Corrigan, Martina

Subject: Triage

Start: Mon 29/05/2017 08:00
End: Mon 29/05/2017 08:30

Recurrence: Weekly
Recurrence Pattern: every Monday from 08:00 to 08:30

Categories: Followup email

Corrigan, Martina

From: Robinson, Katherine [redacted]
Sent: 17 July 2017 12:51
To: Corrigan, Martina
Subject: FW: OUTSTANDING TRIAGE

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

t: [redacted]
e: [redacted]

From: Evans, Marie
Sent: 17 July 2017 12:36
To: Robinson, Katherine
Subject: RE: OUTSTANDING TRIAGE

[redacted] – Yes,
[redacted] – Yes
[redacted] - Yes
[redacted] - Yes
[redacted] – Yes
[redacted] – Not yet = MY patient and this email wasn't sent to Paulette.

Kind Regards
Marie

Marie Evans
Service Administrator
Ground Floor
Ramone Building
CAH

E: [redacted]
T: [redacted]

INTERNAL: EX [redacted] ***if dialling from Avaya phone.***
If dialling from old phone please dial [redacted]
EXTERNAL : [redacted]

From: Robinson, Katherine
Sent: 17 July 2017 12:08
To: Evans, Marie
Subject: FW: OUTSTANDING TRIAGE

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

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

From: Corrigan, Martina
Sent: 17 July 2017 12:07
To: Robinson, Katherine
Subject: FW: OUTSTANDING TRIAGE

Katherine

Just checking were these referrals returned?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

Changed My Number

***INTERNAL: EXT** Personal Information redacted by the USI **if dialling from Avaya phone. If dialling from old phone please dial** Personal Information redacted by the USI*
***EXTERNAL :** Personal Information redacted by the USI*
***Mobile:** Personal Information redacted by the USI*

From: Coleman, Alana
Sent: 07 July 2017 13:03
To: Elliott, Noleen
Cc: Browne, Leanne; Evans, Marie; Corrigan, Martina; Robinson, NicolaJ; O'Brien, Aidan
Subject: OUTSTANDING TRIAGE

Hi Noleen,

Below is the current outstanding triage.

CAH	Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information	Personal Information	30	Personal Information redacted by the USI	Personal Information redacted by the USI	URO	GURO	ROUTINE	OC	
CAH	Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information	Personal Information redacted by the USI	10	Personal Information redacted by the USI	Personal Information redacted by the USI	URO	GURO	ROUTINE	GPR	
CAH	Personal Information redacted by the USI	Personal Information	Personal Information redacted by the USI	Personal Information	71	Personal Information redacted by the USI	Personal Information redacted by the USI	URO	AOB	URGENT	OC	19

CAH	Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information	Personal Information	37		Personal Information redacted by the USI	URO	GURO	ROUTINE	GPR	19	
CAH	Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information	65	Personal Information redacted	Personal Information redacted by the USI	URO	GURO	ROUTINE	OC	21/06/2017	
CAH	Personal Information redacted by the USI	Personal Information redacted by the USI	Personal Information	Personal Information	35			URO	MY	ROUTINE	OC	21/0	

Many Thanks
Alana

Registration and Booking Clerk
Referral and Booking Centre
Ramone Building
CAH
Tel : Personal Information redacted by the USI

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 14 April 2017 16:58
To: Carroll, Ronan
Subject: RE: MHPS case

I don't know – forwarding what you had sent to Siobhan so I am not sure what was given to him?

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

INTERNAL: EX [redacted] ***if dialling from Avaya phone. If dialling from old phone please dial*** [redacted]
EXTERNAL : [redacted]
Mobile: [redacted]

From: Carroll, Ronan
Sent: 14 April 2017 16:51
To: Corrigan, Martina
Subject: RE: MHPS case
Importance: Low

Ok but what AP has he got ie one with no notes or one with notes permissible

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: Corrigan, Martina
Sent: 14 April 2017 16:50
To: Carroll, Ronan
Subject: RE: MHPS case

Notes are in his office but the longest is waiting x 2 weeks on results.

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

INTERNAL: EXT [redacted] ***if dialling from Avaya phone. If dialling from old phone please dial*** [redacted]
EXTERNAL : [redacted]

Mobile: Personal Information redacted by the USI

From: Carroll, Ronan
Sent: 14 April 2017 16:42
To: Corrigan, Martina
Subject: RE: MHPS case
Importance: High

So what does AOB have re this AP?

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 14 April 2017 15:49
To: Carroll, Ronan
Subject: RE: MHPS case

Ronan

Action Plan attached and the relevant piece is below – all other consultants store charts in their offices awaiting results etc… so we never got agreement on whether he couldn't store these in his office?

> *Notes tracked out to Mr O'Brien must be tracked out to him for the shortest period possible for the management of a patient.*
> *Notes must not be stored in Mr O'Brien's office.* *(just checking on this as all other consultants do have notes in their offices?)*

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

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From: Carroll, Ronan
Sent: 14 April 2017 15:36
To: Corrigan, Martina
Subject: RE: MHPS case

Tks have you the AP – was AOB supposed to have notes in his office?

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care

Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 14 April 2017 15:22
To: Carroll, Ronan
Cc: Weir, Colin
Subject: RE: MHPS case

Ronan

Please see below update on action plan:

Concern 1

Mr O'Brien has just completed his first week as Urologist oncall (since he came back). I have checked this morning and I can confirm that all referrals including Red Flags have been triaged and returned appropriately

Concern 2

Apart from the 13 already identified missing notes Mr O'Brien has 63 further charts in his office which are all recent and are awaiting for results. There are no other missing charts and no evidence of charts being taken off-site.

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I can confirm that all clinics that Mr O'Brien has done since his return to work have been dictated on by digital dictation and all patients have a plan and outcome included.

Concern 4

Mr O'Brien has only had one Theatre list since his return (last Wednesday 5 April)
There were 6 patients listed and I can confirm none were previous private patients

If you should require any further detail please do not hesitate to contact me.

Regards

Martina

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Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

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Mobile Personal Information redacted by the USI

From: Carroll, Ronan
Sent: 12 April 2017 15:26
To: Corrigan, Martina; Weir, Colin
Subject: FW: MHPS case
Importance: High

Martina
As discussed yesterday – can u provide this update asap pls
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Personal Information redacted by USI

From: Khan, Ahmed
Sent: 12 April 2017 12:55
To: Gishkori, Esther; Carroll, Ronan
Cc: Hynds, Siobhan
Subject: MHPS case

Dear Esther & Ronan,
I would be grateful for an update regarding adherence to action plan for Mr O'Brien's MHPS Case.

Siobhan, for information.

Regards
Dr Ahmed Khan
AMD& Case Manager

Sent from my BlackBerry 10 smartphone.

Corrigan, Martina

From: Carroll, Ronan [redacted]
Sent: 23 May 2017 22:38
To: Hynds, Siobhan
Cc: Corrigan, Martina; Weir, Colin
Subject: RE: Return to Work Action Plan February 2017 (2)
Attachments: Return to Work Action Plan February 2017 FINAL..docx

Importance: High

Tks Siobhan – Martina need to ensure notes in AOB's office are recycled through

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob [redacted]

From: Hynds, Siobhan
Sent: 11 May 2017 11:08
To: Carroll, Ronan
Cc: Corrigan, Martina
Subject: RE: Return to Work Action Plan February 2017 (2)

Ronan

Sorry for the delay with this – I have attached the final version.

Siobhan

From: Carroll, Ronan
Sent: 14 April 2017 17:12
To: Hynds, Siobhan
Cc: Corrigan, Martina
Subject: FW: Return to Work Action Plan February 2017 (2)

Siobhan
Can I ask what version of the AP did AOB receive?
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob [redacted]

From: Corrigan, Martina
Sent: 14 April 2017 17:10
To: Carroll, Ronan
Subject: RE: Return to Work Action Plan February 2017 (2)

I wrote the query and highlighted as I didn't think we could say this on the AP when the others consultants in all specialities keep notes in their offices but I never heard back on what the decision was.

Martina

Martina Corrigan

Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

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From: Carroll, Ronan
Sent: 14 April 2017 17:09
To: Corrigan, Martina
Subject: RE: Return to Work Action Plan February 2017 (2)

Who wrote the query on notes? & who was checking this out?

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 14 April 2017 17:01
To: Carroll, Ronan
Subject: FW: Return to Work Action Plan February 2017 (2)
Importance: High

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

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From: Carroll, Ronan Personal Information redacted by the USI
Sent: 08 February 2017 15:22
To: Corrigan, Martina; Hynds, Siobhan
Subject: RE: Return to Work Action Plan February 2017 (2)
Importance: High

Martina tks
Siobhan please see amended AP for AOB

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 08 February 2017 15:20
To: Carroll, Ronan
Subject: Return to Work Action Plan February 2017 (2)

Ronan

See my amendments – happy to discuss further. I am assuming that the timeliness of ward rounds etc. will be discussed as part of the review of his job plan?

Regard

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital
Telephone: Personal Information redacted by the USI
Mobile : Personal Information redacted by the USI

Southern Health and Social Care Trust

Quality Care - for you, with you

MR A O'BRIEN, CONSULTANT UROLOGIST
RETURN TO WORK PLAN / MONITORING ARRANGEMENTS
MEETING 9 FEBRUARY 2017

Following a decision by case conference on 26 January 2017 to lift an immediate exclusion which was in place from 30 December 2017, this action plan for Mr O'Brien's return to work will be in place pending conclusion of the formal investigation process under Maintaining High Professional Standards Framework.

The decision of the members of the case conference is for Mr O'Brien to return as a Consultant Urologist to his full job role as per his job plan and to include safeguards and monitoring around the 4 main issues of concerns under investigation. An urgent job plan review will be undertaken to consider any workload pressures to ensure appropriate supports can be put in place.

Mr O'Brien's return to work is based on his:

- strict compliance with Trust Policies and Procedures in relation to:
    - Triaging of referrals
    - Contemporaneous note keeping
    - Storage of medical records
    - Private practice
- agreement to comply with the monitoring mechanisms put in place to assess his administrative processes.

Currently, the Urology Team have scheduled and signed off clinical activity until the end of March 2017, patients are called and confirmed for the theatre lists up to week of 13 March. Therefore on immediate return, Mr O'Brien will be primarily undertaking clinics and clinical validation of his reviews, his inpatient and day case lists. This work will be monitored by the Head of Service and reported to the Assistant Director.

CONCERN 1

- That, from June 2015, 783 GP referrals had not been triaged in line with the agreed / known process for such referrals.

Mr O'Brien, when Urologist of the week (once every 6 weeks), must action and triage all referrals for which he is responsible, this will include letters received via the booking

centre and any letters that have been addressed to Mr O'Brien and delivered to his office. For these letters it must be ensured that the secretary will record receipt of these on PAS and then all letters must be triaged. The oncall week commences on a Thursday AM for seven days, therefore triage of all referrals must be completed by 4pm on the Friday after Mr O'Brien's Consultant of the Week ends.

Red Flag referrals must be completed daily.

All referrals received by Mr O'Brien will be monitored by the Central Booking Centre in line with the above timescales. A report will be shared with the Assistant Director of Acute Services, Anaesthetics and Surgery at the end of each period to ensure all targets have been met.

CONCERN 2

- That, 307 sets of patient notes were returned by Mr O'Brien from his home, 88 sets of notes located within Mr O'Brien's office, 13 sets of notes, tracked to Mr O'Brien, are still missing.

Mr O'Brien is not permitted to remove patient notes off Trust premises.

Notes tracked out to Mr O'Brien must be tracked out to him for the shortest period possible for the management of a patient.

Notes must not be stored in Mr O'Brien's office. Notes should remain located in Mr O'Brien's office for the shortest period required for the management of a patient.

CONCERN 3

- That 668 patients have no outcomes formally dictated from Mr O'Brien's outpatient clinics over a period of at least 18 months.

All clinics must be dictated at the end of each clinic/theatre session via digital dictation. This is already set up in the Thorndale Unit and will be installed on the computer in Mr O'Brien's office and on his Trust laptop and training is being organised for Mr O'Brien on this. This dictation must be done at the end of every clinic and a report via digital dictation will be provided on a weekly basis to the Assistant Director of Acute Services, Anaesthetics and Surgery to ensure all outcomes are dictated.

An outcome / plan / record of each clinic attendance must be recorded for each individual patient and this should include a letter for any patient that did not attend as there must be a record of this back to the GP.

CONCERN 4

- A review of Mr O'Brien's TURP patients identified 9 patients who had been seen privately as outpatients, then had their procedure within the NHS. The waiting times for these patients are significantly less than for other patients.

Mr O'Brien must adhere to all aspects of the Trust Private Practice Policy, ' A Guide to Paying Patients' and in particular to 'Referral of Private Patients to NHS Lists which states that '*any patient changing their status after having been provided with private services should not be treated on a different basis to other NHS patients as a result of having previously held private status: patients referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients'.*

The scheduling of patient's must be undertaken by the secretary, who will check the list with Mr O'Brien and then contact the patient for their appointment. This process is in keeping with the practice established within the Urology team.

Any deviation from compliance with this action plane must be referred to the MHPS Case Manager immediately.

Corrigan, Martina

From: Carroll, Ronan
Sent: 23 June 2017 17:48
To: Corrigan, Martina
Cc: Hynds, Siobhan; Weir, Colin
Subject: RE: MHPS case update on 23 June 2017

Importance: High

Martina
Tks for this largely +ve update. Re Concern 2 I would ask that notes are dealt with by 30th June, otherwise we are return ing to the previous position
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 23 June 2017 15:36
To: Carroll, Ronan
Subject: FW: MHPS case update on 23 June 2017

Ronan

Update as of today 23 June 2017

Concern 1

Mr O'Brien was last oncall from 13 – 19th May and I can confirm all letters were triaged within the timescales his next oncall is from 29th June until 5 July.

Concern 2

Apart from the 13 already identified missing notes Mr O'Brien has 85 further charts in his office. This amount has been increasing each week and whilst some are moving on there are some that haven't been actioned. I have emailed Mr O'Brien earlier this week and listed these and I reminded him that as part of the action plan that *Notes should never be stored off site and should only be tracked out and in your office for the shortest time possible* and I asked him to please address as many of these as he could. I will check early next week to ensure that he has dealt with and got these moved back to files. I will update again on this concern next week. Mr O'Brien held a clinic in South West Acute Hospital on Monday 8th May (the first since his return) and I left and collected the notes from SWAH and I can confirm that there were none missing. There are no other missing charts and no evidence of charts being taken off-site.

Concern 3

I can confirm that all clinics that Mr O'Brien has done since his return to work have been dictated on by digital dictation and all patients have a plan and outcome included.

Concern 4

Mr O'Brien has had theatre lists on 31 May, 7, 14, 21st June 2017
There were a total of 18 patients listed and I can confirm none were previous private patients

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

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Received from Martina Corrigan on 18/07/2022. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: Carroll, Ronan
Sent: 19 July 2017 15:55
To: Corrigan, Martina; Weir, Colin
Subject: RE: FW: triage not returned

Tuesday good for me

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 19 July 2017 15:54
To: Weir, Colin; Carroll, Ronan
Subject: RE: FW: triage not returned

Ok

Aidan's availability next week is:

In SWAH all day Monday
Admin (off-site) on Tuesday AM as agreed – potentially could ask him to come in late morning before his Clinic in the PM
Wednesday theatres starting at 12MD-8pm
Thursday AM – SPA - could meet – Thurs PM MDT
Friday AM – Oncology Clinic and Friday PM SPA/Admin

You can let me know

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

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Mobile: Personal Information redacted by the USI

From: Weir, Colin
Sent: 19 July 2017 15:07
To: Corrigan, Martina; Carroll, Ronan
Subject: RE: FW: triage not returned

Fri doesn't suit make it next week

Colin Weir FRCSEd, FRCSEng, FFSTEd
Consultant Surgeon | Honorary Lecturer in Surgery | AMD Education and Training |Clinical Director SEC
Southern Health and Social Care Trust

int Personal Information redacted by the USI direct Personal Information redacted by the USI

Secretary Collette Mc Caul
int Personal Information redacted by the USI direct Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 19 July 2017 15:04
To: Carroll, Ronan; Weir, Colin
Subject: RE: FW: triage not returned

Ronan

I have run a fresh report there now – there are 75 charts now tracked to Mr O'Brien's office. A reduction of 30 from the last time I ran this. The longest is 3 February 2017 and comment is 'private patient cabinet'. Then 24 February x 3 charts with comments – Result for Mr O'Brien to see, and 2 x Mr O'Brien's admin. Below is the change in what is being returned to records since last time I ran this which is 45 – and then there has been 15 additional for July,

Aidan will be off-site tomorrow AM pre-viewing for MDT and then he will be at MDT tomorrow afternoon, Friday AM he has an oncology clinic and then Audit in the PM, so really only availability to meet would be between clinic and audit on Friday lunchtime?

Can you let me know what suits to meet with him?

Date Chart Borrowed	Total as of June 2017	Total as of 19 July 2017	Total charts returned
Jan 2017	1	0	1
Feb 2017	5	4	1
March 2017	11	9	2
April 2017	37	15	22
May 2017	35	16	19
June 2017	16	16	0
July 2017	NA	15	N/A
Total Charts	**105**	**75**	**45**

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

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From: Carroll, Ronan
Sent: 19 July 2017 12:31
To: Corrigan, Martina; Weir, Colin
Subject: FW: FW: triage not returned

Any update

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 14 April 2017 15:22
To: Carroll, Ronan
Cc: Weir, Colin
Subject: RE: MHPS case

Ronan

Please see below update on action plan:

Concern 1

Mr O'Brien has just completed his first week as Urologist oncall (since he came back). I have checked this morning and I can confirm that all referrals including Red Flags have been triaged and returned appropriately

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Apart from the 13 already identified missing notes Mr O'Brien has 63 further charts in his office which are all recent and are awaiting for results. There are no other missing charts and no evidence of charts being taken off-site.

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I can confirm that all clinics that Mr O'Brien has done since his return to work have been dictated on by digital dictation and all patients have a plan and outcome included.

Concern 4

Mr O'Brien has only had one Theatre list since his return (last Wednesday 5 April)
There were 6 patients listed and I can confirm none were previous private patients

If you should require any further detail please do not hesitate to contact me.

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

INTERNAL: EXT [redacted] ***if dialling from Avaya phone. If dialling from old phone please dial*** [redacted]
EXTERNAL : [redacted]
Mobile: [redacted]

From: Carroll, Ronan
Sent: 12 April 2017 15:26
To: Corrigan, Martina; Weir, Colin

Subject: FW: MHPS case
Importance: High

Martina
As discussed yesterday – can u provide this update asap pls
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Personal Information redacted by the USI

From: Khan, Ahmed
Sent: 12 April 2017 12:55
To: Gishkori, Esther; Carroll, Ronan
Cc: Hynds, Siobhan
Subject: MHPS case

Dear Esther & Ronan,
I would be grateful for an update regarding adherence to action plan for Mr O'Brien's MHPS Case.

Siobhan, for information.

Regards
Dr Ahmed Khan
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[redacted]

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Thanks

Martina

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Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

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ATICs/Surgery & Elective Care
Personal Information redacted by the USI

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Subject: MHPS case

Dear Esther & Ronan,
I would be grateful for an update regarding adherence to action plan for Mr O'Brien's MHPS Case.

Siobhan, for information.

Regards
Dr Ahmed Khan
AMD& Case Manager

Sent from my BlackBerry 10 smartphone.

Corrigan, Martina

From: Corrigan, Martina
Sent: 14 April 2017 16:50
To: Carroll, Ronan
Subject: RE: MHPS case

Notes are in his office but the longest is waiting x 2 weeks on results.

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

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Mobile: Personal Information redacted by the USI

From: Carroll, Ronan
Sent: 14 April 2017 16:42
To: Corrigan, Martina
Subject: RE: MHPS case
Importance: High

So what does AOB have re this AP?

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 14 April 2017 15:49
To: Carroll, Ronan
Subject: RE: MHPS case

Ronan

Action Plan attached and the relevant piece is below – all other consultants store charts in their offices awaiting results etc… so we never got agreement on whether he couldn't store these in his office?

> *Notes tracked out to Mr O'Brien must be tracked out to him for the shortest period possible for the management of a patient.*
> *Notes must not be stored in Mr O'Brien's office. (just checking on this as all other consultants do have notes in their offices?)*

Thanks

Martina

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From: Carroll, Ronan
Sent: 14 April 2017 15:36
To: Corrigan, Martina
Subject: RE: MHPS case

Tks have you the AP – was AOB supposed to have notes in his office?

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 14 April 2017 15:22
To: Carroll, Ronan
Cc: Weir, Colin
Subject: RE: MHPS case

Ronan

Please see below update on action plan:

Concern 1

Mr O'Brien has just completed his first week as Urologist oncall (since he came back). I have checked this morning and I can confirm that all referrals including Red Flags have been triaged and returned appropriately

Concern 2

Apart from the 13 already identified missing notes Mr O'Brien has 63 further charts in his office which are all recent and are awaiting for results. There are no other missing charts and no evidence of charts being taken off-site.

Concern 3

I can confirm that all clinics that Mr O'Brien has done since his return to work have been dictated on by digital dictation and all patients have a plan and outcome included.

Concern 4

Mr O'Brien has only had one Theatre list since his return (last Wednesday 5 April)
There were 6 patients listed and I can confirm none were previous private patients

If you should require any further detail please do not hesitate to contact me.

Regards

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From: Carroll, Ronan
Sent: 12 April 2017 15:26
To: Corrigan, Martina; Weir, Colin
Subject: FW: MHPS case
Importance: High

Martina
As discussed yesterday – can u provide this update asap pls
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Personal Information redacted by the USI

From: Khan, Ahmed
Sent: 12 April 2017 12:55
To: Gishkori, Esther; Carroll, Ronan
Cc: Hynds, Siobhan
Subject: MHPS case

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Siobhan, for information.

Regards
Dr Ahmed Khan
AMD& Case Manager

Sent from my BlackBerry 10 smartphone.

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 14 April 2017 16:58
To: Carroll, Ronan
Subject: RE: MHPS case

I don't know – forwarding what you had sent to Siobhan so I am not sure what was given to him?

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

Changed My Number

INTERNAL: EXT [redacted] ***if dialling from Avaya phone. If dialling from old phone please dial*** [redacted]
EXTERNAL : [redacted]
Mobile: [redacted]

From: Carroll, Ronan
Sent: 14 April 2017 16:51
To: Corrigan, Martina
Subject: RE: MHPS case
Importance: Low

Ok but what AP has he got ie one with no notes or one with notes permissible

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]

From: Corrigan, Martina
Sent: 14 April 2017 16:50
To: Carroll, Ronan
Subject: RE: MHPS case

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Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

Changed My Number

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Concern 1

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Concern 2

Apart from the 13 already identified missing notes Mr O'Brien has 63 further charts in his office which are all recent and are awaiting for results. There are no other missing charts and no evidence of charts being taken off-site.

Concern 3

I can confirm that all clinics that Mr O'Brien has done since his return to work have been dictated on by digital dictation and all patients have a plan and outcome included.

Concern 4

Mr O'Brien has only had one Theatre list since his return (last Wednesday 5 April)
There were 6 patients listed and I can confirm none were previous private patients

If you should require any further detail please do not hesitate to contact me.

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From: Carroll, Ronan
Sent: 12 April 2017 15:26
To: Corrigan, Martina; Weir, Colin
Subject: FW: MHPS case
Importance: High

Martina
As discussed yesterday – can u provide this update asap pls
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Personal Information redacted by the USI

From: Khan, Ahmed
Sent: 12 April 2017 12:55
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Siobhan, for information.

Regards
Dr Ahmed Khan
AMD& Case Manager

Sent from my BlackBerry 10 smartphone.

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 05 May 2017 15:11
To: Carroll, Ronan
Subject: RE: MHPS case update on 5 May 2017

Ronan

I have updated this but note that Dr Khan wants monthly update which would be end of next week – do you want to send or will I update again next week?

Concern 1

Mr O'Brien has not been oncall since 6-12 April as per last update. He is due to be Urologist oncall from 18 May and I will update once he has finished this week.

Concern 2

Apart from the 13 already identified missing notes Mr O'Brien has 68 further charts in his office which are all recent and are awaiting for results. There are no other missing charts and no evidence of charts being taken off-site.

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Mr O'Brien has had theatre lists on 5th and 26th April and on 3rd May
There were a total of 17 patients listed and I can confirm none were previous private patients

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Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

INTERNAL: EX [redacted] ***if dialling from Avaya phone. If dialling from old phone please dial*** [redacted]
EXTERNAL : [redacted]
Mobile: [redacted]

From: Carroll, Ronan
Sent: 04 May 2017 12:21
To: Corrigan, Martina
Subject: FW: MHPS case

Martina
Can we get this done pls for tomorrow

Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI

From: Khan, Ahmed
Sent: 04 May 2017 12:20
To: Carroll, Ronan
Cc: Hynds, Siobhan
Subject: RE: MHPS case

Ronan, Please send monthly update by end of next week (12th May).
Thanks,
Ahmed

Dr Ahmed Khan
Consultant Paediatrician
Associate Medical Director &
MHPS Case Manager
SHSCT

From: Carroll, Ronan
Sent: 14 April 2017 16:44
To: Khan, Ahmed
Cc: Hynds, Siobhan; Chada, Neta
Subject: FW: MHPS case
Importance: High

Ahmed
As requested – update on AOB AP
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

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Corrigan, Martina

From: Carroll, Ronan [redacted]
Sent: 08 May 2017 09:20
To: Corrigan, Martina
Cc: Khan, Ahmed; Hynds, Siobhan
Subject: RE: MHPS case update on 5 May 2017

Importance: High

Martina
I would wish our auditing to continue weekly the reason being if anything starts to slip we can act quickly
Siobhan re notes in his office – what went to AOB regarding this?
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob [redacted]

From: Corrigan, Martina
Sent: 05 May 2017 15:11
To: Carroll, Ronan
Subject: RE: MHPS case update on 5 May 2017

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Siobhan, for information.

Regards
Dr Ahmed Khan
AMD& Case Manager

Sent from my BlackBerry 10 smartphone.

Corrigan, Martina

From: Hynds, Siobhan
Sent: 11 November 2018 20:30
To: Corrigan, Martina
Subject: Re: AOB Action plan

Thanks Martina.

S

Sent from my BlackBerry 10 smartphone.

From: Corrigan, Martina
Sent: Saturday, 10 November 2018 08:37
To: Khan, Ahmed; Hynds, Siobhan
Cc: Carroll, Ronan
Subject: AOB Action plan

Dear all,

As requested, please see below for this week commencing 5 November 2018

CONCERN 1 – There are 4 letters waiting on etriage for Mr O'Brien:
1 x Red Flag added yesterday
3 x Routine one added on 29th October and two added on 30 October 2018. (these three are in breach of the week turnaround time

CONCERN 2 – there are currently 40 casenotes tracked on PAS to Mr O'Brien's office.

CONCERN 3 – Mr O'Brien has one clinic letter waiting on digital dictation (8/11/18) and 17 ward discharges awaiting on digital dictation

CONCERN 4 – adhered to – no more of Mr O'Brien's patients that had been seen privately as an outpatient has been listed,

Should you require anything further, please do not hesitate to contact me.

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

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Corrigan, Martina

From: Khan, Ahmed
Sent: 23 November 2018 13:16
To: Corrigan, Martina
Cc: Hynds, Siobhan; Carroll, Ronan
Subject: RE: AOB Action plan

Martina, Please note I would only need monthly reports or earlier only if any issues.

Thanks
AK

On 23 Nov 2018 13:09, "Corrigan, Martina" Personal information redacted by USI wrote:
Dear all,

As requested, please see below for this week commencing 23 November 2018
(Please note that Mr O'Brien was supposed to be oncall this week but had to go off and his oncall week including the triage was covered by his colleagues)

CONCERN 1 – There are 0 letters waiting on etriage for Mr O'Brien:

CONCERN 2 – there are currently 27 casenotes tracked on PAS to Mr O'Brien's office.

CONCERN 3 – Mr O'Brien has 0 clinic letters waiting on digital dictation

CONCERN 4 – adhered to – no more of Mr O'Brien's patients that had been seen privately as an outpatient has been listed,

Should you require anything further, please do not hesitate to contact me.

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Corrigan, Martina

From: Khan, Ahmed
Sent: 23 September 2019 16:18
To: Hynds, Siobhan; OKane, Maria
Cc: Haynes, Mark; Corrigan, Martina; Toal, Vivienne; Chada, Neta
Subject: RE: URGENT - FOR RESPONSE TODAY - GMC Response - AOB

From: Hynds, Siobhan
Sent: 23 September 2019 14:05
To: OKane, Maria
Cc: Haynes, Mark; Corrigan, Martina; Toal, Vivienne; Chada, Neta; Khan, Ahmed
Subject: URGENT - FOR RESPONSE TODAY - GMC Response - AOB
Importance: High

Hi Maria

Further to our conversation earlier this morning in respect of information required for the GMC – please see below:

GMC Triage Team require the following additional information urgently:

1. Along with your referral of Dr O'Brien, you forwarded a copy of the MHPS Investigation Case Manager Determination (dated September 2018). Given the Report was completed last year, was there any specific reason the referral to the GMC was delayed?

The MHPS Case Manager Determination was notified to the Practitioner on 1 October 2018. The decision of the Case Manager at that time was not to refer to GMC but to conclude the internal process first, which was referral to a conduct panel. On further discussion of the MHPS case with the Trust's GMC liaison officer, a request to the Trust was made for referral to GMC and this was made by the Trust's Medical Director.

Ahmed Khan Comments: This case has been discussed regularly at shsct trust and GMC Liaison meetings throughout 2018. The MHPS report was concluded and provided to clinician in Oct 2018. Think shortly afterwards in discussion with GMC Liaison officer it was decided to make GMC referral.

2. The MHPS Determination highlighted a number of "wider, systemic findings that must be addressed by the Trust" and "systemic failures by managers at all levels, both clinical and operational". What exactly were these specific systemic issues; have any inspections of these issues taken place. We also need information on what the Trust have done to address these issues so far?

The MHPS determination highlighted 'failures by managers at all levels, both clinical and operational' – this referred to failings to manage concerns in respect of the Practitioner when the issues were first known and on-going thereafter. The concerns about the Practitioner were known to managers at a number of levels within the organisation over a number of years and the report noted that management of the concerns was not as it should have been.

The Trust have committed to an independent review of the relevant administrative processes and roles and responsibilities. This review has not yet commenced.

3. It is noted that the Trust were also asked to carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels, and to look at the full system wide problems. Has this review has been completed; what were the findings (or an update on the current progress)?

Please see above.

4. The referral also raised questions about Dr O'Brien's lack of insight into the concerns raised about his practice. Can you confirm specific details of what these issues were, including any examples suggesting the doctor lacked insight?

The MHPS Case Investigator referred to a lack of insight on the part of the practitioner in the formal investigation report following conclusion of the investigation. This was primarily in respect of the Practitioner's responses during the investigation into the issues of concern and impact of his administrative practices on the HSC patients on his caseload. The one clear example of his lack of insight was in respect of his response on the impact on the 5 patients with a confirmed cancer diagnosis.

5. We note there was a return to work plan meeting held on 09/02/2017 where Dr O'Brien was informed of what he needed to do in terms of his admin processes. Was his return to work monitored in any way by the Trust at that time and if so, what was the outcome?

The return to work action plan was put in place at the time of Mr O'Brien's return to work and this continues to be monitored by the operational Head of Service. The Head of Service reports any deviation from the action plan, by exception, to the MHPS Case Manager.

6. In addition, is Dr O'Brien's admin processes/work still being monitored at the present time? If so, can the Trust provide an update on how the doctor is currently performing and whether he is managing his administrative duties effectively?

As of Monday 16 September 2019, the operational Head of Service has notified the MHPS Case Manager of a deviation from the action plan by Mr O'Brien. The scale of this deviation is currently being scoped and a meeting will be held with Mr O'Brien once the full extent of this deviation is known. Prior to this, Mr O'Brien has been working in line with the return to work action plan.

7. Have there been any recent or new concerns raised about his practice (or his admin processes) that haven't already been considered under the MHPS or the Trust SAI Investigations?

Please see above I respect of a very recent deviation from the Trust's return to work action plan in respect of Mr O'Brien's administrative practices. I have no information in respect of further SAIs.

8. Has Dr O'Brien made any recent statements or provided any evidence, in response to the concerns being raised about him?

I am not aware of any recent statements.

9. When we spoke on 14 March 19 (see attached) you advised that SHSCT staff have come under external pressure not to challenge Dr O'Brien (pressure from his high-profile/influential private patients). Can the Trust provide any further information to support this/in relation to this?

10. We don't appear to have a copy of the formal local/SAI Investigation Report (we only have the MHPS Case Manager Determination). We understand that you indicated the Report(s) would be posted to us – however we don't appear to have received it. Could an electronic copy to be forwarded to?

I have no information in respect of points 7 to 10 that I can assist with.

Martina / Dr Chada / Dr Khan – can I please check with you that my draft responses above are accurate and that there is nothing further you would wish to add?

Regards,

Siobhan

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 13 July 2017 08:32
To: Carroll, Ronan; Weir, Colin
Subject: FW: triage not returned

Please see Aidan's response below

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

INTERNAL: EX [redacted] ***if dialling from Avaya phone. If dialling from old phone please dial*** [redacted]
EXTERNAL : [redacted]
Mobile: [redacted]

From: O'Brien, Aidan
Sent: 12 July 2017 13:59
To: Corrigan, Martina
Subject: RE: triage not returned

Martina,

I have just read this email, finding it so demoralising.

I deferred returning these referrals as each day's bundle included patients who needed to be contacted so that the appropriate triage decision could be made.
Whether because of it being the holiday period, it proved difficult, and in some cases, impossible to contact patients.
I therefore returned the referrals, making fail safe decisions, but having kept a record of patients who may require a more immediate management.
One such was [redacted] has a stone in her left ureter and who returned my calls this morning to advise that she was in pain, which I expected her to be.
I had returned her triaged referral to have an Urgent Appointment at a New Clinic, whenever that would have happened.
However, I have arranged her admission today for left ureteroscopic lithotripsy on the emergency list.
By virtue of the returned referrals not having been collected today, 12 July, I have been able to amend the triage decision.

I came in to the hospital today to review a couple of patients admitted since their referrals.
Having done so, I thought I would do some work in my office.
Then I read your emails.

I know how referrals are triaged and returned on time!
It is most certainly not by taking the time to ensure that each patient's current state is most appropriately and expeditiously assessed and managed.

As a consequence of my doing so, I have dictated letters to the referring doctors, and to the patients if I have been unable to speak to them by telephone, in over 50 cases, requesting scans, having conditions treated appropriately, and so forth.
By doing so, investigation is progressing and patients are hopefully deriving benefit from treatment.

Having done all of that. I personally would have been better off ticking the box, being at home on my leave.
And [redacted], she would also be at home, with persistent colic, awaiting the urgent outpatient appointment.

Aidan.

From: Corrigan, Martina
Sent: 11 July 2017 17:40
To: O'Brien, Aidan
Cc: Weir, Colin; Carroll, Ronan
Subject: triage not returned

Aidan

As per your return to work Action Plan:

Concern 1

Mr O'Brien, when Urologist of the week (once every 6 weeks), must action and triage all referrals for which he is responsible, this will include letters received via the booking centre and any letters that have been addressed to Mr O'Brien and delivered to his office – for these letters the secretary will have to record receipt of these on PAS and then these letters must all be triaged. The oncall week commences on a Thursday AM for seven days, therefore triage of all referrals must be completed by 4pm on the Friday after Mr O'Brien's Consultant of the Week ends.

Red Flag referrals must be completed daily.

All referrals received by Mr O'Brien will be monitored by the Central Booking Centre in line with the above timescales. A report will be shared with the Assistant Director of Acute Services, Anaesthetics and Surgery at the end of each period to ensure all targets have been met.

Any deviation from compliance with the targets will be referred to the MHPS Case Manager immediately.

I have been advised by the booking centre that there are 30 'paper' outpatient referrals not returned from your week oncall and this must be addressed urgently please.

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

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Corrigan, Martina

From: Corrigan, Martina
Sent: 14 April 2017 16:50
To: Carroll, Ronan
Subject: RE: MHPS case

Notes are in his office but the longest is waiting x 2 weeks on results.

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

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From: Carroll, Ronan
Sent: 14 April 2017 16:42
To: Corrigan, Martina
Subject: RE: MHPS case
Importance: High

So what does AOB have re this AP?

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 14 April 2017 15:49
To: Carroll, Ronan
Subject: RE: MHPS case

Ronan

Action Plan attached and the relevant piece is below – all other consultants store charts in their offices awaiting results etc… so we never got agreement on whether he couldn't store these in his office?

> *Notes tracked out to Mr O'Brien must be tracked out to him for the shortest period possible for the management of a patient.*
> *Notes must not be stored in Mr O'Brien's office. (just checking on this as all other consultants do have notes in their offices?)*

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

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From: Carroll, Ronan
Sent: 14 April 2017 15:36
To: Corrigan, Martina
Subject: RE: MHPS case

Tks have you the AP – was AOB supposed to have notes in his office?

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 14 April 2017 15:22
To: Carroll, Ronan
Cc: Weir, Colin
Subject: RE: MHPS case

Ronan

Please see below update on action plan:

Concern 1

Mr O'Brien has just completed his first week as Urologist oncall (since he came back). I have checked this morning and I can confirm that all referrals including Red Flags have been triaged and returned appropriately

Concern 2

Apart from the 13 already identified missing notes Mr O'Brien has 63 further charts in his office which are all recent and are awaiting for results. There are no other missing charts and no evidence of charts being taken off-site.

Concern 3

I can confirm that all clinics that Mr O'Brien has done since his return to work have been dictated on by digital dictation and all patients have a plan and outcome included.

Concern 4

Mr O'Brien has only had one Theatre list since his return (last Wednesday 5 April)
There were 6 patients listed and I can confirm none were previous private patients

If you should require any further detail please do not hesitate to contact me.

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

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From: Carroll, Ronan
Sent: 12 April 2017 15:26
To: Corrigan, Martina; Weir, Colin
Subject: FW: MHPS case
Importance: High

Martina
As discussed yesterday – can u provide this update asap pls
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Personal Information redacted by the USI

From: Khan, Ahmed
Sent: 12 April 2017 12:55
To: Gishkori, Esther; Carroll, Ronan
Cc: Hynds, Siobhan
Subject: MHPS case

Dear Esther & Ronan,
I would be grateful for an update regarding adherence to action plan for Mr O'Brien's MHPS Case.

Siobhan, for information.

Regards
Dr Ahmed Khan
AMD& Case Manager

Sent from my BlackBerry 10 smartphone.

Corrigan, Martina

From: Carroll, Ronan
Sent: 23 June 2017 17:48
To: Corrigan, Martina
Cc: Hynds, Siobhan; Weir, Colin
Subject: RE: MHPS case update on 23 June 2017

Importance: High

Martina
Tks for this largely +ve update. Re Concern 2 I would ask that notes are dealt with by 30th June, otherwise we are return ing to the previous position
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 23 June 2017 15:36
To: Carroll, Ronan
Subject: FW: MHPS case update on 23 June 2017

Ronan

Update as of today 23 June 2017

Concern 1

Mr O'Brien was last oncall from 13 – 19th May and I can confirm all letters were triaged within the timescales his next oncall is from 29th June until 5 July.

Concern 2

Apart from the 13 already identified missing notes Mr O'Brien has 85 further charts in his office. This amount has been increasing each week and whilst some are moving on there are some that haven't been actioned. I have emailed Mr O'Brien earlier this week and listed these and I reminded him that as part of the action plan that *Notes should never be stored off site and should only be tracked out and in your office for the shortest time possible* and I asked him to please address as many of these as he could. I will check early next week to ensure that he has dealt with and got these moved back to files. I will update again on this concern next week. Mr O'Brien held a clinic in South West Acute Hospital on Monday 8th May (the first since his return) and I left and collected the notes from SWAH and I can confirm that there were none missing. There are no other missing charts and no evidence of charts being taken off-site.

Concern 3

I can confirm that all clinics that Mr O'Brien has done since his return to work have been dictated on by digital dictation and all patients have a plan and outcome included.

Concern 4

Mr O'Brien has had theatre lists on 31 May, 7, 14, 21st June 2017
There were a total of 18 patients listed and I can confirm none were previous private patients

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

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Corrigan, Martina

From: Carroll, Ronan
Sent: 19 July 2017 15:55
To: Corrigan, Martina; Weir, Colin
Subject: RE: FW: triage not returned

Tuesday good for me

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 19 July 2017 15:54
To: Weir, Colin; Carroll, Ronan
Subject: RE: FW: triage not returned

Ok

Aidan's availability next week is:

In SWAH all day Monday
Admin (off-site) on Tuesday AM as agreed – potentially could ask him to come in late morning before his Clinic in the PM
Wednesday theatres starting at 12MD-8pm
Thursday AM – SPA - could meet – Thurs PM MDT
Friday AM – Oncology Clinic and Friday PM SPA/Admin

You can let me know

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

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From: Weir, Colin
Sent: 19 July 2017 15:07
To: Corrigan, Martina; Carroll, Ronan
Subject: RE: FW: triage not returned

Fri doesn't suit make it next week

Colin Weir FRCSEd, FRCSEng, FFSTEd
Consultant Surgeon | Honorary Lecturer in Surgery | AMD Education and Training |Clinical Director SEC
Southern Health and Social Care Trust

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Secretary Collette Mc Caul
int Personal Information redacted by the USI direct Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 19 July 2017 15:04
To: Carroll, Ronan; Weir, Colin
Subject: RE: FW: triage not returned

Ronan

I have run a fresh report there now – there are 75 charts now tracked to Mr O'Brien's office. A reduction of 30 from the last time I ran this. The longest is 3 February 2017 and comment is 'private patient cabinet'. Then 24 February x 3 charts with comments – Result for Mr O'Brien to see, and 2 x Mr O'Brien's admin. Below is the change in what is being returned to records since last time I ran this which is 45 – and then there has been 15 additional for July,

Aidan will be off-site tomorrow AM pre-viewing for MDT and then he will be at MDT tomorrow afternoon, Friday AM he has an oncology clinic and then Audit in the PM, so really only availability to meet would be between clinic and audit on Friday lunchtime?

Can you let me know what suits to meet with him?

Date Chart Borrowed	Total as of June 2017	Total as of 19 July 2017	Total charts returned
Jan 2017	1	0	1
Feb 2017	5	4	1
March 2017	11	9	2
April 2017	37	15	22
May 2017	35	16	19
June 2017	16	16	0
July 2017	NA	15	N/A
Total Charts	**105**	**75**	**45**

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

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From: Carroll, Ronan
Sent: 19 July 2017 12:31
To: Corrigan, Martina; Weir, Colin
Subject: FW: FW: triage not returned

Any update

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

Corrigan, Martina

From: Corrigan, Martina
Sent: 11 July 2017 17:41
To: Carroll, Ronan
Cc: Weir, Colin
Subject: FW: MHPS case update on 11 July 2017

Update as of today 11 July 2017

Concern 1

Mr O'Brien was last oncall from 29 June until 7 July and I can confirm all letters on etriaged were triaged however the booking centre advises that there are still 30 outstanding 'paper' referrals that he has not returned although I do know that he is working this week on his Annual Leave as has been emailing me about theatre lists and he did return some triage today. I have sent him an email about this, this afternoon.

Concern 2

Apart from the 13 already identified missing notes Mr O'Brien has 90 further charts in his office. This amount has been increasing each week and whilst some are moving on there are now quite a few that haven't been actioned. I have emailed Mr O'Brien again today and I again reminded him that as part of the action plan that *Notes should never be stored off site and should only be tracked out and in your office for the shortest time possible* and I asked him to please address as many of these as he could. There are no other missing charts and no evidence of charts being taken off-site.

Concern 3

I can confirm that all clinics that Mr O'Brien has done since his return to work have been dictated on by digital dictation and all patients have a plan and outcome included.

Concern 4

Mr O'Brien has had one theatre list since the last report on 28 June which had 5 patients listed and I can confirm none were previous private patients

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

Changed My Number

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Corrigan, Martina

From: Corrigan, Martina
Sent: 31 July 2017 09:06
To: Carroll, Ronan; Hynds, Siobhan
Cc: Weir, Colin
Subject: RE: Charts in Office

Yes this is correct

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

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From: Carroll, Ronan
Sent: 28 July 2017 17:53
To: Hynds, Siobhan
Cc: Corrigan, Martina; Weir, Colin
Subject: RE: Charts in Office

Yes & yes
Martina correct?

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mob Personal Information redacted by the USI

From: Hynds, Siobhan
Sent: 28 July 2017 17:41
To: Carroll, Ronan
Subject: RE: Charts in Office

Ronan

I understand all charts stored in AOB's office have been removed. Can I clarify if the follow up dictation or reports have been done in a timely manner on the charts?

Thanks

Siobhan

From: Carroll, Ronan
Sent: 11 July 2017 17:55
To: Hynds, Siobhan
Subject: FW: Charts in Office

FYI

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by the USI

From: Corrigan, Martina
Sent: 11 July 2017 17:40
To: O'Brien, Aidan
Cc: Carroll, Ronan; Weir, Colin
Subject: Charts in Office

Aidan

As per your return to work action plan:

Notes should never be stored off site and should only be tracked out and in your office for the shortest time possible - having checked on PAS today there are 90 charts stored in your office dating back to January 2017. I had emailed you 21 June 2017 (attached) and these charts are still tracked out to you.

Therefore, Colin has asked that I arrange for you to meet with him, Ronan and myself on your return from Annual Leave next week and we can discuss when this best suits on Monday.

Regards

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

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Corrigan, Martina

From: Robinson, Katherine
Sent: 04 October 2018 14:22
To: Corrigan, Martina
Subject: RE: REALLY URGENT

Ok ill get it to you asap and then you can answer my email!

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

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From: Corrigan, Martina
Sent: 04 October 2018 14:21
To: Robinson, Katherine
Subject: REALLY URGENT

Katherine

I have to a report for Ronan on Mr O'Brien's digital dictation, can you check for me is he up-to-date? Or if not what is outstanding please?

Thanks

Martina

Martina Corrigan
Head of ENT, Urology, Ophthalmology and Outpatients
Craigavon Area Hospital

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Corrigan, Martina

From: Wallace, Stephen
Sent: 25 August 2020 18:09
To: Toal, Vivienne; Hynds, Siobhan; Carroll, Ronan; Corrigan, Martina; McClements, Melanie
Subject: FW: MHPS Case Manager Determination

From: Wallace, Stephen
Sent: 31 July 2020 09:15
To: OKane, Maria; Khan, Ahmed
Subject: RE: MHPS Case Manager Determination

Thanks Ahmed for taking the time to catch up yesterday.

Just to confirm further to speaking the purpose of the specific work detailed below will be in respect to the MHPS process and will focus on Trust urology administrative processes for management of patients referred to the service.

Thanks
S.

From: Khan, Ahmed
Sent: 29 July 2020 12:33
To: Wallace, Stephen
Cc: Hynds, Siobhan
Subject: RE: MHPS Case Manager Determination

Stephen, thanks. It was clear during this investigations; system wide failure happed at many levels within Acute directorate therefore my recommendation was to provide recommendation for system wide problems in acute Directorate & not to just only focus on urology department. Happy to discuss further.

Regards,
Ahmed

From: Wallace, Stephen
Sent: 27 July 2020 13:47
To: Khan, Ahmed
Cc: Hynds, Siobhan
Subject: MHPS Case Manager Determination

Ahmed,

Further to the AOB investigation conducted in 2018 under MHPS framework the report makes reference to an administrative review (below).

- *I recommend the Trust to carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. The review*

should look at the full system wide problems to understand and learn from the findings.

Below you will see are a draft terms of reference regarding this, can you confirm if these terms of reference encapsulate the requirements of the recommendation?

Thanks
Stephen

Purpose

The purpose of the review, is to review the Trust urology administrative processes for management of patients referred to the service.

Objectives

The review will consider the present Trust urology administrative processes regarding referrals to the service and recommendations for the future, rather than past and pre-existing processes. The review in particular will consider the following:

- The administration processes regarding the receipt of and triage of patients referred to the urology service from all sources
- The effectiveness of monitoring of the administration processes including how and where this is information is reviewed
- The roles and responsibilities of operational management and clinical staff in providing oversight of the administrative processes
- The effectiveness of the triggers and escalation processes regarding non-compliance with administration processes
- To identify any potential gaps in the system where processes can be strengthened

Outputs

The Reviewer should provide a report which seeks to address the issues listed above. The report should provide recommendations on improvements to Trust urology administrative processes. Any recommendations should be evidence-based and proportionate, with consideration given to their implementation.

Scope

The review should consider current Trust urology administrative processes for the management of referrals to the service. This is a forward-looking review and, as such, will not consider past decisions.

Timing

The report, including any recommendations of the review, must be submitted to the Trust Acute Director by end September 2020.

Governance and Methodology

The Reviewer will be appointed by, and accountable to, the Trust Acute Director for delivery of the review. Details of the governance which achieves this accountability and the methodology for the review - including evidence gathering, consultation with operational and clinical staff - will be agreed between the Reviewer and the Trust Acute Director by 5th August 2020.

Corrigan, Martina

From:	Wallace, Stephen
Sent:	31 July 2020 12:33
To:	OKane, Maria; Haynes, Mark; Corrigan, Martina; McClements, Melanie; Hynds, Siobhan; Toal, Vivienne
Subject:	Terms of Reference - Review of Administrative Processes

Dear all,

Please see below terms of reference for the review of administration processes as per MHPS recommendation, these have been reviewed by Dr Khan. Dr's Rose McCullagh and Mary Donnelly have agreed to conduct this work and will commence next week.

Regards
Stephen

Purpose

The purpose of the review, is to review the Trust urology administrative processes for management of patients referred to the service.

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Corrigan, Martina

From:	Wallace, Stephen
Sent:	01 August 2020 09:13
To:	Donnelly, Mary; McCullagh, Rose
Cc:	McClements, Melanie; OKane, Maria; Hynds, Siobhan; Toal, Vivienne; Haynes, Mark; Corrigan, Martina; Carroll, Ronan
Subject:	Administration Review Terms of Reference

Rose / Mary, please see terms of reference for the administration review below

Give me a call if you have any questions

Thanks
Stephen

Purpose

The purpose of the review, is to review the Trust urology administrative processes for management of patients referred to the service.

Objectives

The review will consider the present Trust urology administrative processes regarding referrals to the service and recommendations for the future, rather than past and pre-existing processes. The review in particular will consider the following:

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Corrigan, Martina

From: McCullagh, Rose
Sent: 04 August 2020 12:17
To: Wallace, Stephen; Donnelly, Mary
Cc: McClements, Melanie; OKane, Maria; Hynds, Siobhan; Toal, Vivienne; Haynes, Mark; Corrigan, Martina; Carroll, Ronan
Subject: RE: Administration Review Terms of Reference

Thanks Stephen . We have our first meeting Thursday 6 th August.
Mary and I will keep you informed of our progress regularly.
What is the deadline for completion?
What format do you wish it presented?
Rose.

Rose McCullagh
AMD OPPC
Mob Personal Information redacted by the USI

From: Wallace, Stephen
Sent: 01 August 2020 09:13
To: Donnelly, Mary; McCullagh, Rose
Cc: McClements, Melanie; OKane, Maria; Hynds, Siobhan; Toal, Vivienne; Haynes, Mark; Corrigan, Martina; Carroll, Ronan
Subject: Administration Review Terms of Reference

Rose / Mary, please see terms of reference for the administration review below

Give me a call if you have any questions

Thanks
Stephen

Purpose

The purpose of the review, is to review the Trust urology administrative processes for management of patients referred to the service.

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- The effectiveness of monitoring of the administration processes including how and where this is information is reviewed
- The roles and responsibilities of operational management and clinical staff in providing oversight of the administrative processes

- The effectiveness of the triggers and escalation processes regarding non-compliance with administration processes
- To identify any potential gaps in the system where processes can be strengthened

Outputs

The Reviewer should provide a report which seeks to address the issues listed above. The report should provide recommendations on improvements to Trust urology administrative processes. Any recommendations should be evidence-based and proportionate, with consideration given to their implementation.

Scope

The review should consider current Trust urology administrative processes for the management of referrals to the service. This is a forward-looking review and, as such, will not consider past decisions.

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The report, including any recommendations of the review, must be submitted to the Trust Acute Director by end September 2020.

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The Reviewer will be accountable to, the Trust Acute Director for delivery of the review. Details of the governance which achieves this accountability and the methodology for the review - including evidence gathering, consultation with operational and clinical staff - will be agreed between the Reviewer and the Trust Acute Director by 5th August 2020.

Corrigan, Martina

From: Donnelly, Mary
Sent: 17 September 2020 15:40
To: Corrigan, Martina
Subject: Document2
Attachments: Document2.docx

Hi Martina
Could you have a read through when you get a chance?
Thanks a million
Mary

Findings

1. **The administration processes regarding the receipt of and triage of patients referred to the urology service from all sources**

Current process – *Referrals to Southern Trust Urology come from a number of different sources within Primary and Secondary Care and also include referrals from the private sector. Referrals are made mainly via CCG (Clinical Communications Gateway) from Primary care (although not exclusively) and in paper format from other sources.*

All referrals are triaged by the Consultant of the week, for the CCG referrals this involves working through a digital list and paper referrals are viewed physically by the Consultant after they have been scanned and dated.

Recommendation –*We recommend moving to an amalgamated electronic list which would incorporate all CCG referrals and also all paper referrals, this list would be locked at an agreed time each week to ensure no patient could be added after the list had been triaged. This process would provide an additional layer of assurance regarding the avoidance of referrals becoming mislead and also to ensure chronicity of referrals in terms of triage was adhered to.*

2. **The effectiveness of monitoring of the administration processes including how and where this is information is reviewed**

Current process- *The monitoring of this service is carried out by the Administration team with cross cover arrangements in place*. There is also a level of oversight by the booking centre.

Recommendation-*We recommend that this process in terms of the administration team and booking centre is formalised and an effective Standard Operating Procedure is put in place with regular review*.

3. **The roles and responsibilities of operational management and clinical staff in providing oversight of the administrative processes**

Current process – *The role of the Consultant of the week and the checking mechanism by the member of the administration team are clear.*

Recommendation – *Again we recommend an effective SOP for the administration processes but also feel that increased communication between clinical teams regarding roles may be helpful and may prevent*

the need to escalate difficulties. In particular the role of locum Consultants should be clearly defined with appropriate safety-netting in place.

4. **The effectiveness of the triggers and escalation processes regarding non-compliance with administration processes**

Current Process – *The administration checking process allows non-compliance to be detected and remedied.*

Recommendation – *Formalisation of the current escalation processes involving the administration team is likely to be beneficial and as already described open communication between clinical teams where difficulties arise may result in the need for less escalation.*

5. **To identify any potential gaps in the system where processes can be strengthened**

Current Process- *The dual system of digital referrals and paper referrals may present issues with dealing with referrals in an appropriate chronological manner.*

Recommendation – *In conclusion the amalgamation of both paper and digital referrals into a single list which can be easily checked is likely to be beneficial.*

Formalised Standard Operating procedures for all processes with adequate safety netting and increased open communication between clinical teams and locum Consultants is likely to see benefits

Southern Health and Social Care Trust

Admin Review Processes

Introduction

This review of administrative processes followed a formal investigation into concerns about an individual Consultant under the Maintaining High Professional Standards Framework (MHPS). The main concerns highlighted concern over the Consultant's way of working, their administrative processes and their management of workloads.

The MHPS Case Manager made a number of recommendations one of which was a recommendation that in order for the Trust to understand fully the failings in the case, the Trust should *'carry out an independent review of the relevant administrative processes with clarity on roles and responsibilities at all levels within the Acute Directorate and appropriate escalation processes. It recommended that the review should look at the full system wide problems to understand and learn from the findings'.*

The formal MHPS investigation focused on four main areas of concern::

1. Non-triage of GP and other consultant referrals
2. Non-dictation on patients who had attended outpatient clinics
3. Hospital notes being stored off Trust premises, namely the Consultant's home
4. The Consultant was found to have scheduled his private patient's sooner and outside of clinical priority.

The table below:

- highlights and describes the issues of concern
- identifies the gaps that led to the concerns raised
- advises on the policies and processes now in place
- describes the ongoing risks/ flaws
- explains the escalation process for non-adherence

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Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
1. Triage	Pre 2014 Due to the delayed triage of referrals, the decision was taken to add to the OP waiting list the referral at the clinical priority that the GP had assigned. .	2014-2017 For routine and Urgent GP referrals, non-adherence and non-enforcement of the IEAP, resulted in referrals not being returned within the appropriate timeframe, which then resulted in a lost opportunity to either upgrade or downgrade urgent/routine referrals	2017-current The introduction of e-Triage on 27/3/17 enabled referrals to be monitored with respect to the triage process. The revised triage process (draft) detailed in the word document below is based on the current IEAP also addresses these issues of timely and appropriate triaging TRIAGE PROCESS April 21.docx	Current Consultant-to-Consultant referrals (including outside of Trust) are not currently manged through e-Triage so there is still a risk that these could be delayed. Remaining specialties that still do not use e-Triage are being addressed Services not using eTriage.docx	Consultant to Consultant referrals to be added to e-Triage and the PDF SOP to be updated Consultant to Consultant Referrals. Remaining specialties to be added to e-Triage The triage process continues to be monitored weekly and needs to be complied to and enforced where necessary	After 7 days Non- triage of urgent and routine referrals is escalated by the Referral & Booking Centre to the Operational Support Lead for the Clinical Area After 21 days OSL to escalate to Lead Clinician and HOS and copy Assistant Director of Functional & Support Services After 28 days HOS escalates to AD & AMD to address. After 35 days AD & AMD escalates to Director of Acute

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
2. Undictated Clinics	Some patients not having a letter dictated following an outpatient consultation resulting in no outcome recorded on PAS.	There is no system or process that provides assurance that each outpatient consultation generates an outpatient outcome letter	All Medical staff must understand that a letter is required for every outpatient attendance.	A limitation with the G2 system is that it simply records speech and generates a letter. However G2 is unable to correlate the letter dictated against the outpatient attendance.	The Trust has been working on the G2/PAS interface. This major piece of work required integration with the help of BSO. It is now in 'live' mode and is being piloted by one consultant with positive feedback. This will provide the Trust with more assurance around the dictation of outpatient clinics. A policy and guidance document needs to be developed and circulated to all Medical Staff to reiterate that a letter must be done for all outpatient attendance including for patients who do not attend. Update typing SOP to highlight that when a letters is not dictated for a patient that the secretary raises with	When the secretary is typing the clinics she must escalate to the Consultant by e mail and cc their service administrator if there are any letters missing on Digital Dictation. <u>If no response After 7 days</u> This is escalated to the Service Administrator. <u>After 14 days</u> Service Administrator to escalate to Lead Clinician and HOS <u>After 21 days</u> HOS escalates to AD & AMD to address.

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
2. Undictated Clinics					the consultant and line manager in the first instance. Secretaries need to do a check and balance after every clinic checking that every patient has a letter dictated. Secretaries to stipulate on their backlog reports if they know of any undictated clinics/letters Monthly typing reports require to be produced and shared throughout all divisions At Junior doctor changeover inductions, the importance of timely and accurate dictating of all outpatients they have reviewed must be highlighted to them.	<u>After 28 days</u> AD & AMD escalates to Director of Acute

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
3. Hospital Notes	Patient's hospital records electronically casenote tracked to a consultant and a location.	When patients hospital records were required same not in the tracked location At a time health records did complete IR1 forms but were advised to stop , by the Director at that time.	Current tracking system is a function on Patient Administrative System (PAS) Missing Charts are investigated and an IR1 form is completed if not found	There is currently no system which identifies that a chart is not where it is tracked to other than manual searches.	Any missing notes need to have an IR1 raised to highlight the problem. These should be reported to the respective areas. All staff managing patient notes should be reminded of the need for accuracy on PAS when tracking notes and patient records should be returned to file as soon as possible. All consultants need to be reminded regularly that all charts are tracked in their name and that it is their responsibility to ensure the notes are kept in the location that the notes are tracked to. Business Case for IFit which is an electronic	Service Administrators to do spot-checks of offices and highlight any issues of charts being stored beyond a reasonable time period IR1's to be monitored by the Head of health records and to escalate to the AD FSS Division for repeat 'Borrower' missing notes and any concerns over a particular consultant should be escalated to Clinical

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
					tracking system using barcode technology (as used in other Trusts in NI) to be considered for funding until the NI Electronic Patient Record replaces paper records under the Encompass Project This had been previously submitted and approved but no funding identified.	Director/AMD and AD
4. Private Patients	Patients who had been initially reviewed privately were added to the waiting list in a non-chronological manner	No monitoring of patients seen privately where they are entered onto the waiting list	This is governed by the Private Patient policy	It relies on the integrity of the consultant to comply with the private patient policy.	Revise the policy for paying patients in the Trust and share with all clinical teams.  Guide-to-Paying-Patients-Southern-Trust- Data Quality Release notice for recording of	Secretaries have been given the codes to use to add private patients to the waiting list. A report is now on business objects for private patients added to waiting lists the private patient officer reconciles and chases up missing forms .

Issues Identified	Description of issue	Gaps that led to the problems	Policies or processes in place	Ongoing Risks/Flaws	Action Required to address ongoing risks/flaws	Escalation for non-adherence
					private patient activity on PAS to be shared amongst clinical teams.  0023-18 PAS OP REFERRRAL PRIVATE	<u>After 7 days the private patient officer</u> If forms haven't been received by Private Patient Office this is escalated to the HOS/CD. <u>After 14 days</u> HOS escalates to AD & AMD to address. <u>After 21 days</u> AD & AMD escalates to Medical Director

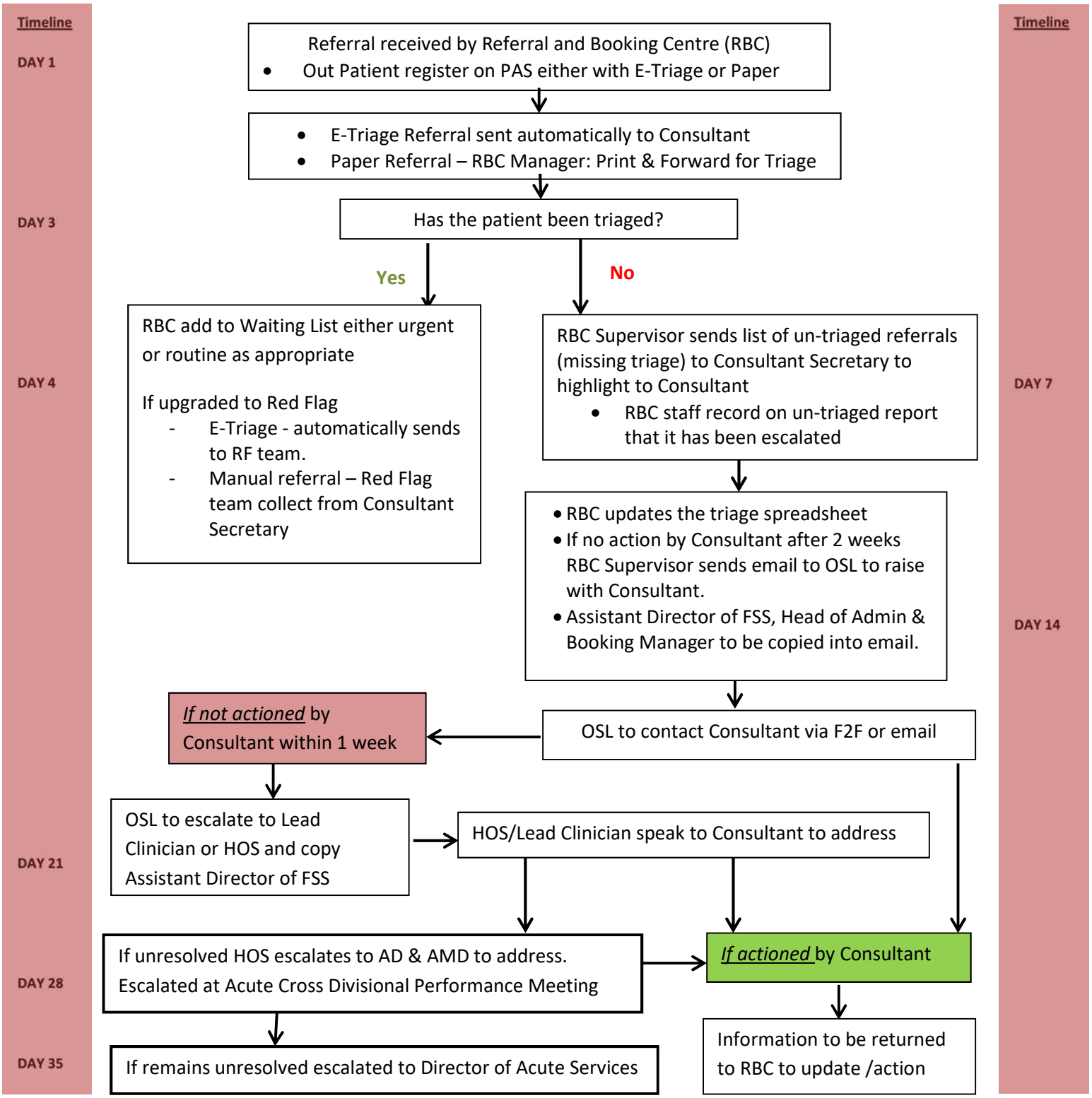
TRIAGE PROCESS

This process is developed by the Region under the IEAP (Integrated Elective Access Protocol) Referrals should be returned within 72 hrs but the Southern Trust have agreed 1 week to assist Clinicians as a more reasonable approach.

- **Red Flag referrals should be returned from Triage within 24hrs**
- **Urgent referrals should be returned from Triage within 72hrs**
- **Routine referrals should be returned from Triage within week.**

PURPOSE OF TRIAGE

- Consultant triage is to confirm that the speciality is appropriate and the clinical urgency is appropriate.
- It directs the referral to an appropriate service within the speciality (e.g. to vascular surgeons etc.)
- It allows the Consultant to request any investigations which the patient will require prior to outpatient attendance
- The Consultant can return referrals with advice and no outpatient attendance where appropriate.



Note: This process will incur a minimum of 5 weeks in total if referral is un-triaged within the target times which means that if the referral is upgraded to Red Flag it is in excess of 14 day Red Flag turnaround.
It is the responsibility of the Consultant to ensure Triage is done within the appropriate timescales detailed above.

Services not using e-triage	
ORTHOPAEDIC GERIATRICS	Planned e-triage commencement Jan/Feb 2021
HAEMATOLOGY	Planned implementation postpone due to service pressures
NEPHROLOGY	Currently taking a break from e-triage, will relook at recommencing early 2021
GENERAL MEDICINE	Minimal referrals to this service but working with service looking towards implementation early 2021
BREAST SURGERY	Consultants not currently keen on e-triage – reengaged with service
GERIATRIC MEDICINE	Currently engaging with service

Southern Health and Social Care Trust

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ADMINISTRATIVE & CLERICAL Standard Operating Procedure

Title	Consultant to Consultant Referrals	
S.O.P. Section	Referral and Booking Centre	
Version Number	v1.0	**Supersedes:** v0.1
Author	Katherine Robinson	
Page Count	3	
Date of Implementation	January 2011	
Date of Review	January 2012	**To be Reviewed by:** Admin and Clerical Manager's Group
Approved by	Admin and Clerical Manager's Group	

Standard Operating Procedure (S.O.P)
Referral and Booking Centre Procedures

Introduction

This SOP outlines the procedures followed by the Referral and Booking Centre to recognise a referral is in place from one consultant to another.

Implementation

This procedure is already effective and in operation in the Referral and Booking Centre.

Consultant to Consultant Referrals

The secretary for the consultant referring the patient should OP REG the patient on PAS with the OP REG date being the date the decision to refer was made (eg the clinic date)

This is done by using the Function:
DWA – ORE.

The name of the *referring consultant* should be entered into the comment field NOT the name of the consultant being referred to. Referrals should then be directed to the Referral and Booking Centre not to the secretary.

This will ensure that the patient now appears on a PTL and that the booking clerks will know who referred the patient and when.

When doing this the **Referral Source should be OC** (Other Consultant) **and NOT CON.**

Patients registered with a referral source as ‘Con’ do not appear on a PTL and can be missed.

Although all referrals are date stamped when they are received into the Referral and Booking centre **–** the original referral date will remain and will not be amended.

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A GUIDE TO PAYING PATIENTS

V.2 [11th February 2016]

DOCUMENT – VERSION CONTROL SHEET	
Title	Title: Guide to Paying Patients Version: 2
Supersedes	Supersedes: Guidelines for Management of Private Patients
Originator	Name of Author: Anne Brennan Title: Senior Manager Medical Directorate
Approval	Referred for approval by: Anne Brennan Date of Referral: 27th March 2014 to: • Trust Senior Management Team • Trust LNC
Circulation	Issue Date: 16th October 2014 Circulated By: Medical Directorate Issued To: As per circulation List: All Medical Staff
Review	Review Date: February 2017 Responsibility of (Name): Norma Thompson Title: Senior Manager Medical Directorate

CONTENTS

1. INTRODUCTION

1.1 The Trust came into existence on 1 April 2007 and is responsible for providing acute care across three sites namely:-

- Craigavon Area Hospital, Portadown
- Daisy Hill Hospital, Newry
- South Tyrone Hospital, Dungannon

1.2 The Trust welcomes additional income that can be generated from the following sources:-

- Private Patients
- Fee Paying Services
- Overseas Visitors

1.3 All income generated from these sources is deemed to make a valued contribution to the running costs of the Trust and will be reinvested to improve our facilities to benefit NHS and private patients alike.

1.4 All policies and procedures in relation to these areas will be carried out in accordance with Trust guidelines.

1.5 For further information please do not hesitate to contact the Paying Patient Office. [email: paying.patients@southerntrust.hscni.net or http://www.southerndocs.hscni.net/paying-patients/

2. OBJECTIVES

2.1 The purpose of this guideline is to:

- Standardise the manner in which all paying patient practice is conducted in the organisation.
- Raise awareness of the duties and responsibilities within the health service of medical staff engaging in private practice and fee paying services within the Trust.
- Raise awareness of the duties and responsibilities of all Trust staff, clinical and non-clinical in relation to the treatment of paying patients and fee paying services within the Trust.
- Ensure fairness to both NHS patients and fee paying patients at all times.
- Clarify for relevant staff the arrangements pertaining to paying patients and to give guidance relating to
  - record keeping
  - charging

- procedures and
- responsibilities for paying patient attendances, admissions and fee paying services.

- Clarify charging arrangements when consultants undertake fee paying services within the Trust.

3. CATEGORIES OF WORK COVERED BY THIS GUIDE

3.1 Fee Paying Services

3.1.1 Any paid professional services, other than those falling within the definition of Private Professional Services, which a consultant carries out for a third party or for the employing organisation and which are not part of, nor reasonably incidental to, Contractual and Consequential Services. A third party for these purposes may be an organisation, corporation or individual, provided that they are acting in a health related professional capacity, or a provider or commissioner of public services. Examples of work that fall within this category can be found in Schedule 10 of the Terms and Conditions (Appendix 1).

3.2 Private Professional Services *(also referred to as 'private practice')*

3.2.1 The diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under Article 31 of the Health and Personal Social Services (Northern Ireland) Order 1972), excluding fee paying services as described in Schedule 10 of the terms and conditions.

3.2.2 Work in the general medical, dental or ophthalmic services under Part IV of the Health and Personal Social Services (Northern Ireland) Order 1972 (except in respect of patients for whom a hospital medical officer is allowed a limited 'list', e.g. members of the hospital staff).

3.3 Overseas Visitors

3.3.1 The National Health Service provides healthcare free of charge to people who are a permanent resident in the UK/NI. A person does not become an ordinarily resident simply by having British Nationality; holding a British Passport; being registered with a GP, or having an NHS number. People who do not permanently live in NI/UK are not automatically entitled to use the NHS free of charge.

3.3.2 **RESIDENCY** is therefore the main qualifying criterion.

4. POLICY STATEMENT

4.1 Medical consultant staff have the right to undertake Private Practice and Fee paying services within the Terms and Conditions of the new Consultant Contract as agreed within their annual job plan review and with the approval of the Medical Director.

4.2 This Trust provides the same care to all patients, regardless of whether the cost of their treatment is paid for by HSC Organisations, Private Medical Insurance companies or by the patient.

4.3 Private Practice and Fee Paying services at the Trust will be carried out in accordance with:

- The Code of Conduct for private practice, the recommended standard of practice for NHS consultants as agreed between the BMA and the DHSSPS (Appendix 2).
- Schedule 9 of the Terms and Conditions of the Consultant contract which sets out the provisions governing the relationship between HPSS work and private practice (Appendix 8).
- The receipt of additional fees for Fee Paying services as defined in Schedule 10 of the Terms and Conditions of the Consultant Contract (Appendix 1).
- The principles set out in Schedule 11 of the above contract (Appendix 5).

4.4 All patients treated within the Trust, whether private or NHS should, where possible:

- be allocated a unique hospital identifier
- be recorded on the Patient Administration System and
- have a Southern Health & Social Care Trust chart.

4.5 The Trust shall determine the prices to be charged in respect of all income to which it is entitled as a result of private practice or other fee paying services which take place within the Trust.

5. CONSULTANT MEDICAL STAFF RESPONSIBILITIES

5.1 Private Practice

5.1.1 While Medical consultant staff have the right to undertake Private Practice within the Terms and Conditions of the new Consultant Contract as agreed within their annual job plan review, it is the responsibility of consultants, prior to the provision of any diagnostic tests or treatment to:

- ensure that their private patients (whether In, Day or Out) are identified and notified to the Paying Patients Officer.

- ensure full compliance with the Code of Conduct for Private Practice (see Appendix 2) in relation to referral to NHS Waiting Lists.
- ensure that patients are aware of and understand the range of costs associated with private treatment including hospital costs and the range of professional fees which the patient is likely to incur, to include Surgeon/Physician, Anaesthetist, Radiologist, Pathologist, hospital charges. Leaflets can be obtained from the Paying Patients Officer or the Paying Patients section of Southern Docs website – click here.
- obtain prior to admission and at each outpatient attendance a signed, witnessed Undertaking to Pay form (Appendix 3) which must then be sent to the Paying Patient Officer for the relevant hospital at least three weeks before the admission date. This document must contain details of all diagnostic tests and treatments prescribed.
- Establish the method of payment at the consultation stage and obtain details of insured patients' private medical insurance policy information. The Trust requires this information to be forwarded to the Paying Patient Officer **prior to admission** so that patients' entitlement to insurance cover can be established. This should be recorded on the Undertaking to Pay form [Appendix 3].
- Ensure that all patients, where appropriate, are referred by the appropriate channels, i.e. GP/other consultant.
- Ensure that private patient services that involve the use of NHS staff or facilities are not undertaken except in emergencies, unless an undertaking to pay for treatment has been obtained from (or on behalf of) the patient, in accordance with the Trust's procedures.
- Ensure that information pertaining to their private patient work is included in their annual whole practice appraisal.

5.2 Fee Paying Services - *see Appendix 1 for examples*

5.2.1 The Consultant job plan review will cover the provision of fee paying services within the Trust. Consultants are required to declare their intention to undertake Fee Paying Services work by forwarding the Paying Patient Declaration form to the Medical Director's office.

5.2.2 A price list for fee paying services is available from the Paying Patients Office or the Paying Patients section of Southern Docs website – click here. It is the responsibility of the Consultant to ensure that the Trust is reimbursed for all costs incurred while facilitating fee paying services work undertaken. These costs could include:

- use of Trust accommodation;
- tests or other diagnostic procedures performed;
- radiological scans.

5.2.3 Consultants who engage in fee paying activities within the Trust are required to remit to the Trust on a quarterly basis the income due.

1.2.4 Consultants should retain details of all patients seen for medical legal purposes. These should be submitted by the consultant on a quarterly basis along with the corresponding payment. See Section 11 for further details.

5.3 Additional Programmed Activities

5.3.1 Consultants should agree to accept an extra paid programmed activity in the Trust, if offered, before doing private work. The following points should be borne in mind:

- If Consultants are already working 11 Programmed Activities (PAs) (or equivalent) there is no requirement to undertake any more work.
- A Consultant could decline an offer of an extra PA and still work privately, but with risk to their pay progression for the year in question.
- Any additional PAs offered must be offered equitably between all Consultants in that specialty; if a colleague takes up those sessions there would be no detriment to pay progression for the other Consultants.

5.3.2 Consultant Medical Staff are governed by The Code of Conduct for Private Practice 2003 (at Appendix 2).

6. RESTRICTIONS ON PRIVATE PRACTICE FOR CONSULTANT MEDICAL STAFF

6.1 New Consultants

6.1.1 Newly appointed consultants (including those who have held consultant posts elsewhere in the NHS, or equivalent posts outside the NHS) may not undertake private practice within the Trust or use the Trusts facilities or equipment for private work, until the arrangements for this have been agreed in writing with the Trust Medical Director. A job plan must also have been agreed. An application to undertake private practice should be made in writing to the Medical Director through completion of the Paying Patient Declaration. New consultants permitted to undertake private work must make themselves known to the Paying Patients Officer.

6.2 Locum Consultants

6.2.1 Locum consultants may not engage in Private Practice within the first three months of appointment and then not until the detailed Job Plan has been agreed with the relevant Clinical Manager and approval has been granted by the Medical Director. This is subject to the agreement of the patient/insurer.

6.3 Non Consultant Grade Medical Staff

6.3.1 Non-consultant medical staff practitioners such as Associate Specialists may undertake Category 2 or private outpatient work, with the approval of the

Medical Director following confirmation that the practitioner undertakes such work outside his/her programmed activities as per their agreed job plan.

6.3.2 Other than in the circumstances described above, staff are required to assist the consultant to whom they are responsible with the treatment of their private patients in the same way as their NHS patients. The charge paid by private patients to the hospital covers the whole cost of the hospital treatment including that of all associated staff.

7. CHANGE OF STATUS BETWEEN PRIVATE AND NHS

7.1 Treatment Episode

7.1.1 A patient who sees a consultant privately shall continue to have private status throughout the entire treatment episode.

7.2 Single Status

7.2.1 An outpatient cannot be both a Private and an NHS patient for the treatment of the one condition during a single visit to an NHS hospital.

7.3 Outpatient Transfer

7.3.1 However a private outpatient at an NHS hospital is legally entitled to change his/her status for any a subsequent visit and seek treatment under the NHS, subject to the terms of any undertaking he/she has made to pay charges.

7.4 Waiting List

7.4.1 A patient seen privately in consulting rooms who then becomes an NHS patient joins the waiting list at the same point as if his/her consultation had taken place as an NHS patient.

7.5 Inpatient Transfer

7.5.1 A private inpatient has a similar legal entitlement to change his/her status. This entitlement can only be exercised when a significant and unforeseen change in circumstances arises e.g. when they enter hospital for a minor operation and they are found to be suffering from a different more serious complaint. He/she remains liable to charges for the period during which he/she was a private patient.

7.6 During Procedure

7.6.1 A patient may request a change of status during a procedure where there has been an unpredictable or unforeseen complexity to the procedure. This can be tested by the range of consent required for the procedure.

7.7 Clinical Priority

7.7.1 A change of status from Private to NHS must be accompanied by an assessment of the patient's clinical priority for treatment as an NHS patient.

7.8 Change of Status Form

7.8.1 Where a change of status is required a 'Change of Status' Form (Appendix 4) must be completed and sent to the Paying Patients Officer. This includes the reason for the change of status which will be subject to audit and must be signed by both the consultant and Paying Patients Officer. The Paying Patients Officer will ensure that the Medical Director approves the 'Change of Status' request.

7.8.2 It is important to note that until the Change of Status form has been approved by the Medical Director the patient's status will remain private and they may well be liable for charges.

8. TRUST STAFF RESPONSIBILITIES RELATING TO PRIVATE PATIENTS AND FEE PAYING SERVICES

8.1 A private patient is one who formally undertakes to pay charges for healthcare services regardless of whether they self-pay or are covered by insurance and all private patients must sign a form to that effect (Undertaking to Pay form at Appendix 3) prior to the provision of any diagnostic tests or treatments. Trust staff are required to have an awareness of this obligation.

8.2 The charge which private patients pay to the Trust covers the total cost of the hospital treatment excluding consultant fees. Trust staff are required to perform their duties in relation to all patients to the same standard. No payment should be made to or accepted by any non-consultant member of Trust staff for carrying out normal duties in relation to any patients of the Trust.

9. OPERATIONAL ARRANGEMENTS

9.1 Each hospital within the Trust has a named officer [Paying Patients Officer] who should be notified in advance of all private patient admissions and day cases. The Paying Patient Officer is responsible for ensuring that the Trust recovers all income due to the Trust arising from the treatment of private patients.

9.2 The Paying Patients Officer, having received the signed and witnessed Undertaking to Pay **Form at least three weeks** before the planned procedure will identify the costs associated with the private patient stay, will confirm entitlement to insurance cover where relevant and will raise invoices on a timely basis. [See Flow Chart 1]

9.3 The Medical Director will advise the Paying Patients Officer when a consultant has been granted approval to undertaken private practice. The Paying Patients Officer will advise the consultant of the procedures involved in undertaking private practice in the Trust.

9.4 Clinical governance is defined as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

9.5 This framework applies to all patients seen within this Trust. It is therefore a fundamental requirement of Clinical Governance that all patients treated within the Trust must be examined or treated in an appropriate clinical setting.

9.6 Any fee or emolument etc. which may be received by an employee in the course of his or her clinical duties shall, unless the Trust otherwise directs, be surrendered to the Trust. For further information please see Southern Trust Gifts and Hospitality Standards of Conduct policy.

9.7 Record Keeping Systems and Private Patients

9.7.1 All patients regardless of their status should, where possible, be recorded on Hospital Systems and their status classified appropriately. These systems include for example:

- Patient Administration System (PAS)
- Northern Ireland Maternity System (NIMATS)
- Laboratory System
- Radiology System(e.g. Sectra, PACS, NIRADS, RIS etc)

9.8 Health Records of Private Patients

9.8.1 All hospital health records shall remain the property of the Trust and should only be taken outside the Trust to assist treatment elsewhere:

- when this is essential for the safe treatment of the patient
- when an electronic record of the destination of the notes is made using the case note tracking system
- when arrangements can be guaranteed that such notes will be kept securely
- provided that nothing is removed from the notes

9.8.2 Consultants who may have access to notes for private treatment of patients must agree to return the notes without delay. Either originals or copies of the patient's private notes should be held with their NHS notes. Patients' notes should not be removed from Trust premises. Requests for notes for medico-legal purposes should be requested by plaintiff's solicitor through the normal channels.

9.8.3 Since the Trust does not have a right of access to patient notes held in non NHS facilities, when patients are seen privately outside the Trust their first appointment within the Trust, unless with the same consultant, will be treated as a 'new appointment' rather than a 'review appointment'.

9.8.4 In the event of a 'Serious Adverse Incident' or legal proceedings the Trust may require access to private patient medical records which should be held in accordance with GMC Good Record Keeping Guidance.

9.9 Booking Arrangements for Admissions and Appointments

9.9.1 A record of attendance should be maintained, where possible, for all patients seen in the Trust. All private in, day and out patients should as far as possible be pre-booked on to the hospital information systems. Directorates are responsible for ensuring that all relevant information is captured and 'booking in' procedures are followed. Each department should ensure that all such patients are recorded on PAS etc. within an agreed timescale which should not extend beyond month end.

9.10 Walk Ins

9.10.1 A private patient who appears at a clinic and has no record on PAS should be treated for record keeping purposes in exactly the same manner as an NHS patient (walk in) i.e. relevant details should be taken, registry contacted for a number and processed in the usual fashion. A record should be kept of this patient and the Paying Patient Officer informed.

9.11 Radiology

9.11.1 All patients seen in Radiology should be given a Southern Health and Social Care hospital number.

9.12 Private Patient Records

9.12.1 All records associated with the treatment of private patients should be maintained in the same way as for NHS patients. This includes all files, charts, and correspondence with General Practitioners.

9.12.2 Accurate record keeping assists in the collection of income from paying patients.

9.12.3 It should be noted that

- any work associated with private patients who are not treated within this Trust or consultants private diary work and correspondence associated with patients seen elsewhere should not be carried out within staff time which is paid for by the Trust.

9.13 Tests Investigations or Prescriptions for Private Patients

9.13.1 The consultant must ensure that the requests for all laboratory work, ie. radiology, prescriptions, dietetics, physiotherapy etc. are clearly marked as Private.

9.13.2 Consultants should not arrange services, tests investigations or prescriptions until the person has signed an Undertaking to Pay form which will cover the episode of care [Appendix 3]. This must be submitted three weeks before any planned procedure.

9.14 Medical Reports

9.14.1 In certain circumstances Insurance Companies will request a medical report from the consultant. It is the consultant's responsibility to ensure that this report is completed in the timeframe required by the insurance company otherwise the Trust's invoice may remain unpaid in whole or in part until the report has been received and assessed.

10. FINANCIAL ARRANGEMENTS - PRIVATE PATIENTS

10.1 Charges to Patients

10.1.1 Where patients, who are private to a consultant, are admitted to the hospital, or are seen as outpatients, charges for investigations/diagnostics will be levied by the hospital. A full list of charges is available from the Paying Patient Office on request. Patients should be provided with an estimate of the total fee that they will incur **before** the start of their treatment.

10.1.2 Prices are reviewed regularly to ensure that all costs are covered. A calendar of pricing updates will be agreed.

10.2 Charges for Use of Trust Facilities for Outpatients

10.2.1 It is the responsibility of the Doctor to recover the cost from the patient and reimburse the Trust, on a quarterly basis, for any outpatients which have been seen in Trust facilities. [See Flow Chart 2]

10.2.2 A per patient cost for the use of Trust facilities for outpatients is available. This will be reviewed annually.

10.2.3 It is responsibility of the doctor to maintain accurate records of outpatient attendances. It is an audit requirement that the Trust verifies that all income associated with use of Trust facilities for outpatients has been identified and collected. Accordingly, Doctors are required to submit a quarterly return to the Paying Patient office with the names of the patients seen together with details of any treatment or tests undertaken. This information should accompany the payment for the relevant fees as outlined above.

10.2.4 A Undertaking to Pay form will only be required if investigations/diagnostics are required.

10.3 Basis of Pricing

10.3.1 Charges are based on an accommodation charge, cost of procedure, including any prosthesis, and on a cost per item basis for all diagnostic tests and treatments e.g. physiotherapy, laboratory and radiology tests, ECGs etc. They do not include consultants' professional fees. Some package prices may be agreed.

10.4 Uninsured Patients – Payment Upfront

10.4.1 Full payment prior to admission is required from uninsured patients. Consultants should advise patients that this is the case. The patient should be advised to contact the Paying Patients Officer regarding estimated cost of treatment. [See Flow Chart 4]

10.5 Insured Patients

10.5.1 The Undertaking to Pay Form also requires details of the patient's insurance policy. The Paying Patients Officer will raise invoices direct to the insurance company where relevant, in accordance with the agreements with individual insurance companies.

10.5.2 Consultants, as the first port of contact and the person in control of the treatment provided, should advise the patient to obtain their insurance company's permission for the specified treatment to take place within the specified timescale. [See Flow Chart 4]

10.6 Billing and Payment

10.6.1 The Paying Patients Officer co-ordinates the collation of financial information relating to patients' treatment, ensures that uninsured patients pay deposits and that invoices are raised accordingly. The financial accounts department will ensure all invoices raised are paid and will advise the Private Patient Officer in the event of a bad debt.

10.7 Audit

10.7.1 The Trust's financial accounts are subject to annual audit and an annual report is issued to the Trust Board, which highlights any area of weakness in control. Adherence to the Paying Patient Policy will form part of the Trust's Audit Plan. Consultants are reminded that they are responsible for the identification and recording of paying patient information. Failure to follow the procedures will result in investigation by Audit and if necessary, disciplinary action under Trust and General Medical Council regulations.

11. FINANCIAL ARRANGEMENTS FOR FEE PAYING SERVICES

11.1 Consultants may see patients privately or for fee paying services within the Trust only with the explicit agreement of the Medical Director, in accordance with their Job Plan. Management will decide to what extent, if any, Trust facilities, staff and equipment may be used for private patient or fee paying services and will ensure that any such services do not interfere with the organisation's obligations to NHS patients. This applies whether private services are undertaken in the consultant's own time, in annual or unpaid leave. [See Flow Chart 3]

11.2 In line with the Code of Conduct standards, private patient services should take place at times that do not impact on normal services for NHS patients. Private patients should normally be seen separately from scheduled NHS patients.

11.3 Fee Paying Services Policy (Category 2)

11.3.1 Fee Paying Services (Category 2) work is distinct from private practice, however it is still non NHS work as outlined in the 'Terms and Conditions for Hospital Medical and Dental Staff'. Refer to schedules 10 and 11 (Appendices 1 & 5 respectively) for further details.

11.3.2 There are a number of occasions when a Category 2 report will be requested, and they will usually be commissioned by, employers, courts, solicitors, Department of Work and Pensions etc. the report may include radiological opinion, blood tests or other diagnostic procedures

11.3.3 It is the responsibility of the Doctor to ensure that the Trust is reimbursed for all costs incurred in undertaking Category 2 work, this not only includes the use of the room but also the cost of any tests undertaken.

11.3.4 In order to comply with the Trusts financial governance controls it is essential that all Fee Paying services are identified and the costs recovered. It is not the responsibility of the Trust to invoice third parties for Category 2 work.

11.3.5 It is the responsibility of the Doctor to recover the cost from the third party and reimburse the Trust, on a quarterly basis, for any Category 2 services they have undertaken, including the cost of any treatments/tests provided.

11.3.6 The Category 2 (room only) charge per session will be reviewed annually.

11.3.7 A per patient rate may be available subject to agreement with the Paying Patient Manager

11.3.8 It is responsibility of the doctor to maintain accurate records of Category 2 attendances. It is an audit requirement that the Trust verifies that all income associated with Category 2 has been identified and collected.

11.3.9 Doctors are required to submit a quarterly return to the Paying Patient office with the names of the patients seen together with details of any treatment or tests undertaken. This information should accompany the payment for the relevant fees of Category 2 work as outlined above and should be submitted no later than ten days after the quarter end.

11.3.10 In order to comply with Data Protection requirements, Doctors must therefore inform their Category 2 clients that this information is required by the Trust and obtain their consent. Consultants should make a note of this consent.

11.3.11 Compliance to this policy will be monitored by the Paying Patient Manager and the Medical Director's Office.

11.3.12 The Consultant is responsible to HM Revenue and Customs to declare for tax purposes all Category 2 income earned. The Trust has no obligation in this respect.

11.3.13 Any Category 2 work undertaken for consultants by medical secretaries must be completed outside of their normal NHS hours. Consultants should be aware of their duty to inform their secretaries that receipt of such income is subject to taxation and must be declared to HM Revenue and Customs. It is recommended that Consultants keep accurate records of income and payment.

12. RENUNCIATION OF PRIVATE FEES

12.1 In some departments, consultants may choose to forego their private fees for private practice or for fee paying services in favour of a Charitable Fund managed by the Trust that could be drawn upon at a later stage for, by way of example, Continuous Professional Development / Study Leave.

12.2 For income tax purposes all income earned must be treated as taxable earnings. The only way in which this income can be treated as non taxable earnings of the consultant concerned is if the consultant signs a 'Voluntary Advance Renunciation of Earnings form' (Appendix 7) and declares that the earnings from a particular activity will belong to a named charitable fund and that the earnings will not be received by the consultant. In addition a consultant should never accept a cheque made out to him or her personally. To do so attracts taxation on that income and it cannot be subsequently renounced. Therefore all such income renounced in advance should be paid directly into the relevant fund. Income can only be renounced if it has not been paid to the individual and a Register of these will be maintained by the Charitable Funds Officer.

12.3 The Trust will be required to demonstrate that income renounced in favour of a Charitable Fund is not retained for the use of the individual who renounces it. Thus, in the event of any such consultant subsequently drawing on that fund, any such expenditure approval must be countersigned by another signatory on the fund.

13. OVERSEAS VISITORS - NON UK PATIENTS

(Republic of Ireland, EEA, Foreign Nationals)

PLEASE NOTE THIS IS ONLY A BRIEF GUIDE FOR FURTHER INFORMATION PLEASE CONTACT THE PAYING PATIENT OFFICE

13.1 The NHS provides healthcare free of charge to people who are 'ordinarily resident' in the UK. People who do not permanently live in the UK lawfully are not automatically entitled to use the NHS free of charge.

13.2 **RESIDENCY** is the therefore the main qualifying criterion, applicable regardless of nationality, being registered with a GP or having been issued a HC/NHS number, or whether the person holds a British Passport, or lived and paid taxes or national insurance contributions in the UK in the past.

13.3 Any patient attending the Trust who cannot establish that they are an ordinary resident and have lawfully lived in the UK permanently for the last 12 months preceding treatment are not entitled to free non ED hospital treatment whether they are registered with a GP or not. A GP referral letter cannot be accepted solely as proof of a patient's permanent residency and therefore entitlement to treatment.

13.4 For all new patients attending the Trust, residency must be established. All patients will be asked to complete a declaration to confirm residency, (regardless of race/ethnic origin). If not the Trust could be accused of discrimination.

13.5 Where there is an element of doubt as to whether the patient is an 'ordinary resident' eg no GP/ H&C number or non UK contact details, the Paying Patients Officer must be alerted immediately.

13.6 Emergency Department

13.6.1 Treatment given in an Emergency Department, Walk in Clinic or Minor Inuries Unit is free of charge if it is deemed to be immediate and necessary.

13.6.2 The Trust should always provide immediate and necessary treatment whether or not the patient has been informed of or agreed to pay charges .There is no exemption from charges for 'emergency' treatment other than that given in the accident and emergency department. Once an overseas patient is transferred out of Emergency Department their treatment becomes chargeable.

13.6.3 All patients admitted from Emergency Department must be asked to complete declaration of residency status.

13.6.4 This question is essential in trying to establish whether the patient is an overseas patient or not and hence liable to pay for any subsequent care provided.

13.6.5 If the patient is not an ordinary resident or there is an element of doubt eg no GP/ no H&C Number, the patient should be referred to Paying Patients Office to determine their eligibility.

13.6.6 If the person has indicated that they are a visitor to Northern Ireland, the overseas address must be entered as the permanent address on the correct Patient Administrative System and the Paying Patients Office should be notified immediately.

13.7 Outpatient Appointments

13.7.1 In all cases where the patient has not lived in Northern Ireland for 12 months or relevant patient data is missing such as H&C number, GP Details etc the patient must be referred to the Paying Patients Office to establish the patient's entitlement to free NHS treatment. This must be established before an appointment is given.

13.8 Review Appointments

13.8.1 Where possible follow up treatment should be carried out at the patient's local hospital, however if they are reviewed at the Trust they must be informed that they will be liable for charges.

13.8.2 If a consultant considers it appropriate to review a patient then they must sign a statement to this effect waiving the charges that would have been due to the Trust.

13.9 Elective Admission

13.9.1 A patient should not be placed onto a waiting list until their entitlement to free NHS Treatment has been established. Where the Patient is chargeable, the Trust should not initiate a treatment process until a deposit equivalent to the estimated full cost of treatment has been obtained.

13.10 Referral from other NHS Trusts

13.10.1 When a Consultant accepts a referral from another Trust the patients' status should, where possible, be established prior to admission. However, absence of this information should not delay urgent treatment.

13.10.2 The Trust will operate a policy of 'Stabilise and Transfer'.

14. AMENITY BED PATIENTS

14.1 Within the Trust's Maternity Service, a number of beds are assigned Amenity Beds. It is permissible for NHS patients who require surgical delivery and an overnight stay to pay for any bed assigned as an Amenity Bed. This payment has no effect on the NHS status of the patient. All patients identified as amenity will be recorded on PAS as APG and an Undertaking to Pay for an Amenity Bed form (Appendix 6) should be completed ideally before obtaining the amenity facilities.

15. GLOSSARY

Undertaking to Pay Form

Private Patients may fund their treatment, or they may have private medical insurance. In all cases Private Patients must sign an 'Undertaking to Pay' form (Appendix 3). This is a legally binding document which, when signed prior to treatment, confirms the patient as personally liable for costs incurred while at hospital and confirms the Patient's Private status. ALL private patients, whether insured or not are obliged to complete and sign an 'Undertaking to Pay' form, prior to commencement of treatment. Consultants therefore, as the first point of contact should ensure that the Paying Patients Officer is advised to ensure completion of the 'Undertaking to Pay' form.

Fee Paying Services
Any paid professional services, other than those falling within the definition of Private Professional Services, which a consultant carries out for a third party or for the employing organisation and which are not part of, nor reasonably incidental to, Contractual and Consequential Services. A third party for these purposes may be an organisation, corporation or individual, provided that they are acting in a health related professional capacity, or a provider or commissioner of public services. Examples of work that fall within this category can be found in Schedule 10 of the Terms and Conditions (Appendix 1).

Private Professional Services *(Also referred to as 'private practice')*

- the diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under Article 31 of the Health and Personal Social Services (Northern Ireland) Order 1972), excluding fee paying services as described in Schedule 10 of the terms and conditions (Appendix 1).

- work in the general medical, dental or ophthalmic services under Part IV of the Health and Personal Social Services (Northern Ireland) Order 1972 (except in respect of patients for whom a hospital medical officer is allowed a limited 'list', e.g. members of the hospital staff).

Non UK patients
A person who does not meet the 'ordinarily resident' test.

Job Plan
A work programme which shows the time and place of the consultant's weekly fixed commitments.

16. APPENDIX 1: SPECIFIC EXAMPLES OF FEE PAYING SERVICES - SCHEDULE 10

1. Fee Paying Services are services that are not part of Contractual or Consequential Services and not reasonably incidental to them. Fee Paying Services include:

   a. work on a person referred by a Medical Adviser of the Department of Social Development, or by an Adjudicating Medical Authority or a Medical Appeal Tribunal, in connection with any benefits administered by an Agency of the Department of Social Development;

   b. work for the Criminal Injuries Compensation Board, when a special examination is required or an appreciable amount of work is involved in making extracts from case notes;

   c. work required by a patient or interested third party to serve the interests of the person, his or her employer or other third party, in such nonclinical contexts as insurance, pension arrangements, foreign travel, emigration, or sport and recreation. (This includes the issue of certificates confirming that inoculations necessary for foreign travel have been carried out, but excludes the inoculations themselves. It also excludes examinations in respect of the diagnosis and treatment of injuries or accidents);

   d. work required for life insurance purposes;

   e. work on prospective emigrants including X-ray examinations and blood tests;

   f. work on persons in connection with legal actions other than reports which are incidental to the consultant's Contractual and Consequential Duties, or where the consultant is giving evidence on the consultant's own behalf or on the employing organisation's behalf in connection with a case in which the consultant is professionally concerned;

   g. work for coroners, as well as attendance at coroners' courts as medical witnesses;

   h. work requested by the courts on the medical condition of an offender or defendant and attendance at court hearings as medical witnesses, otherwise than in the circumstances referred to above;

   i. work on a person referred by a medical examiner of HM Armed Forces Recruiting Organisation;

   j. work in connection with the routine screening of workers to protect them or the public from specific health risks, whether such screening is a statutory obligation laid on the employing organisation by specific regulation or a voluntary undertaking by the employing organisation in pursuance of its general liability to protect the health of its workforce;

   k. occupational health services provided under contract to other HPSS, independent or public sector employers;

   l. work on a person referred by a medical referee appointed under the Workmen's Compensation (Supplementation) Act (Northern Ireland) 1966; work on prospective students of universities or other institutions of further education, provided that they are not covered by Contractual and Consequential Services. Such examinations may include chest radiographs;

m. Appropriate examinations and recommendations under Parts II and IV of the Mental Health (Northern Ireland) Order 1986 and fees payable to medical members of Mental Health Review Tribunals;

n. services performed by members of hospital medical staffs for government departments as members of medical boards;

o. work undertaken on behalf of the Employment Medical Advisory Service in connection with research/survey work, i.e. the medical examination of employees intended primarily to increase the understanding of the cause, other than to protect the health of people immediately at risk (except where such work falls within Contractual and Consequential Services);

p. completion of Form B (Certificate of Medical Attendant) and Form C (Confirmatory Medical Certificate) of the cremation certificates;

q. examinations and reports including visits to prison required by the Prison Service which do not fall within the consultant's Contractual and Consequential Services and which are not covered by separate contractual arrangements with the Prison Service;

r. examination of blind or partially-sighted persons for the completion of form A655, except where the information is required for social security purposes, or by an Agency of the Department of Social Development, or the Employment Service, or the patient's employer, unless a special examination is required, or the information is not readily available from knowledge of the case, or an appreciable amount of work is required to extract medically correct information from case notes;

s. work as a medical referee (or deputy) to a cremation authority and signing confirmatory cremation certificates;

t. medical examination in relation to staff health schemes of local authorities and fire and police authorities;

u. delivering lectures;

v. medical advice in a specialised field of communicable disease control;

w. attendance as a witness in court;

x. medical examinations and reports for commercial purposes, e.g. certificates of hygiene on goods to be exported or reports for insurance companies;

y. advice to organisations on matters on which the consultant is acknowledged to be an expert.

17. APPENDIX 2 - A CODE OF CONDUCT FOR PRIVATE PRACTICE

November 2003

Recommended Standards of Practice for NHS Consultants

An agreement between the BMA's Northern Ireland Consultants and Specialists Committee and the Department of Health, Social Services and Public Safety for consultants in Northern Ireland.

A CODE OF CONDUCT FOR PRIVATE PRACTICE: RECOMMENDED STANDARDS FOR NHS CONSULTANTS, 2003

Contents

Part I: Introduction

Scope of Code

1.1 This document sets out recommended standards of best practice for NHS consultants in England about their conduct in relation to private practice . The standards are designed to apply equally to honorary contract holders in respect of their work for the NHS. The Code covers all private work, whether undertaken in non-NHS or NHS facilities.

1.2 Adherence to the standards in the Code will form part of the eligibility criteria for clinical excellence awards.

1.3 This Code should be used at the annual job plan review as the basis for reviewing the relationship between NHS duties and any private practice.

Key Principles

1.4 The Code is based on the following key principles:

- NHS consultants and NHS employing organisations should work on a partnership basis to prevent any conflict of interest between private practice and NHS work. It is also important that NHS consultants and NHS organisations minimise the risk of any perceived conflicts of interest; although no consultant should suffer any penalty (under the code) simply
- because of a perception;
- The provision of services for private patients should not prejudice the interest of NHS patients or disrupt NHS services;
- With the exception of the need to provide emergency care, agreed NHS commitments should take precedence over private work; and
- NHS facilities, staff and services may only be used for private practice with the prior agreement of the NHS employer.

Part II: Standards of Best Practice

Disclosure of Information about Private Practice

1.2 Consultants should declare any private practice, which may give rise to any actual or perceived conflict of interest, or which is otherwise relevant to the practitioner's proper performance of his/her contractual duties. As part of the annual job planning process, consultants should disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of NHS work and out of hours cover.

2.2 Under the appraisal guidelines agreed in 2001, NHS consultants should be appraised on all aspects of their medical practice, including private practice. In line with the requirements of revalidation, consultants should submit evidence of private practice to their appraiser.

Scheduling of Work and On-Call Duties

2.3 In circumstances where there is or could be a conflict of interest, programmed NHS commitments should take precedence over private work. Consultants should ensure that, except in emergencies, private commitments do not conflict with NHS activities included in their NHS job plan.

2.4 Consultants should ensure in particular that:

- private commitments, including on-call duties, are not scheduled during times at which they are scheduled to be working for the NHS (subject to paragraph 2.8 below);
- there are clear arrangements to prevent any significant risk of private commitments disrupting NHS commitments, e.g. by causing NHS activities to begin late or to be cancelled;

- private commitments are rearranged where there is regular disruption of this kind to NHS work; and private commitments do not prevent them from being able to attend a NHS emergency while they are on call for the NHS, including any emergency cover that they agree to provide for NHS colleagues. In particular, private commitments that prevent an immediate response should not be undertaken at these times.

2.5 Effective job planning should minimise the potential for conflicts of interests between different commitments. Regular private commitments should be noted in a consultant's job plan, to ensure that planning is as effective as possible.

2.6 There will be circumstances in which consultants may reasonably provide emergency treatment for private patients during time when they are scheduled to be working or are on call for the NHS. Consultants should make alternative arrangements to provide cover where emergency work of this kind regularly impacts on NHS commitments.

2.7 Where there is a proposed change to the scheduling of NHS work, the employer should allow a reasonable period for consultants to rearrange any private sessions, taking into account any binding commitments entered into (e.g. leases).

Provision of Private Services alongside NHS Duties

2.8 In some circumstances NHS employers may at their discretion allow some private practice to be undertaken alongside a consultant's scheduled NHS duties, provided that they are satisfied that there will be no disruption to NHS services. In these circumstances, the consultants should ensure that any private services are provided with the explicit knowledge and agreement of the employer and that there is no detriment to the quality or timeliness of services for NHS patients.

Information for NHS Patients about Private Treatment

2.9 In the course of their NHS duties and responsibilities consultants should not initiate discussions about providing private services for NHS patients, nor should they ask other NHS staff to initiate such discussions on their behalf.

2.10 Where a NHS patient seeks information about the availability of, or waiting times for, NHS and/or private services, consultants should ensure that any information provided by them, is accurate and up-to-date and conforms with any local guidelines.

2.11 Except where immediate care is justified on clinical grounds, consultants should not, in the course of their NHS duties and responsibilities, make arrangements to provide private services, nor should they ask any other NHS staff to make such arrangements on their behalf unless the patient is to be treated as a private patient of the NHS facility concerned.

Referral of Private Patients to NHS Lists

2.12 Patients who choose to be treated privately are entitled to NHS services on exactly the same basis of clinical need as any other patient.

2.13 Where a patient wishes to change from private to NHS status, consultants should help ensure that the following principles apply:

- a patient cannot be both a private and a NHS patient for the treatment of one condition during a single visit to a NHS organisation;
- any patient seen privately is entitled to subsequently change his or her status and seek treatment as a NHS patient;
- any patient changing their status after having been provided with private services should not be treated on a different basis to other NHS patients as a result of having previously held private status;
- patients referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients; and
- should a patient be admitted to an NHS hospital as a private inpatient, but subsequently decide to change to NHS status before having received treatment, there should be an assessment to determine the patient's priority for NHS care.

Promoting Improved Patient Access to NHS Care and Increasing NHS Capacity

2.14 Subject to clinical considerations, consultants should be expected to contribute as fully as possible to maintaining a high quality service to patients, including reducing waiting times and improving access and choice for NHS patients. This should include co-operating to make sure that patients are given the opportunity to be treated by other NHS colleagues or by other providers where this will maintain or improve their quality of care, such as by reducing their waiting time.

2.15 Consultants should make all reasonable efforts to support initiatives to increase NHS capacity, including appointment of additional medical staff.

Part III – Managing Private Patients in NHS Facilities

3.1 Consultants may only see patients privately within NHS facilities with the explicit agreement of the responsible NHS organisation. It is for NHS organisations to decide to what extent, if any, their facilities, staff and equipment may be used for private patient services and to ensure that any such services do not interfere with the organisation's obligations to NHS patients.

3.2 Consultants who practise privately within NHS facilities must comply with the responsible NHS organisation's policies and procedures for private practice. The NHS organisation should consult with all consultants or their representatives, when adopting or reviewing such policies.

Use of NHS Facilities

3.3 NHS consultants may not use NHS facilities for the provision of private services without the agreement of their NHS employer. This applies whether private services are carried out in their own time, in annual or unpaid leave, or – subject to the criteria in paragraph 2.8 - alongside NHS duties.

3.4 Where the employer has agreed that a consultant may use NHS facilities for the provision of private services:

- the employer will determine and make such charges for the use of its services, accommodation or facilities as it considers reasonable;

- any charge will be collected by the employer, either from the patient or a relevant third party; and

- a charge will take full account of any diagnostic procedures used, the cost of any laboratory staff that have been involved and the cost of any NHS equipment that might have been used.

3.5 Except in emergencies, consultants should not initiate private patient services that involve the use of NHS staff or facilities unless an undertaking to pay for those facilities has been obtained from (or on behalf of) the patient, in accordance with the NHS body's procedures.

3.6 In line with the standards in Part II, private patient services should take place at times that do not impact on normal services for NHS patients. Private patients should normally be seen separately from scheduled NHS patients. Only in unforeseen and clinically justified circumstances should an NHS patient's treatment be cancelled as a consequence of, or to enable, the treatment of a private patient.

Use of NHS Staff

3.7 NHS consultants may not use NHS staff for the provision of private services without the agreement of their NHS employer.

3.8 The consultant responsible for admitting a private patient to NHS facilities must ensure, in accordance with local procedures, that the responsible manager and any other staff assisting in providing services are aware of the patient's private status.

18. APPENDIX 3 - PRIVATE / NOT ORDINARILY RESIDENT IN UK NOTIFICATION AND UNDERTAKING TO PAY FORM

Southern Health and Social Care Trust
Quality Care - for you, with you

PRIVATE / NOT ORDINARILY RESIDENT IN UK NOTIFICATION AND UNDERTAKING TO PAY FORM

Private Patient: Yes ☐ No ☐ **Non-Ordinarily Resident in UK:** Yes ☐ No ☐

Name of Patient:			
Address:			
Postcode:	Telephone No:		
Date of Birth:			
H&C Number:			
Name of Insurer:		**Self Funding**	☐
Insurer Policy No:			

I have been seeing this person as a private patient. They are to be admitted / referred to _____ Hospital on _____ as an _____

Inpatient Referral	☐	**Obstetrics** ☐ Estimated Duration of Stay	**Medical** ☐ Estimated Duration of Stay	**Surgical** ☐ Estimated Duration of Stay	**T & O** ☐ Estimated Duration of Stay
Day Case Referral	☐				
Diagnostics (Inpatient or Outpatient)	☐	**Laboratory** ☐ [please detail]	**Radiology** [pleas ☐ detail]	**Other** [e.g. ☐ Pharmacy]	

Undertaking to Pay Confirmation To be completed by Consultant			
I have advised the patient named above of the estimated hospital charges and of my fees			
Signed Consultant		**Date**	
Undertaking to Pay To be completed by the person who will pay the account			
I understand and agreed to pay Southern Health and Social Care Trust all charges[1] associated with this episode of care[2] .Where the Consultant may deem further procedures/investigations necessary which will incur additional charges, I understand that this may result in a different cost from that quoted to me and I undertake to pay the full costs incurred.			
Signed Patient		**Date**	

RETURN TO PAYING PATIENTS OFFICE CRAIGAVON AREA HOSPIAL/DAISY HILL HOSPITAL [email:payingpatients@southerntrust.hscni.net]

[1] A list of Tariffs is available from the Private Patients office

[2] Episode of Care – The total treatment of either an inpatient or day case patient from diagnosis through to discharge

Southern Health and Social Care Trust - A Guide to Paying Patients

19. APPENDIX 4 APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

Southern Health and Social Care Trust
Quality Care - for you, with you

APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

Name of Patient:	
Address:	
Postcode:	
Date of Birth:	
H&C Number:	
Name of Consultant	
Date of Last Private Consultation	

I have been seeing this person as a private patient. He/she has now been referred to Hospital as an NHS patient.

		Clinical Priority
Inpatient Referral	☐	
Outpatient Referral	☐	
Day Case Referral	☐	

Signed Consultant	
Effective Date	

Consultants are reminded that in good practice a patient who changes from private to NHS status should receive all subsequent treatment during that episode of care under the NHS as outlined in A Code of Conduct for Private Practice.

PLEASE FORWARD TO PAYING PATIENTS OFFICE [paying.patients@southerntrust.hscni.net]

20. APPENDIX 5 PRINCIPLES GOVERNING RECEIPT OF ADDITIONAL FEES – SCHEDULE 11

Principles Governing Receipt of Additional Fees - Schedule 11

1. In the case of the following services, the consultant will not be paid an additional fee, or - if paid a fee - the consultant must remit the fee to the employing organisation:

- any work in relation to the consultant's Contractual and Consequential Services;
- duties which are included in the consultant's Job Plan, including any additional Programmed Activities which have been agreed with the employing organisation;
- fee paying work for other organisations carried out during the consultant's Programmed Activities, unless the work involves minimal disruption and the employing organisation agrees that the work can be done in HPSS time without the employer collecting the fee;
- domiciliary consultations carried out during the consultant's Programmed Activities;
- lectures and teaching delivered during the course of the consultant's clinical duties;
- delivering lectures and teaching that are not part of the consultant's clinical duties, but are undertaken during the consultant's Programmed Activities.
- Consultants may wish to take annual leave [having given the required 6 week notice period] to undertake fee paying work [e.g. court attendance] in this instance the consultant would not be required to remit fees to the Trust.

This list is not exhaustive and as a general principle, work undertaken during Programmed Activities will not attract additional fees.

2. Services for which the consultant can retain any fee that is paid:

- Fee Paying Services carried out in the consultant's own time, or during annual or unpaid leave;
- Fee Paying Services carried out during the consultant's Programmed Activities that involve minimal disruption to HPSS work and which the employing organisation agrees can be done in HPSS time without the employer collecting the fee;
- Domiciliary consultations undertaken in the consultant's own time, though it is expected that such consultations will normally be scheduled as part of Programmed Activities1;
- Private Professional Services undertaken in the employing organisation's facilities and with the employing organisation's agreement during the consultant's own time or during annual or unpaid leave;
- Private Professional Services undertaken in other facilities during the consultant's own time, or during annual or unpaid leave;
- Lectures and teaching that are not part of the consultant's clinical duties and are undertaken in the consultant's own time or during annual or unpaid leave;

- Preparation of lectures or teaching undertaken during the consultant's own time irrespective of when the lecture or teaching is delivered.

This list is not exhaustive but as a general principle the consultant is entitled to the fees for work done in his or her own time, or during annual or unpaid leave.

And only for a visit to the patient's home at the request of a general practitioner and normally in his or her company to advise on the diagnosis or treatment of a patient who on medical grounds cannot attend hospital.

21. APPENDIX 6 - UNDERTAKING TO PAY CHARGES FOR AN AMENITY BED

Southern Health and Social Care Trust
Quality Care - for you, with you

UNDERTAKING TO PAY CHARGES FOR AN AMENITY BED

Name of Patient:	
Address:	
Postcode:	
Date of Birth:	
Hospital Number:	

Site: Craigavon ☐ Daisy Hill ☐

I was allocated an amenity bed on (date): _____ **(time)**

Ward: _____ **Consultant:** _____

I undertake to pay the Southern Health Social Care Trust £39 per night for an amenity bed, which has been provided for me at my request.

Number of days Amenity Bed required: _____

I understand that if I am required to stay in hospital more days than anticipated, the midwifery staff will ask me if I wish to continue and pay for the amenity bed, or if I wish to be transferred to the open ward.

Patient's Signature: _____ **Date:** _____

Midwife's Signature: _____ **Date:** _____

To be completed by WARD CLERK OR MIDWIFE when patient is being transferred /discharged from an amenity bed.

Date transferred / discharged from amenity bed _____

Signed by midwife / ward clerk when transferred / discharged _____

22. APPENDIX 7 – AGREEMENT FOR THE VOLUNTARY ADVANCE RENUNCIATION OF EARNINGS FROM FEE PAYING ACTIVITIES

HSC Southern Health and Social Care Trust
Quality Care - for you, with you

AGREEMENT FOR THE VOLUNTARY ADVANCE RENUNCIATION OF EARNINGS FROM FEE PAYING ACTIVITIES

I *(name)* _____

Request that any monies due to me from patients in relation to fees from
(description of activity)

_____

_____

_____

_____

_____

_____

_____

Shall be transferred to *(Charity title and reference)* _____

For its sole use in the advancement of its aims in accordance with the Trust Deed until directed otherwise by me in writing.

This request is to take effect from (date*):* _____

Signed, sealed and delivered by: _____
(Full name in BLOCK CAPITALS)

Date: _____

In the presence of: _____

Date: _____

Address:: _____

_____

_____

_____ **Postcode:** _____

_____

23. APPENDIX 8 - PROVISIONS GOVERNING THE RELATIONSHIP BETWEEN HPSS WORK AND PRIVATE PRACTICE - SCHEDULE 9

1. This Schedule should be read in conjunction with the 'Code of Conduct for Private Practice', which sets out standards of best practice governing the relationship between HPSS work and private practice.

2. The consultant is responsible for ensuring that their provision of Private Professional Services for other organisations does not:

   - result in detriment to HPSS patients;
   - diminish the public resources that are available for the HPSS.

Disclosure of information about Private Commitments

3. The consultant will inform his or her clinical manager of any regular commitments in respect of Private Professional Services or Fee Paying Services. This information will include the planned location, timing and broad type of work involved.

4. The consultant will disclose this information at least annually as part of the Job Plan Review. The consultant will provide information in advance about any significant changes to this information.

Scheduling of Work and Job Planning

5. Where a conflict of interest arises or is liable to arise, HPSS commitments must take precedence over private work. Subject to paragraphs 10 and 11below, the consultant is responsible for ensuring that private commitments do not conflict with Programmed Activities.

6. Regular private commitments must be noted in the Job Plan.

7. Circumstances may also arise in which a consultant needs to provide emergency treatment for private patients during time when he or she is scheduled to be undertaking Programmed Activities. The consultant will make alternative arrangements to provide cover if emergency work of this kind regularly impacts on the delivery of Programmed Activities.

8. The consultant should ensure that there are arrangements in place, such that there can be no significant risk of private commitments disrupting HPSS commitments, e.g. by causing HPSS activities to begin late or to be cancelled. In particular where a consultant is providing private services that are likely to result in the occurrence of emergency work, he or she should ensure that there is sufficient time before the scheduled start of Programmed Activities for such emergency work to be carried out.

9. Where the employing authority has proposed a change to the scheduling of a consultant's HPSS work, it will allow the consultant a reasonable period in line with Schedule 6, paragraph 2 to rearrange any private commitments. The employing organisation will take into account any binding commitments that the consultant may have entered into (e.g. leases). Should a consultant wish to reschedule private commitments to a time that would conflict with Programmed Activities, he or she should raise the matter with the clinical manager at the earliest opportunity.

Scheduling Private Commitments Whilst On-Call

10. The consultant will comply with the provisions in Schedule 8, paragraph 5 of these Terms and Conditions. In addition, where a consultant is asked to provide emergency cover for a colleague at short notice and the consultant has previously arranged private commitments at the same time, the consultant should only agree to provide such emergency cover if those private commitments would not prevent him Or her returning to the relevant HPSS site at short notice to attend an emergency. If the consultant is unable to provide cover at short notice it will be the employing organisation's responsibility to make alternative arrangements and the consultant will suffer no detriment in terms of pay progression as a result.

Use of HPSS Facilities and Staff

11. Where a consultant wishes to provide Private Professional Services at an HPSS facility he or she must obtain the employing organisation's prior agreement, before using either HPSS facilities or staff.

12. The employing organisation has discretion to allow the use of its facilities and will make it clear which facilities a consultant is permitted to use for private purposes and to what extent.

13. Should a consultant, with the employing organisation's permission, undertake Private Professional Services in any of the employing organisation's facilities, the consultant should observe the relevant provisions in the 'Code of Conduct for Private Practice'.

14. Where a patient pays privately for a procedure that takes place in the employing organisation's facilities, such procedures should occur only where the patient has given a signed undertaking to pay any charges (or an undertaking has been given on the patient's behalf) in accordance with the employing organisation's procedures.

15. Private patients should normally be seen separately from scheduled HPSS patients. Only in unforeseen and clinically justified circumstances should a consultant cancel or delay an HPSS patient's treatment to make way for his or her private patient.

16. Where the employing organisation agrees that HPSS staff may assist a consultant in providing Private Professional Services, or provide private services on the consultant's behalf, it is the consultant's responsibility to ensure that these staff are aware that the patient has private status.

17. The consultant has an obligation to ensure, in accordance with the employing organisation's procedures, that any patient whom the consultant admits to the employing organisation's facilities is identified as private and that the responsible manager is aware of that patient's status.

18. The consultant will comply with the employing organisation's policies and procedures for private practice

Patient Enquiries about Private Treatment

19. Where, in the course of his or her duties, a consultant is approached by a patient and asked about the provision of Private Professional Services, the consultant may provide only such standard advice as has been agreed between the employing organisation and appropriate local consultant representatives for such circumstances.

20. The consultant will not during the course of his or her Programmed Activities make arrangements to provide Private Professional Services, nor ask any other member of staff to make such arrangements on his or her behalf, unless the patient is to be treated as a private patient of the employing organisation.

21. In the course of his/her Programmed Activities, a consultant should not initiate discussions about providing Private Professional Services for HPSS patients, nor should the consultant ask other staff to initiate such discussions on his or her behalf.

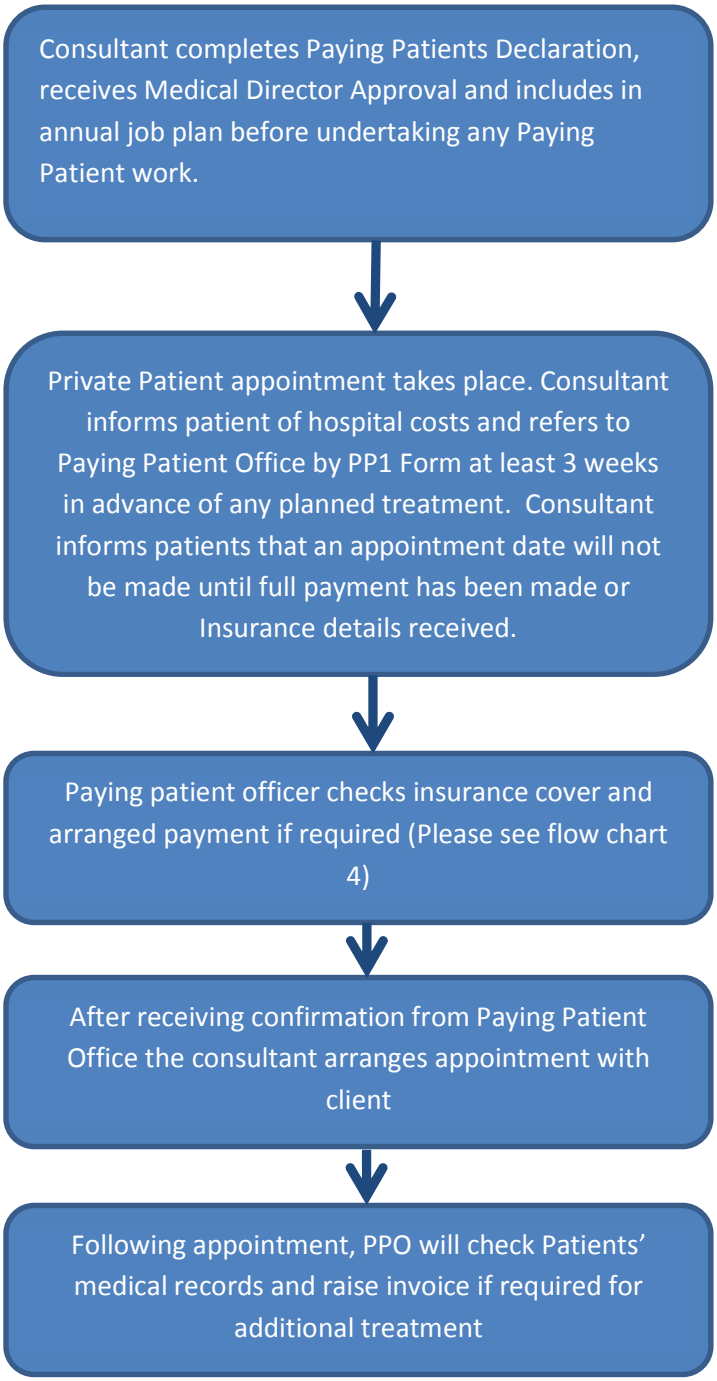
22. Where an HPSS patient seeks information about the availability of, or waiting times for, HPSS services and/or Private Professional Services, the consultant is responsible for ensuring that any information he or she provides, or arranges for other staff to provide on his or her behalf, is accurate and up-to-date.

Promoting Improved Patient Access to HPSS Care

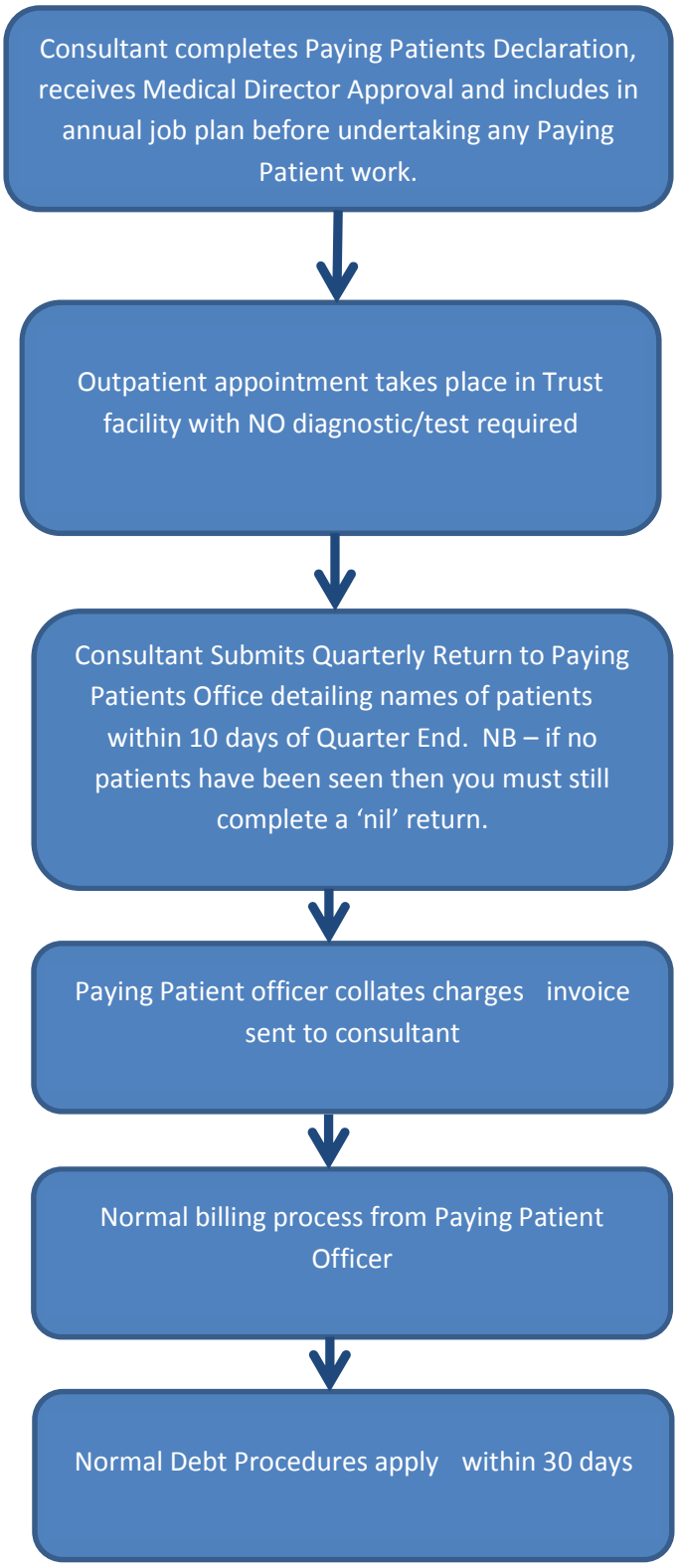
23. Subject to clinical considerations, the consultant is expected to contribute as fully as possible to reducing waiting times and improving access and choice for HPSS patients. This should include ensuring that, as far as is practicable, patients are given the opportunity to be treated by other HPSS colleagues or by other providers where this will reduce their waiting time and facilitate the transfer of such patients.

24. The consultant will make all reasonable efforts to support initiatives to increase HPSS capacity, including appointment of additional medical staff and changes to ways of working.

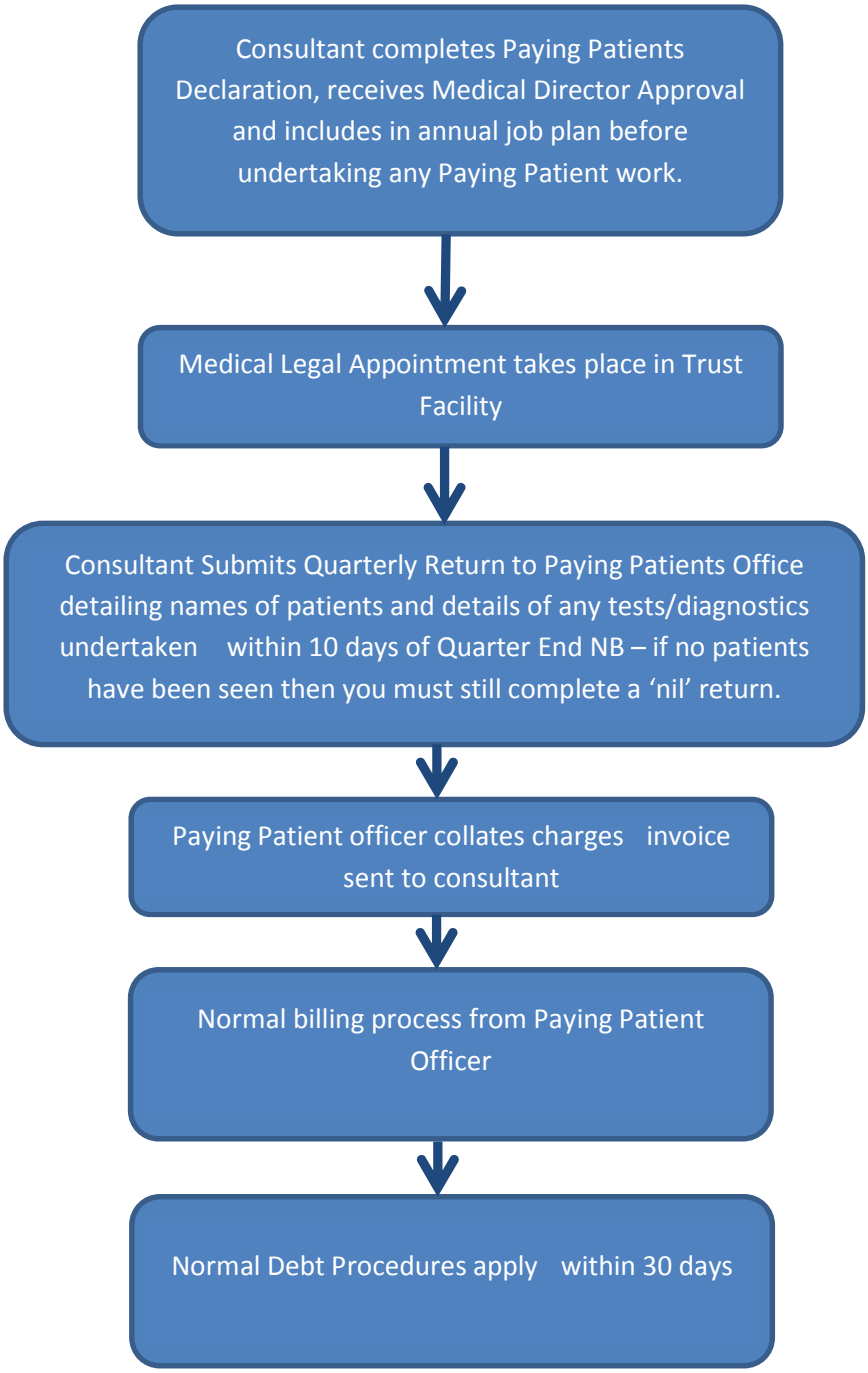
24. FLOW CHART 1 - PAYING PATIENTS [Inpatients]



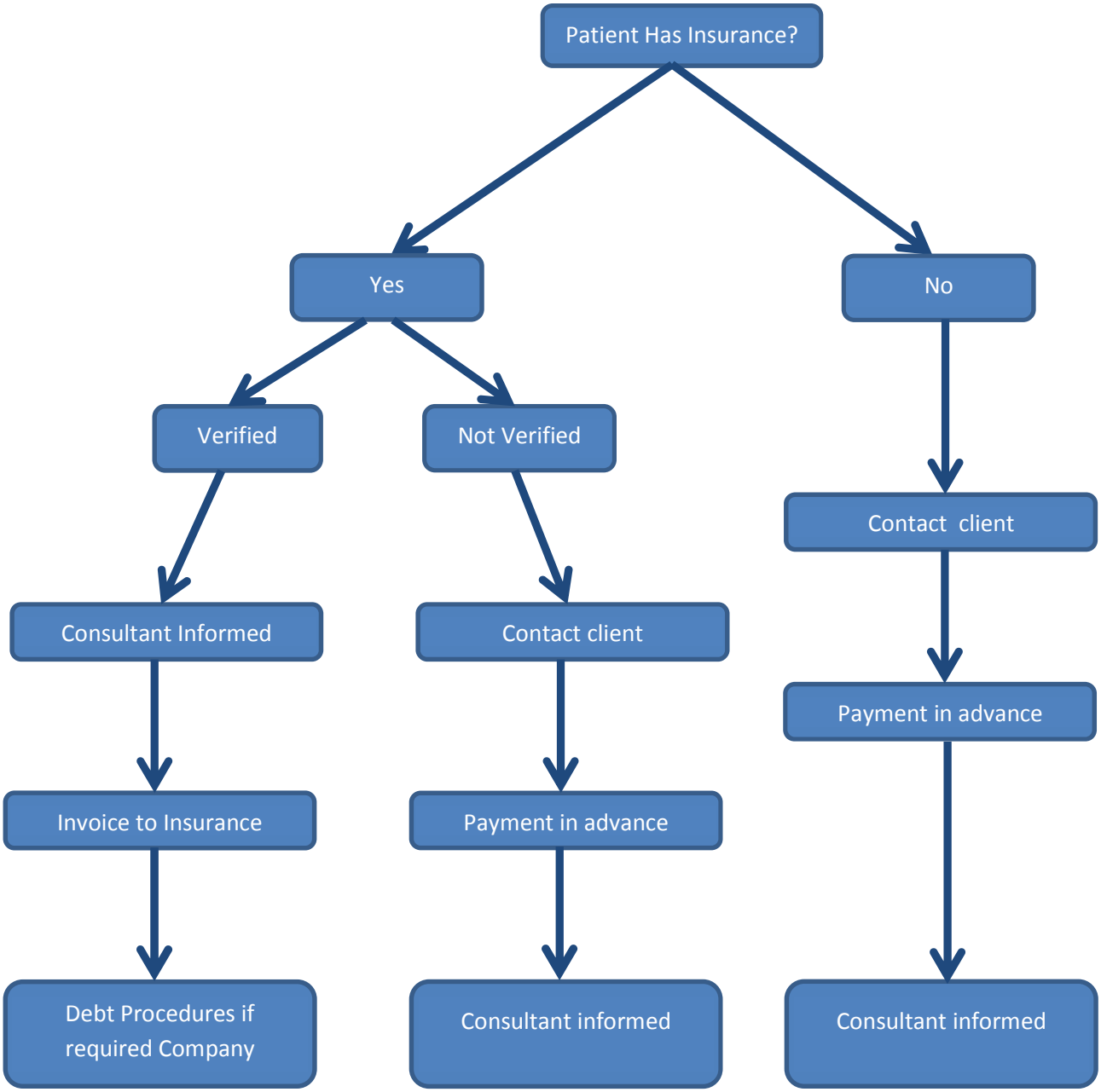
25. FLOW CHART 2 - PAYING PATIENTS [Outpatients]



26. FLOW CHART 3 - PAYING PATIENTS [Fee Paying Services]



27. FLOW CHART 4 – PATIENT INSURANCE



Health and Social Care Board

0023/18

Query Request Form

Requires Immediate Response: Yes

Reason for Immediate Response: Required as an action following Internal Audit review of management of private patients

☐	**Data Definition**	X	**Recording Issue**
X	**Technical Guidance**	☐	**Other**

Name: Personal Information redacted by the USI **Date:** 8th August 2018

Organisation: BHSCT **Contact Number:** Personal information redacted by USI

Subject Heading: PAS OP Referral Source Code – Private to NHS

a) Issue: ***Please provide as much detail as possible in order for the query to be considered and resolved as quickly as possible. This query form will be published on SharePoint when resolved.***

Belfast Trust requests a Referral Source Code on PAS for outpatients who change status from Private to NHS. Currently there is no guidance for identifying such patients.

Patient who attends Trust as a private patient has category recorded as PPG. When treatment completed OP registration should be closed with Discharge Reason – Treatment Completed, however if during their treatment the patient decides to change status to NHS the OP registration should be closed with Discharge Reason – Transfer to NHS and a new OP registration opened:
PAS with referral source PTN (Private to NHS) (suggested code), mapped to Internal Value (2) and CMDS Value (11) on Referral Source Masterfile and category as NHS.

This will ensure that the original category of PPG is not overwritten to NHS and the information recorded as per the Draft Technical Guidance on Private and Overseas Patients is not lost.

Belfast Trust request that the above is adopted as regional PAS Technical Guidance.

b) Response:

When a patient transfers from Private to NHS during their treatment period the OP registration should be closed using:

Discharge Reason code: TNHS – Transfer from Private to NHS

A new OP registration should be opened using:

Referral Source code: PTN – Private to NHS

Approved by: Acute Hospital Information Group

Date: 11/09/2018 **Response Published:** Yes / ~~No~~

Email: *HSCDataStandards@hscni.net*
HSC Data Standards Helpdesk: *(028) 9536 2832*

These forms are available on the Information Standards & Data Quality SharePoint Site at *http://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Helpdesk.aspx*