and hypersensitivity, can result in poor conduct including a failure to abide by organisational rules, poor team relationships and leadership, withdrawal or non-participation and a failure to comply with reasonable management requests. Behavioural issues can also put patient safety at risk.

1.3 How to use this guide

This guide is not a substitute for the provisions of local performance management procedures including Performers' List Regulations and Maintaining High Professional Standards in the Modern NHS (MHPS) and should be read alongside these procedures or existing frameworks for managing poor performance. Instead, this guide sets out principles and practical steps, which can be followed across all healthcare sectors and in any healthcare profession. It is written for primary care organisations (PCOs) and their successor bodies as well as organisations providing hospital and community (H&C) services, in both the NHS and independent sectors of healthcare.

This guide is not designed for use with trainees. Deanery procedures exist for dealing with practitioners in difficulty, although the approaches outlined here may still facilitate a resolution of the concern in an employment context. However, conduct matters that are not related directly to training (for example, persistent lateness) may be dealt with by the contracting or employing organisation's local procedures in liaison with the Deanery.

This guide can be used alongside other NCAS publications including *How to conduct a local performance investigation* and other good practice guides available from our website. The guide makes the assumption that advice and support will be sought from the local HR resource or the responsible organisational manager at all stages of the management process. In addition, contacting NCAS will provide access to our expert advisers - senior staff from a variety of backgrounds in the clinical, managerial and legal professions with considerable experience in handling concerns about professional practice. They will provide help about the handling of specific cases and the options for addressing the concerns: for example, in the form of a behavioural assessment and remediation (see our website for details about how to contact NCAS).

Different regulations, frameworks and guidance will apply across different professions and jurisdictions within the UK and so it is important to consult fully the applicable legislation and guidance. NCAS advisers can advise on this in specific cases.

1.4 Terms

Key NCAS terms used in this guide are:

Practitioners: doctors, dentists and pharmacists. These are professions within NCAS' current remit, although organisations may find this guide useful for other health professionals.

Concerns about practice: any aspects of a practitioner's performance or conduct, which may:

- pose a threat or potential threat to patient safety;
- expose healthcare services to financial or other substantial risk;
- undermine the reputation or efficiency of healthcare services in some significant way;
- be outside acceptable practice guidelines and standards.

Responsible manager: the person to whom a practitioner reports and who holds responsibility for handling the possible impact of the practitioner's behaviour on their clinical practice. This might be the Medical Director, Clinical Director or another manager. The responsible manager's prime concern is fitness for purpose of the individual – is the practitioner fit to meet the requirements of their job? In medicine, the responsible manager may also be the responsible officer. If this is not the case, there should be clear lines of communication between the responsible manager and the responsible officer.

Responsible officer: From 1 January 2011, a senior doctor who is appointed by a healthcare organisation to discharge responsibilities under the Medical Profession (Responsible Officers) Regulations 2010. Those responsibilities include ensuring that the organisation carries out regular appraisals of medical practitioners; establishing and implementing procedures to investigate concerns about a medical practitioner's fitness to practise; where appropriate, referring a medical practitioner to the GMC; and making recommendations to the GMC about a medical practitioner's fitness to practise. The responsible officer may also be the responsible manager, but the distinction between the two aspects of their role is important. There should be clear lines of communication between the responsible manager and responsible officer where these roles are undertaken by separate individuals within an organisation.

2. Categorising the concern

2.1 Recognising behavioural markers

Concerns about practice in relation to an individual's behaviour and conduct may present in different ways.

Although it may be easy to identify a practitioner who is consistently rude and aggressive towards colleagues, practitioners who are agreeable may also present behavioural difficulties for example by not being sufficiently assertive or by being over-cautious and reliant on help from others. In other circumstances, a practitioner's desire to do a job well and particularly to please their patients, may at times border on an overly fixed or rigid approach that means their behaviour can cause conflict and tension with others. This may include for example prescribing antibiotics that patients request against local and national guidance or doggedly rebooking follow-ups with medical staff when trust policy is for nurse follow-up or discharge back to primary care from hospital.

Recognising the behavioural markers and dealing with concerns early on may prevent escalation to a serious problem. It is important to determine what standard or organisational rule has been breached and whether the possible cause of this may relate to health as this informs the process to be followed.

2.2 Health and behaviour

It is not uncommon for behavioural problems to manifest because of an underlying health concern such as depression, anxiety, substance misuse, personality disorder or cognitive impairment, as well as some physical disorders. At referral, 9% of NCAS cases have both a behavioural and health component. Health concerns including disability can affect a practitioner's mood, concentration, energy and temperament. The feelings brought about by behavioural and conduct issues, before or when an individual becomes subject to performance management, can themselves lead to poor health

It is important early on to determine the extent to which a behavioural or conduct problem may result from health factors or may be a standalone issue. Appropriate health advice, including specialist mental health advice where required, should be sought first where an underlying health condition is suspected or known about. This advice should cover not only the status of any health problem but also advice concerning the prognosis and management of risk arising from possible future episodes in recurrent problems.

It is also incumbent on the practitioner to recognise where their health may be affecting their performance as part of their responsibilities under the GMC Guide to Good Medical Practice, GDC Standards for Dental Professionals and GPhC Standards of conduct, ethics and performance.

Depending on the findings, it may be that the primary concern is one of health. The practitioner should therefore be subject to health procedures in the first instance. The responsible manager should revert to conduct procedures only when all reasonable steps under health procedures have been exhausted. The NCAS good practice guide *Handling concerns about a practitioner's health: a guide for managers* provides further information about managing practitioners with health concerns (available from the NCAS website).

2.3 Other personal circumstances affecting behaviours

It is also important to explore, particularly where the behaviour appears out of character, whether there are any personal circumstances for which the individual may need appropriate support. A

preliminary conversation with the practitioner may clarify this and whether there are relevant and genuine contributory factors.

2.4. Formal action on conduct issues

Thinking about behaviour can assist in considering what may lie behind a concern and the approach that may shape remediation.[4] However, there is some distinction between conduct and behaviour in procedural terms. Where formal action is appropriate, irrespective of the cause or type of behaviours, the matter should be dealt with first according to local conduct procedures, either under Performers List Regulations, where those apply, or under Part III of Maintaining High Professional Standards or other appropriate local procedures.

Often there are multiple factors contributing to concerns about a case. It is important to assess what are the core strands to the concern as this informs which procedure to use.

In primary care, decisions need to be made about whether the concerns are sufficiently serious to trigger Performers List Regulations (2004 & 2010) action or in the case of contractor pharmacists, NHS (Pharmaceutical Services) Regulations 2005.

MHPS (Part III) makes the distinction between general conduct and conduct of a professional nature. Whilst the process is essentially the same in that local conduct procedures will apply as they will for all members of staff, for matters relating to professional concerns independent professional advice (not necessarily external) should be sought and any panel must include a member who is medically or dentally qualified and who is not employed by the organisation. However, whatever external advice is sought the decision still remains with the Trust as to what action should be taken.

MHPS Part IV indicates that cases concerning both conduct and capability should usually be combined under capability. This is not helpful when conduct issues predominate because, at present, capability proceedings are significantly more specialised and complex, with key legal cases bearing on them. However, the guidance allows, "there may be occasions where it is necessary to pursue a conduct issue separately."

Managers and practitioners also need to avoid the potential mistake of classifying misconduct that has clinical consequences as capability. For example, rude and unpleasant behaviour in theatre will disrupt teamwork and may increase risks to patients. Similarly failure to follow clinical protocols may be due to inattention or disregard [behavioural problems, hence misconduct] rather than failing to recognise the clinical circumstances when they should be applied [clinical capability].

Determining the principal category of the concern is therefore important as not only does it inform process but also the organisation may be challenged or be subject to an injunction by the practitioner if the wrong procedure is applied.

In Wales although MHPS is not implemented the above consideration is helpful when considering action under WHC (90) 22.

2.5 Preparing to handle the concern

Generally, our experience is that the following factors can be a consideration when deciding which category might be appropriate:

- Deciding first whether health is the prevalent factor
- Reviewing whether matters of conduct and capability can rightfully be separated. For example, there is evidence of recent action being taken in regard to the conduct previously (for example a live warning or documented counselling) or the issues of capability are

minor, distinct and separate and as such they can be resolved through remediation

- Whether the concern arises from wilful, careless, inappropriate or unethical behaviour
- Whether the practitioner has disregarded matters which he/she of which he/she was aware, or could reasonably have been expected to make himself or herself aware (this is likely to be conduct)
- Inappropriate clinical practice arising from a lack of specialist knowledge or skills; for example, where a clinician has taken on work or new tasks for which he/she and, on occasion, the service in which they work, is inadequately trained or supervised. This may be accompanied by a lack of awareness into the concerns that employers may have in this regard
- Behaviour that contravenes the guidance in the GMC guide to Good Medical Practice may fall within the parameters of conduct and may justify referral to the GMC, in parallel with local action. *Referral to the Regulator does not preclude Performers List action around suitability. PCOs should make their own decisions as to whether they hold sufficient evidence to take action using Performers or Pharmaceutical List action independently of Regulator action*
- A persistent failure to engage with the performance management action and/or to accept the need for remediation may give rise to the matter being treated as conduct irrespective of the nature of the concern.

A further dimension may arise if the practitioner raises a counter complaint or a concern about clinical care, which may constitute a "protected disclosure" under the Public Interest Disclosure Act 1998; in other words, they could be considered a "whistleblower". In these circumstances, any complaint or organisational concern brought forward by the practitioner should be treated consistently with the normal organisational procedures for reviewing concerns that are raised in this way and may not necessarily take precedence over any action the organisation may wish to take in response to the conduct matter. The two processes can run in parallel although there may be occasions when it is legitimate to conclude one investigation before embarking on the other.

In secondary care, medical managers and clinical tutors can expect to deal with behavioural problems on a regular basis. This will be even more common for HR managers and therefore it is important that whoever is involved in managing the concern maintains organisational consistency in the action taken.

In primary care, behavioural problems may be hidden within the practice setting and only come to light because of a serious incident, complaint or partnership dispute.

3. Engaging the practitioner

3.1 Responding to concerns[5]

When responding to a concern about behaviour or conduct, the employment and/or contractual relationship between the individual concerned and their organisation is important in determining the response and the subsequent action available.

For directly employed practitioners any action should be consistent with the relevant local procedures.

For primary care practitioners initial approaches to the practitioner about the concerns may need to be documented but informal, (in the sense that formal regulations may not be invoked initially) PCOs should be aware that both contractual and Performers List Regulations may be used. In secondary care, the structure of the approach should be framed around the requirements of MHPS in respect of doctors and dentists. The principles of MHPS may be equally applied in the case of pharmacists.

Initial action regarding performance may be taken by individual practices in respect of those doctors and dentists whom they employ or with whom they are in partnership although information regarding this would usually be expected to be passed on to the PCO as the holder of the Performers List if this did not resolve the concern. Serious concerns would normally be shared with the PCO from the start. In the case of sole contractors, the PCO may be involved at an earlier stage.

Once a concern becomes known, there are a number of factors that need consideration when developing a response. These include:

- Is there sufficient information to provide reasonable grounds for further action?
- Is the source of the information reliable?
- Does the issue immediately affect patient care or present a risk to staff?
- Who is the right person to take this forward?
- Who else needs to be involved?
- Is the practitioner aware of the concerns?
- Have there been previous concerns and, if so, how recently and what action was taken?
- Does the problem behaviour appear to come from one individual or could the concerns be a collective team matter?

While some of these issues may seem straightforward to address, they may be complicated by organisational factors such as a breakdown in relationships between the individual and their colleagues. In some instances, relationship breakdown may also affect those with a responsibility for addressing the concern, particularly where matters have become personalised.

As should be the case when handling any performance concern, it is important to ensure that case managers and investigators are impartial and are seen to be so by all parties. They must be sufficiently skilled to deal with the concern. There must be clear distance between those involved in the investigative process, including the reporting of this to the board members, and those who have a responsibility to hear and make decisions about the concerns if they proceed to a formal hearing.

3.2 Raising the concern with the practitioner

A discussion with the practitioner about the concern should take place at the first available

opportunity, except where this may relate to potential criminal or fraudulent acts where the Police or Counter Fraud Services may be leading on any enquiries.

In approaching any discussion, particularly where this may be the opening for difficult feedback, it may be helpful for the investigator to be accompanied and to advise the practitioner to have someone to attend with them. These discussions should be conducted in accordance with the correct local or national procedure. It is helpful in the initial discussion to set out:

- The intent and purpose of the meeting clarifying whether it represents a formal part of any process
- A description as far as possible (without being accusatory) of the areas of conduct or behaviours that have raised concerns supported by facts, observations and relevant documentation e.g. appraisals, records of Serious Untoward Incidents, letters of complaint., clinical audit findings, and feedback from Multi Disciplinary Team meetings.

The discussion also provides an opportunity to listen to, and give consideration to, the response of the practitioner. On conclusion of the meeting, there should be a clear understanding of any proposed action and this should be documented.
Sometimes feelings will be running high. From a manager's perspective, it is important to be able to attend appropriately to any emotional response without being derailed from the main purpose of the meeting. Problems are most likely where a manager is upset or angry about the perceived behaviour of the practitioner, especially if this leads to any sort of pre-judgment. It is important that the organisation takes a non-judgmental stance.

Recognising that the practitioner is likely to experience the complaint or allegation of misconduct as "bad news" it follows that managers should

- allow time for the information to sink in
- repeat key messages and confirm in writing
- ensure that the practitioner is accompanied
- ensure support is available and offered
- arrange a further meeting
- maintain regular communication with the practitioner – especially if they are suspended or excluded.

3.3 The practitioner's response

From a practitioner's perspective, it is important they keep in mind how difficult peers, other clinical staff, patients and relatives find it to raise such concerns. The practitioner will need to be encouraged to take time to register what is being said and talk it over with someone else before deciding on any response. It is important to emphasise, that while allegations of misbehaviour are inevitably personal, the actions of the employer or contractor are largely determined by policy and are usually impersonal.

The practitioner may need both emotional and practical support to help manage their feelings (particularly anger and shame) and to deal with the local investigation and what may arise from this Therefore robust professional support and representation is helpful and may avoid responses that are unhelpful and unproductive. Responsible managers should encourage practitioners to seek support from, for example, their defence body, professional association or local medical/dental/pharmaceutical committee.

Equally, a denial or non-acceptance by the practitioner of the matters raised does not invalidate genuine concerns that need action. Any dispute about the facts should not be allowed to escalate to an argument or impasse; both the organisation and the practitioner should have an opportunity to present their case fully to any subsequent hearing if this is warranted.

Any counter allegations by the practitioner should be fully investigated separately and robustly. This does not necessarily need to take place in advance of any current action about their conduct in accordance with the relevant local procedures. Regard will need to be given, however, about the extent to which the two investigations may overlap or if it is important to clarify the practitioner's complaint before proceeding with the conduct investigation.

Any action taken should be proportionate and reasonable in the circumstances of the concern and take account of the findings of the initial discussion. Where an individual has demonstrated some acceptance of the feedback and remorse for the difficulties created, the opportunity for improvement through a process of remediation may be greater and may avoid initially any requirement for formal action.

The approach taken will depend also on the nature and seriousness of the misconduct, the extent of the concern, whether there are genuine contributory factors (such as workload pressures) and the action that is required in order to maintain consistency in the application of local procedures. In this context, there may already be organisational precedents set that might inform a response.

In general, an individual can expect

- to be treated fairly and consistently
- where appropriate to be offered reasonable opportunity for remediation, particularly where there has been no previous cause for concern
- to receive a copy of the relevant performance management policies
- to have adequate opportunity to respond to the complaint/concern
- to be represented (at any stage of the process) and to call appropriate witnesses
- to receive all the information that will be relied upon to make a decision
- to appeal any decision if permitted within the process
- to take their case to an employment tribunal if they feel they have been unfairly treated.

An employer or contracting body is entitled to

- expect compliance with the contract
- expect appropriate standards of performance and conduct
- expect reasonable instructions to be followed
- safeguard patient safety and the welfare of staff
- investigate concerns
- share information about a performance concern where there is a duty of care to do so, including referral to the relevant regulatory body (the practitioner should be informed of this)
- take disciplinary action where appropriate
- dismiss where there are justifiable grounds for ending a contract.

In primary care, except in the case of a sole practitioner, several named persons will hold the contract. If the behaviour or conduct of one of these leads to a contractual breach then the remaining contract holders may deal directly with the poorly performing contract signee or may seek the advice of the PCO as to how to act.

For employees and non-contract holders action on performance concerns may be taken initially by the employer. Concerns are often escalated to the PCO for help when attempts at remediation fail or if the case seems so serious that either Performers' List action or referral to the regulator is indicated. NHS (Pharmaceutical Services) Regulations do not apply to employees so the only recourse is the employer or the regulator.

4. Looking at the evidence

It is important when considering the information available about the concern that this links to the standard of conduct that is felt to have been breached, rather than a subjective judgement assumed by the recipient. General statements (e.g. that someone is 'difficult' or 'challenging') do not provide a basis from which someone can change. Factual descriptions of the concerns and their impact, rather than emotive statements, will give the practitioner clarity on what they should aim for e.g. "When the practitioner deals with some of his patients he is brusque during clinical examination, which can make them upset" can be much more helpful. In primary care, this may relate more to regulatory standards depending on the individual practice policies.

The serious implications of disciplinary action require that full consideration is taken of all the available and relevant evidence of the facts. This should take into account the practitioner's circumstances, with regard to length of service, past performance, health and any further information necessary to inform a decision.

The evidence may therefore need to take account of aspects such as:

- health
- patterns of behaviour and conduct
- previous attempts at remediation
- whether the concerns are already subject to ongoing review or local action
- any "live" disciplinary warnings already in place/any current contractual breach notices
- particular situations that may trigger episodes of poor conduct
- complaints information
- attendance records
- job plan and other external commitments
- relevant organisational change that may be impacting on the situation
- work environment
- personal circumstances
- appraisal information.

The behaviours that are giving rise to the concern about conduct should be set out clearly with examples, including in what setting these have arisen, along with supporting evidence.

There may be a difference or misalignment of views between the practitioner and their employing/contracting organisation as to what constitutes or is defined by them as poor behaviour. Often it is the impact of the behaviour that provides the base for the concern; what is regarded as acceptable behaviour can differ from one individual to another. Where the impact of that behaviour has a detrimental effect on other colleagues or patient care it needs to be determined whether the conduct fell short of the relevant performance standard set by the organisation or the regulator. Even if the conduct does not fall short action may still be required to ensure that the practitioner's standard of behaviour is acceptable to colleagues and patients or, if there is no evidence of concerns, to consider whether the complaints are vexatious.

A practitioner who persistently refuses to accept that their conduct is in breach of acceptable standards or where there is evidence they have misrepresented the position in their account of events may mean that disciplinary action is inevitable. In these circumstances, there may be limited scope for remediation and regulatory action may be required as the practitioner's fitness to practise could be impaired.

Alternatively, while a practitioner recognises there is a performance deficit, this could still require further investigation as this may be only one indicator of a more widespread concern. For example, could an admission of an isolated failure to accept or follow a local clinical guideline mask a wider

and deeper failure to follow other local or national guidance to the detriment of patient care? It is always critical to understand whether what is seen is the extent of a problem or whether it represents the "tip of an iceberg".

In most circumstances, an investigation is likely to be required to establish the facts and to provide clarity where there may be contradictory information. It is important for the terms of reference for the investigation to set out concisely the aspects of conduct giving rise to concern, with a clear description of the associated behaviour. They should not stray into unrelated areas, which may have caused irritation in the past, but are not part of the current episodes of poor performance.

The terms of reference should be shared with the practitioner for comment but not necessarily agreement. However, reasonable account should be taken of any disagreement about the scope of the investigation.

Where the concern is confined to one, relatively low-key event and there is no dispute about the facts, it may be possible to resolve the issue without a full investigation. However, deterioration in behaviour rather than a one-off event will require further investigation, particularly as a downturn in behaviour can link with poor clinical practice.

In addition, where the concerns are comprehensively refuted by other available evidence a full investigation may not be required. Nevertheless, there should be a documented audit trail of the discussions and outcomes along with any action so there is a clear understanding of what was agreed and the consequences of any repetition.

Further guidance is available in the NCAS publication *How to conduct a local performance investigation*.[6]

5. Management and resolution

5.1 Acting on the findings

Any action taken will depend on the findings of the initial review and discussion with the practitioner, and any subsequent investigation. Except in the cases of misconduct sufficiently serious to result in dismissal or, in primary care, removal from the relevant list, the premise of any action taken should be to support the individual in achieving a satisfactory and sustainable improvement in their conduct to enable them to work effectively alongside their colleagues. In some instances, setting out the areas that need improvement will be sufficient without the need for any further action other than monitoring and review.

The organisational response must also be demonstrably fair, consistent with the way all staff are treated in relation to the relevant local procedures and be mindful of precedents already set in this regard. It is important to inform the practitioner of the potential level of any formal action, particularly where dismissal or removal from the relevant list is a possible outcome, as they may be entitled to legal representation.

It should be clear what recourse there is if the practitioner has concerns about the handling of the process (for example, access to a Non Executive Director who under MHPS is required to have an overview of the process). Although MHPS does not apply in primary care, it is still good practice to involve a NED or lay person or equivalent person from within the new proposed structure for primary care.

If it is considered that despite a disciplinary sanction, the individual may have difficulty in modifying behaviour identified as unsatisfactory then, where remediation is appropriate, a judgement has to be made as to the form this should take. This should be based on the circumstances of each case as to what supporting action over and above any sanction is required to help the individual to prevent a further recurrence of the misconduct.

A disciplinary warning may be conditional on certain undertakings such as attending specific training or entering into a behavioural contract, which would set out explicitly the unacceptable behaviours the individual must avoid. It would include a commitment from the individual to improve their conduct over a given time and the consequences if there is no improvement.

Any written warning should set out the reasons for the warning clearly and should be explicit as to what will happen if there is a repetition of the specific misconduct this relates to or any other type of misconduct within the period of the warning.

In some instances, the individual concerns may also be affected by the dynamics and working relationships within the practitioner's team. Any wider concerns may also require review or organisational support. This will avoid placing the individual back into a potentially toxic environment, which may give rise to the same difficulties occurring again because the wider team aspects have not been addressed.

In primary care, disciplinary warnings may be issued in line with practice disciplinary policies or conditions may be placed upon the practitioner using Performers or Pharmaceutical List Regulations. PCOs should be aware that conditions can only be attached in cases where the PCO has enough evidence to justify a removal from the list which action can then be mitigated by the imposition of conditions. If there are insufficient grounds for initial removal then the PCO may consider voluntary agreement to conditions. These can be complex matters to address that take a long time to resolve. There may need to be an amnesty period to allow the practitioner reasonable time to modify behaviour through support and training. Habits and behaviour that have taken a lifetime to form will not change overnight and may require structured support and development.

5.2 Useful tools

There are a number of routes in to supporting a practitioner and an NCAS assessment of behavioural concerns can provide an independent perspective and further information about the behaviours and the possible drivers for these. In addition to thorough psychometric assessment and interview with an experienced occupational psychologist, which is informed by multi-source feedback information, the process also includes a full occupational health assessment.
The combined information can help to inform an action plan to support personal improvement. This is very much a self-directed process and relies on the understanding, engagement and commitment of the practitioner to work through a detailed programme of explicit and time limited objectives. Depending on the scope and content, an action plan may entail costs say in personal coaching. Who takes responsibility, including financial responsibility for these needs to be agreed at the outset.

Other useful tools include

- a behavioural contract
- coaching
- skills-based training.

NCAS advisers can advise on the use of all of the above and the development of action plans.

The overall costs of remediation can be significant and therefore early action is essential in helping to resolve the concern and in curtailing the financial impact of not addressing the problem.

Where the practitioner is employed or contracted to work subsequently, relevant and appropriate information about the action taken including remediation and temporary restriction to practise should be made available to those other employers or contractors.

Further information is available from NCAS' *Back on track Framework for further training.*

5.3 Intractable cases

In some cases, the process of managing performance may have affected relationships to the point where attempting remediation may be difficult or where there remains a divergence of views about what may have precipitated any informal/formal action. At this stage, a mediated discussion, managed by a neutral individual, may give both parties the opportunity to air any residual thoughts or feelings and provide a platform from which to proceed on a developmental basis. NCAS has experience of facilitating this style of discussion where it would be appropriate to do so.

In other instances, some differences between the parties may be irreconcilable particularly if one of the parties feels alienated from the other.

5.4 Contacting NCAS

Dealing with behavioural performance concerns is very difficult but NCAS has over ten years' experience of supporting their resolution. Senior managers working at a local level may have varying levels of experience in this area and we are here to help. Contacting us soon after a concern has been identified may mean that it is resolved before regulatory action is needed. Our advice is therefore to contact us as early as possible. We respond to calls about any aspect of individual or team behaviour and conduct, even where it is not yet clear whether there is evidence of poor practice. Our contact details are on our website.

Annex

Poor performance – evidence and experience

Research evidence

The NCAS 2011 Annual Conference, *Disruptive behaviour – Tackling concerns about practitioner behaviour*, presented a selection of the growing body of evidence on behavioural concerns in practitioners from Europe and North America.

Five broad personality traits – the 'Big Five' - influence our behaviour:

- Emotional Stability – How resilient?
- Extraversion – How sociable?
- Openness – How open to new experiences and change?
- Agreeableness – How collaborative?
- Conscientiousness – How diligent and focussed?

The extent to which an individual exhibits each of these traits, combined with the environment they are in, will influence their behaviour.[7]

Practitioners displaying poor behaviour can be extremely disruptive. Clinical professionals may be autonomous but they never work in isolation and can cause alarm, distress and anger in those working around them and their patients if they behave badly. Behavioural concerns, once identified, should be addressed early.

Other than personality traits, a number of important factors have been identified that can influence behaviour:

- Chronic embitterment – described as being "An emotion encompassing persistent feelings of being let down, insulted or being a loser, and of being revengeful but helpless" can be particularly difficult. Responsible managers may see difficult behaviours arising from practitioners who feel resentful over an incident in the workplace e.g. a fall out with a member of their team, their reaction to having clinical concerns addressed or feeling they are not being listened to when they have concerns about something or someone.[8]
- Team behaviour – a poor balance of individual and team needs e.g. a divergence of individual and team learning and development needs can lead to both individual and team dysfunction.[9]
- Clinical managers' behaviour – the difficulties that many clinical managers experience being asked to take on a role that they have not had the same breadth of training for as their clinical profession can influence how members of their team behave.[10]
- Cultural background – the unspoken rules of interaction in the NHS at national, organisational and team level can be difficult for a practitioner who is used to working in a different way. Their attitude to rules, relationships and how to interact with others may be different.[11]
- Health and behaviour.[12]

NCAS experience

When cases are referred to NCAS, NCAS staff summarise and record the concerns raised after discussion with the referring manager. Of the 927 cases handled by NCAS during the 2010/11

financial year, 59% were recorded as having some sort of behavioural component, either with or without other concerns.

Behavioural difficulties in practitioners who are referred to NCAS include:

- Communication with colleagues
- Team working
- Communication with management
- Communication with patients, carers, relatives
- Aggressive behaviour
- Behaviour under pressure
- Conflict management style
- Leadership style
- Decision-making style
- Erratic/unpredictable behaviour
- Withdrawn/isolated behaviour

These are terms used by NCAS when a practitioner is referred to NCAS, based on what NCAS advisers are told by responsible managers. The list should be seen as indicative rather than exhaustive. However, it shows the range of behavioural difficulties that practitioners are displaying. Practitioners may be referred with a combination of behavioural concerns.

Agreeable practitioners

Problem behaviours may not be immediately obvious. Although it is easy to identify a practitioner who is consistently rude and aggressive towards colleagues as having problem behaviour, some agreeable traits can cause difficulties in the workplace as well. A personality profile analysis of 279 practitioners referred to NCAS produced some unexpected results. Although some of the personality traits we expected were present, some findings were counterintuitive:[13]

What we expected	*What we found*
More emotionally reactive	Somewhat more reactive
More introverted	More introverted
Less open	Less open
Less agreeable	Much MORE agreeable
Less conscientious	Similar to the working population
Under pressure: More arrogant	Under pressure: More perfectionist and more dependent (anxious to please)

Some of these traits may make managing performance concerns difficult. Practitioners who are very agreeable may find it hard to be assertive when dealing with problems in their practice. It can be a practitioner's desire to do a job well and particularly to please their patients that means their behaviour causes conflict with others.

Endnotes

[1] As at financial year end 2010/11. See *2010/11 Casework activity report*. NCAS. 2011.
[2] *Guidebook for managing disruptive physician behaviour*. College of Physicians and Surgeons of Ontario. 2008.
[3] *NCAS Casework: The first 8 years*. NCAS. 2009.
[4] See the NCAS good practice guide *The Back on Track Framework for further training: Restoring practitioners to safe and valued practice* for more guidance on remediation. NCAS. 2010.
[5] See also the NCAS good practice guide *How to conduct a local performance investigation*. NCAS. 2010.
[6] *How to conduct a local performance investigation*. NCAS. 2010.
[7] *Disruptive behaviour – symptom, cause or both?* Dr Gwen Adshead, Dr Deborah Bowman, Dr Jenny King and Professor Alastair Scotland. NCAS Annual Conference 2011: Disruptive behaviour – Tackling concerns about practitioner behaviour.
[8] *Behaviour and embitterment.* Dr Rosemary Field, Ms Claire McLaughlan and Professor Tom Sensky. NCAS Annual Conference 2011.
[9] *Behaviour in teams*. Ms Lynn Markiewicz, Mr William Rial and Mrs Chris Wilkinson. NCAS Annual Conference 2011.
[10] *Bridges or barriers? Impact of clinical managers' behaviour on practitioner behaviour*. Mr David Evans, Dr Megan Joffe and Professor Pauline McAvoy. NCAS Annual Conference 2011.
[11] *Cultural background – impact on behaviour*. Dr Janine Brooks and Dr Debbie Cohen. NCAS Annual Conference 2011.
[12] Health and behaviour. Dr Nick Brown, Dr Peter Dickson, Ms Florence Starr and Mrs Elaine Stevenson. NCAS Annual Conference 2011.
[13] *Personality of doctors in difficulty: Analysis of 120 behavioural assessment cases from NCAS (UK)*. NCAS, Edgecumbe Group, Personnel Assessment Ltd. 2006.

All current NCAS publications can be found at www.ncas.nhs.uk/publications.

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