Please Note: Attachments 6, 7, 8 and 9 in response to S21 No 78 of 2022 can be found at WIT-107951 to WIT-107995. Annotated by the Urology Services Inquiry

Helen Forde
Health Records Manager
C/O Southern Health and Social Care Trust
Craigavon Area Hospital,
68 Lurgan Road, Portadown,
BT63 5QQ

23 September 2022

Dear Madam,

Re: The Statutory Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust

Provision of a Section 21 Notice requiring the provision of evidence in the form of a written statement

I am writing to you in my capacity as Solicitor to the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust (the Urology Services Inquiry) which has been set up under the Inquiries Act 2005 ('the Act').

I enclose a copy of the Urology Services Inquiry's Terms of Reference for your information.

You will be aware that the Inquiry has commenced its investigations into the matters set out in its Terms of Reference. The Inquiry is continuing with the process of gathering all of the relevant documentation from relevant departments, organisations and individuals. In addition, the Inquiry has also now begun the process of requiring individuals who have been, or may have been, involved in the range of matters which come within the Inquiry's Terms of Reference to provide written evidence to the Inquiry panel.

The Urology Services Inquiry is now issuing to you a Statutory Notice (known as a Section 21 Notice) pursuant to its powers to compel the provision of evidence in the form of a written statement in relation to the matters falling within its Terms of Reference.

The Inquiry is aware that you have held posts relevant to the Inquiry's Terms of Reference. The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now or at any stage

throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

The Schedule to the enclosed Section 21 Notice provides full details as to the matters which should be covered in the written evidence which is required from you. As the text of the Section 21 Notice explains, you are required by law to comply with it.

Please bear in mind the fact that the witness statement required by the enclosed Notice is likely (in common with many other statements we will request) to be published by the Inquiry in due course. It should therefore ideally be written in a manner which is as accessible as possible in terms of public understanding.

You will note that certain questions raise issues regarding documentation. As you are aware the Trust has already responded to our earlier Section 21 Notice requesting documentation from the Trust as an organisation. However if you in your personal capacity hold any additional documentation which you consider is of relevance to our work and is not within the custody or power of the Trust and/or has not been provided to us to date, then we would ask that this is also provided with this response.

If it would assist you, I am happy to meet with you and/or the Trust's legal representative(s) to discuss what documents you have and whether they are covered by the Section 21 Notice.

You will also find attached to the Section 21 Notice a Guidance Note explaining the nature of a Section 21 Notice and the procedures that the Inquiry has adopted in relation to such a notice. In particular, you are asked to provide your evidence in the form of the template witness statement which is also enclosed with this correspondence. In addition, as referred to above, you will also find enclosed a copy of the Inquiry's Terms of Reference to assist you in understanding the scope of the Inquiry's work and therefore the ambit of the Section 21 Notice.

Given the tight time-frame within which the Inquiry must operate, the Chair of the Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

If there is any difficulty in complying with this time limit you must make application to the Chair for an extension of time before the expiry of the time limit, and that application must provide full reasons in explanation of any difficulty.

Finally, I would be grateful if you could acknowledge receipt of this correspondence and the enclosed Notice by email to Personal Information redacted by the USI.

Please do not hesitate to contact me to discuss any matter arising.

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

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

THE INDEPENDENT PUBLIC INQUIRY INTO
UROLOGY SERVICES IN THE
SOUTHERN HEALTH AND SOCIAL CARE TRUST

Chair's Notice

[No 78 of 2022]

Pursuant to Section 21(2) of the Inquiries Act 2005

WARNING

If, without reasonable excuse, you fail to comply with the requirements of this Notice you will be committing an offence under section 35 of the Inquiries Act 2005 and may be liable on conviction to a term of imprisonment and/or a fine.

Further, if you fail to comply with the requirements of this Notice, the Chair may certify the matter to the High Court of Justice in Northern Ireland under section 36 of the Inquiries Act 2005, where you may be held in contempt of court and may be imprisoned, fined or have your assets seized.

TO:

Helen Forde
Health Records Manager
C/O Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.

2. The Notice requires you to do the acts set out in the body of the Notice.

3. You should read this Notice carefully and consult a solicitor as soon as possible about it.

4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.

5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by **noon on 21st October 2022.**

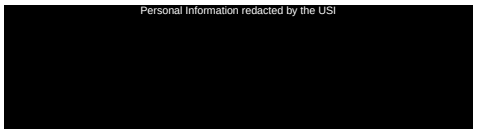
APPLICATION TO VARY OR REVOKE THE NOTICE

AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by **noon on 14th October 2022**.

Upon receipt of such a claim the Chair will then determine whether the Notice should be revoked or varied, including having regard to her obligations under section 21(5) of the Act, and you will be notified of her determination.

Dated this day 23rd September 2022

Signed: 

Christine Smith QC

Chair of Urology Services Inquiry

SCHEDULE
[No 78 of 2022]

SECTION 1 – GENERAL NARRATIVE

General

1. Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"). Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed and, as far as possible, to address your answers in a chronological format.

If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.

Your role

4. Please set out all roles held by you within the Southern Trust, including dates and a brief outline of duties and responsibilities in each post.

5. Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.

6. If your current role involves managing staff, please set out how you carry out this role, e.g. meetings, oral/written reports, assessments, appraisals, etc.

7. What systems were and are in place during your tenure to assure you that appropriate standards were being met by you and maintained by you in fulfilling your role?

8. Was your role subject to a performance review or appraisal? If so, please explain how and by whom this was carried out and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.

9. Where not covered by question 8 above, please set out any relevant policy and guidelines, both internal and external as applicable, governing your role. How, if at all, are you made aware of any updates on policy and guidance relevant to you?

10. What performance indicators, if any, are used to measure performance for your role?

11. How do you assure yourself that you adhere to the appropriate standards for your role? What systems were in place to assure you that appropriate standards were being met and maintained?

12. Have you experience of these systems being by-passed, whether by yourself or others? If yes, please explain in full, most particularly with reference to urology services.

13. What systems of governance do you use in fulfilling your role?

14. Have you been offered any support for quality improvement initiatives during your tenure? If yes, please explain and provide any supporting documentation.

15. During your tenure, who did you understand was responsible for overseeing the quality of services in urology?

16. In your experience, who oversaw the clinical governance arrangements of urology and, how was this done?

17. Did you feel able to provide the requisite service and support to urology services which your role required? If not, why not? Did you ever bring this to the attention of management and, if so, what, if anything, was done? What, if any, impact do you consider your inability to properly fulfill your role within urology had on patient care, governance or risk?

18. Did you feel supported by staff within urology in carrying out your role? Please explain your answer in full.

Urology services

19. Please explain those aspects of your role and responsibilities which are relevant to the operation, governance or clinical aspects of urology services.

20. With whom do you liaise directly about all aspects of your job relevant to urology? Do you have formal meetings? If so, please describe their frequency, attendance, how any agenda is decided and how the meetings are recorded. Please provide the minutes as appropriate. If meetings are informal, please provide examples.

21. In what way is your role relevant to the operational, clinical and/or governance aspects of urology services? How are these roles and responsibilities carried out on a day to day basis (or otherwise)?

22. What is your overall view of the efficiency and effectiveness of governance processes and procedures within urology as relevant to your role?

23. Through your role, did you inform or engage with performance metrics or have any other patient or system data input within urology? How did those systems help identify concerns, if at all?

24. Do you have any specific responsibility or input into any of the following areas within urology? If yes, please explain your role within that topic in full, including naming all others with whom you engaged:

    (i) Waiting times
    (ii) Triage/GP referral letters
    (iii) Letter and note dictation
    (iv) Patient care scheduling/Booking
    (v) Prescription of drugs

(vi) Administration of drugs
(vii) Private patient booking
(viii) Multi-disciplinary meetings (MDMs)/Attendance at MDMs
(ix) Following up on results/sign off of results
(x) Onward referral of patients for further care and treatment
(xi) Storage and management of health records
(xii) Operation of the Patient Administrative System (PAS)
(xiii) Staffing
(xiv) Clinical Nurse Specialists
(xv) Cancer Nurse Specialists
(xvi) Palliative Care Nurses
(xvii) Patient complaints/queries

Concerns

25. Please set out the procedure which you were expected to follow should you have a concern about an issue relevant to patient care and safety and governance.

26. Did you have any concerns arising from any of the issues set out at para 24, (i) – (xvii) above, *or any other matter* regarding urology services? If yes, please set out in full the nature of the concern, who, if anyone, you spoke to about it and what, if anything, happened next. You should include details of all meetings, contacts and outcomes. Was the concern resolved to your satisfaction? Please explain in full.

27. Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.

28. If you did have concerns regarding the practice of any practitioner in urology, what, in your view was the impact of the issue giving rise to concern on the provision, management and governance of urology services?

29. What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?

30. Did you consider that the concern(s) raised presented a risk to patient safety and clinical care? If yes, please explain by reference to particular incidents/examples. Was the risk mitigated in any way?

31. Was it your experience that once concerns were raised, systems of oversight and monitoring were put in place? If yes, please explain in full.

32. In your experience, if concerns are raised by you or others, how, if at all, are the outcomes of any investigation relayed to staff to inform practice?

33. Did you have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated as necessary within urology?

34. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such Governance meeting minutes or notes, or in the Risk Register, whether at Departmental level or otherwise? Please provide any documents referred to.

35. What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?

Staff

36. As relevant, what was your view of the working relationships between urology staff and other Trust staff? Do you consider you had a good working relationship with those with whom you interacted within urology? If you had any concerns regarding staff relationships, did you speak to anyone and, if so, what was done?

37. In your experience, did medical (clinical) managers and non-medical (operational) managers in urology work well together? Whether your answer is yes or no, please explain with examples.

Learning

38. Are you now aware of governance concerns arising out of the provision of urology services which you were not previously aware of? Identify any governance concerns which fall into this category and state whether you could and should have been made aware of the issues at the time they arose and why.

39. Having had the opportunity to reflect on these governance concerns arising out of the provision of urology services, do you have an explanation as to what went wrong within urology services and why?

40. What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and, to the extent that you are aware, the concerns involving Mr. O'Brien in particular?

41. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. Your answer may, for example, refer to an individual, a group or a particular level of staffing, or a particular discipline.

If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

42. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

43. Do you think, overall, the governance arrangements were and are fit for purpose? Did you have concerns specifically about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?

44. If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

UROLOGY SERVICES INQUIRY

USI Ref: Notice 78 of 2022

Date of Notice: 23 September 2022

Witness Statement of: Helen Forde

I, Helen Forde, will say as follows:-

SECTION 1 – GENERAL NARRATIVE

General

1. **Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with or by you, meetings you attended, and actions or decisions taken by you and others to address any concerns. It would greatly assist the inquiry if you would provide this narrative in numbered paragraphs and in chronological order.**

1.1 In response to this question please see points:

a) 12.2
b) 18.1
c) 18.2
d) 20.3
e) 26.1
f) 26.2

g) 26.3
h) 28.1

2. **Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"). Provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. Place any documents referred to in the body of your response as separate appendices set out in the order referred to in your answers. If you are in any doubt about document provision, please do not hesitate to contact the Trust's Solicitor, or in the alternative, the Inquiry Solicitor.**

2.1 All documents referenced in this statement are attached to this statement and can be found in folder S21 78 of 2022 – Attachments.

3. **Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed and, as far as possible, to address your answers in a chronological (**

If there are questions that you do not know the answer to, or if you believe that someone else is better placed to answer a question, please explain and provide the name and role of that other person.

Your role

4. **Please set out all roles held by you within the Southern Trust, including dates and a brief outline of duties and responsibilities in each post.**

4.1 I have had three roles during my employment in the Southern Trust:

a. Head of Admin Services – Oct 2007 – 4/10/2009
b. Head of Health Records – 5/10/2009 – 4/12/2020
c. Admin Manager (zero hours) – Feb 2021 to date

(A) Head of Admin Services – Oct 2007 – Oct 2009

4.2 I was responsible for the line management and provision of admin services in the Community. This was a new role in the newly formed SHSCT and was established to look at admin in the community, with a view to implementing standard working practices and staffing efficiencies.

(B) Head of Health Records – Oct 2009 – Dec 2020

4.3 The role of the Head of Health Records was to ensure the provision of a comprehensive, efficient and effective health records service which included responsibility for Ward Clerks, Outpatient receptionists, Emergency Department and Minor Injuries Admin staff for the Acute Directorate in the Southern Health & Social Care Trust.

4.4 In addition to the responsibility of the above services I also had line management responsibility for the admin staff in these services.

4.5 I retired from this post on 4/12/20.

Please see 1. JD Head of Health Records and Admin Services Band 8a

(c) Admin Manager – Feb 2020 to date

4.6 To provide an admin service to Directorates as required. I worked with the Integrated Maternity and Woman's Health Directorate (IMWH) in setting up systems, developing Standard Operating Procedures and taking forward some small projects, eg., getting information for pregnant ladies translated into several languages. I have now moved to the Urology Lookback Review team and am working on updating spreadsheets and sending letters to patients as required, and uploading information onto the Northern Ireland Electronic Care Record (NIECR).

5. **Please provide a description of your line management in each role, naming those roles/individuals to whom you directly report/ed and those departments, services, systems, roles and individuals whom you manage/d or had responsibility for.**

Head of Admin Services

5.1 I reported directly to Mrs Anita Carroll, Assistant Director of Functional Acute Services.

5.2 I had line management responsibility for the admin staff in the Directorates of Children and Young People, Older People and Primary Care, Mental Health.

Head of Health Records

5.3 I reported directly to Mrs Anita Carroll, Assistant Director of Functional Acute Services.

5.4 From 2009 – 2013 I was responsible for the Health Records Service and the Referral and Booking Service.

5.5 From 2013 – 2020, following an admin review, some changes were made and I was responsible for the Health Records Service and staff, Emergency Department and Minor Injuries admin staff, and Ward Clerks in Acute Services. I retired on 4/12/2020.

5.6 Line Managers -

Service	**Line Manager**
Health Records Craigavon Area Hospital South Tyrone Hospital Banbridge Polyclinic	Pamela Lawson
Health Records Daisy Hill Hospital Villa 3, St Lukes Hospital Armagh Community Hospital	Kate Watters Personal Information redacted by the USI And now Andrea Cunningham
Emergency Department Craigavon Area Hospital Daisy Hill Hospital	Irenee Hewitt retired and replaced with Sinead Corr Helen McCaul
Ward Clerks Craigavon Area Hospital Daisy Hill Hospital	Sinead Corr Helen McCaul

Minor Injuries South Tyrone Hospital	Pamela Lawson

Admin Manager in Acute

5.7 As this post is a zero hours, ad hoc post I assist in specific pieces of work as requested. I had retired from the SHSCT on 4/12/2020 and am available for ad hoc, part time work. When I was in the IMWH Directorate from February 20 to June 20 I reported to Mrs Wendy Clarke, Assistant Director in IMWH. From June 20 I started working with the Lookback Review Team and report to Mrs Sarah Ward, Head of Service. I provide an admin service in the Lookback Review role. I do not manage the service or have any staff management responsibility in this role.

6. **If your current role involves managing staff, please set out how you carry out this role, e.g. meetings, oral/written reports, assessments, appraisals, etc.**

6.1 My current role as Admin Manager in the Lookback Review Team does not involve staff management. However, my previous role of Head of Service for Health Records did involve staff management and I carried out this role by using:

a) Regular meetings with my managers – *please see 2. Agenda of ED and WC Meeting on 19 Nov 2019*
b) One to one with managers – *please see 3. One to One Andrea 16 Oct 2019 and 4. One to One Pamela 13 Nov 2019*
c) Developing and agreeing a Work Plan for my managers – *please see 5. Workplan for HHR managers*

d) Personal Development Plans – *please see 6. KSF 19.6.20 Pamela Lawson*

e) Communication via telephone calls and email

f) Open door policy for managers and staff

g) Visits to the Department

h) I also had monthly One to One's with my manager, along with a Head of Service monthly meeting, and regular communication using telephone and email. This provided a platform to discuss business and raise issues. *Please see 7. FSS HOS notes 23 11 2020*

7. **What systems were and are in place during your tenure to assure you that appropriate standards were being met by you and maintained by you in fulfilling your role?**

7.1 In my role as Head of Health Records I used the following systems:

a) Induction manuals for new staff- *please see 8. Departmental Induction June 2019*

b) Staff trained using a "buddy" system where they worked with another colleague to give them guidance and support as they learnt their new role.

c) PDPs for staff and managers. *Please see 6. KSF 19.6.20 Pamela Lawson*

d) Monthly 1: 1 with my line manager – Anita Carroll. *Please see 9. One to One with Helen Forde Nov 2020*

e) Monthly 1: 1 with the mangers who reported to me where issues could be raised. These managers were Pamela Lawson, Sinead Corr, Helen

McCaul, Andrea Cunningham. *Please see 3. One to One Andrea 16 Oct 2019 and 4. One to One Pamela 13 Nov 2019*

f) Monthly meetings with my manager, Anita Carroll and the other Heads of Service in Functional Support Services, where Datix, complaints and risks were discussed as part of the agenda. *Please see 7. FSS HOS notes 23 11 2020.* These Heads of Service were Sandra McLoughlin, Kate Corley and Katherine Robinson. These discussions were to provide information and learning to the team, for cascading through their service.

g) Good Management Good Records (GMGR) – This guidance provides a framework for consistent and effective records management based on advice and publications from the Ministry of Justice and Public Records Office Northern Ireland. www.health-ni.gov/uk/topics/good-management-good-records. The aim of the guidance is to establish a framework for records management in relation to the creation, use, storage, management and disposal (destruction or archiving) of all types of DoH, HSC and Public Safety records

h) Integrated Elective Access Protocol (IEAP) The purpose of this protocol is to outline the approved processes for managing referrals to outpatient clinics, diagnostic procedures, elective procedures and operations and AHP booking procedures, through to discharge, to allow consistent and fair care and treatment for all patients. *Please see 9a. doh-integrated-elective-access-protocol.*

i) Data Quality reports – see 10.1 a and 10.2

j) Spot checks by Information Governance. *Please see 10. Information Governance Compliance Check Report – Medical Records – CAH*

k) Patient Satisfaction Surveys. *Please see 11. 20160811 Patient Satisfaction Survey*

l) Key Performance Indicators (KPIs) to include number of charts pulled and filed per month, percentage of charts missing for clinics/admission per month. *Please see 12. KPIs Health Records*

m) Spot checks on the wards for chart availability, information recorded correctly. *Please see 13. Ward Clerk Audit Spot Check*

8. **Was your role subject to a performance review or appraisal? If so, please explain how and by whom this was carried out and provide any relevant documentation including details of your agreed objectives for this role, and any guidance or framework documents relevant to the conduct of performance review or appraisal.**

8.1 My role as Head of Health Records was subject to a performance review and this was carried out by my direct line manager – Anita Carroll, Assistant Director of Functional Services. This was carried out as a face to face meeting with an agreed Development Review form being signed by both myself and my line manager. *Please see 9. One to One with Helen Forde Nov 2020*

8.2 Documentation in the form of a KSF Personal Development Review Form was completed. *Please see 14. Helen PDP Part A and B June 2019*

8.3 Guidance of framework documents relevant to the PDP are:

a. Knowledge and Skills Framework (KSF)
b. Good Management Good Records (GMGR) see link in 7.1
c. General Data Protection Regulation (GDPR). *Please see 20. Data Protection Policy*
d. Key Priorities Plan. *Please see 15. FSS Key Priorities 2019 – 2020*
Mandatory training

9. **Where not covered by question 8 above, please set out any relevant policy and guidelines, both internal and external as applicable, governing your role. How, if at all, are you made aware of any updates on policy and guidance relevant to you?**

9.1 Policies governing my role as Head of Health Records are:

(a) Safeguarding the transportation of Patient, Client, Staff files policy. *Please see 16. 20190108_SafeguardingMovementTransportationofPatientClientStaffTrustRecordsFilesOtherMediaBetweenFacilities_Policy_V2*

(b) Records Management Procedures. *Please see 17. 20201230_RecordsManagementProcedures_V4.0 (1)*

(c) Records Management Policy. *Please see 18. 20210303_RecordsManagement Policy_V2.9_IG*

(d) Information Technology Security Policy 1.3 March 2021. Please see 19. *SHSCT Information Technology Security Policy*

(e) SHSCT General Data Protection Regulation and Data Protection Act 2018 Policy. *Please see 20. Data Protection Policy*

(f) Information Governance Framework. Please see 21. *20191121_InformationGovernanceFrameworkReport_V1.0_SHaughey*

(g) Corporate Mandatory Training Policy

(h) Data Quality Policy April 2021. Please see 22. *Data Quality Policy April 2021*

(i) Technical Guidance for Patient Administration System (PAS). Please see 23. *PAS Technical Guidance for Recording Delayed Transfers of Care Definitions and Guidance - Feb 2021*

9.2 I was made aware of updates on policy and guidance relevant to me by:

a) My Assistant Director (Anita Carroll) sat on the Information Governance Committee and so informed me of any updates, changes or new policies relating to Information Governance within my area

b) I sat on the Data Protection Committee and so was involved with any updates, changes or new policies relating to Data Protection. I arranged for the Information Governance team to carry out training on the new GDPR guidance for my staff. This was carried out in face to face training session.

c) Changes, updates or new policies were cascaded down through the Acute Services system, and in addition global emails would be sent

d) All information is available on Sharepoint

e) I chaired the Patient Administration System (PAS) Committee and changes/upgrades to the system, or instruction from the Health and Social Care Board on new ways of recording information were discussed at this meeting. The PAS team would work with staff from the relevant area, eg., if there was a change in recording of admissions they would have worked with the staff involved in admitting patients, in drawing up internal Technical Guidance for PAS applicable for their area. When the recording method and definitions were agreed the guidance would be sent to the managers with admin responsibility in Acute Services and this would have been cascaded through their areas, with relevant training being provided as required. *Please see 23. PAS Technical Guidance for Recording Delayed Transfers of Care Definitions and Guidance - Feb 2021*

10. **What performance indicators, if any, are used to measure performance for your role?**

10.1 Performance indicators for my role as Head of Health Records were:

a) Data Quality Reports
b) KPIs for my service to be provided to my Assistant Director, Anita Carroll
c) IEAP
d) Ward Audit reports
e) Standard Operating Procedures

10.2 Data Quality Reports – my service used the Patient Administration System (PAS) and the Northern Ireland Regional Accident and Emergency System (NIREAS) to record patient activity. The Trust Business Objects system could then interrogate the information held on these systems and provide a suite of data quality reports which would provide information on where there was incorrect data recording. These reports could be provided by the Data Quality team to the managers, or the managers could run these reports themselves as and when required. There was a regular Data Quality meeting at which these reports and incorrect recording would have been discussed. For my areas I ran these reports on a weekly/monthly basis to ensure all information was correct, and discussed any issues with my managers, who then raised these with individual staff. *Please see 24. Validation Reports run by Head of Health Records and Team, and 25. Validation Reports update from Megan***.** The incorrect recording was fixed and action taken in the form of either pointing out the error to the staff member, of if there was a consistent problem with a particular member of staff, or group of staff, in providing retraining that area. The data collection for my areas was very good and staff were informed of the quality of their data collection. *Please see 26. 20191009 eEMS Validation*

10.3 KPIs- I provided KPIs on a monthly basis for my line manager, Anita Carroll. These showed the work carried out in Health Records each month, such as the number of charts pulled per month, the number of charts filed per month, along with the percentage availability of charts for the clinics. *Please see 12. KPIs Health Records*

10.4 All Emergency Department attendances have to have the presenting diagnosis of the patient coded on NIRAES. (N Ireland Accident and Emergency System). A KPI was provided on a monthly basis which showed the number of attendances which were coded and the number of attendances which were not coded. *Please see 12. KPIs Health Records*

10.5 Integrated Elective Access Protocol (IEAP) – this protocol lays out how appointments are to be made and this would have applied to my ward clerks and reception staff. If a patient, on discharge from the ward, required a review appointment the ward clerk would be responsible for making this appointment and following the IEAP guidelines. If the review was to be in 6 weeks or less they would make the appointment and give to the patient, but if the appointment was for more than 6 weeks, they would put the patient onto an outpatient waiting list indicating the time for review, eg., 6 months. This appointment would appear on a waiting list that the Referral and Booking Centre use to send for review appointments. This same process would also apply to the reception staff at the outpatient reception desk. This guidance would be incorporated into the Standard Operating Procedure. *Please see 27. SOP FOR CHECKLIST FOR E-DISCHARGES ON WARD 211115*

10.6 Ward Audit Reports – the Ward Clerk Supervisor would visit the ward to carry out an audit of the practices on the ward. *Please see 13. Ward Clerk Audit Spot Check*

10.7 Standard Operating Procedures (SOPs) – SOPs were in place as a guide to the staff in how to perform their day to day tasks. *Please see 27. SOP FOR CHECKLIST FOR E-DISCHARGES ON WARD 211115*

10.8 There were other performance indicators or monitoring that could have been used, however, due to staffing levels these were not used/carried out. Health Records is a support service for the Directorates. The Trusts were issued with instructions that they had to improve waiting times for inpatient and outpatients as per the IEAP. These were strictly managed, with Trusts having to report on each individual patient who breached their waiting time. Every Trust was under immense pressure to ensure that all patients were seen in the appropriate timeframe. This meant that clinics would have been set up at short notice to make sure patients did not breach their timeframe. Although this was good for the patient it put great strain on all staff, including the Health Records staff who had to get charts at short notice for newly arranged clinics – and make sure the charts were in the right hospital for the clinic. The Health Records Department in Craigavon Area Hospital is spread over 8 libraries on the Craigavon Area Hospital site, and if the chart has been pulled for a clinic, an admission or a query it can be in any location on the site, as well as any location on any of the other Acute sites. Therefore staff plan their work, and prepare several clinics at one time so ensuring that they maximise their time and plan their journeys to each of the libraries and wards for locating the charts. This method of having clinics at short notice prevented the staff in planning their workload as they would have to make their journey for just one chart due to the timeframe they were working to. This made the service much more inefficient, but it met the demand of the short notice clinic. Working practices like this, and also staffing levels did not provide the Health Records service with the ability to carry out more monitoring. One of the monitoring tools that could have been used was looking at all of the charts tracked out to individual offices/locations and checking to see if they were actually where they were tracked out to. (Tracking refers to a function on PAS in which you enter in the hospital number of the chart and you can record that the chart has been sent to a particular office, clinic, ward so when you

need to find this chart you check where it is tracked to and then you go to that location to find it). If we had carried out this monitoring it would have shown us the extent of the number of charts that were tracked to Mr O'Brien's office and his secretary's office but that were not in either office, and then we could have asked Mr O'Brien to declare which of these charts he had at home. You could not assume that if the chart was tracked to his office or his secretary's office and it wasn't there that it would be in his home, as staff did remove charts from locations without tracking them, eg., a doctor may have taken a chart to discuss with another doctor and not told anyone that they were removing the chart, so as far as tracking is concerned it would appear that the chart would be in Mr O'Brien's office, but this would not be the case. However, due to staffing levels and also the fact that I do not think it would have changed anything I did not ask for this to be carried out. My reason for thinking that it would not change anything was based on the fact the none of my previous actions – conversation, email, Datix, escalation to Assistant Director level had resulted in any change.

11. **How do you assure yourself that you adhere to the appropriate standards for your role? What systems were in place to assure you that appropriate standards were being met and maintained?**

11.1 Please see 10.1(a) and 10.2 re Data quality reports, and 10.1(b) and 10.3 re KPI reports

11.2 Spot checks would have been carried out by managers, to ensure that the libraries were locked, no trolleys of charts left unattended, that the size of the chart was appropriate and did not need to be split into smaller charts, that ward areas and receptions were clean, tidy and no confidential information left lying around. Spot checks on the correct wearing of uniform would also have been carried out. Any issues were immediately brought to the attention of the staff and resolved.

11.3 I had regular team meetings with my managers – Pamela Lawson, Sinead Corr, Helen McCaul and Andrea Cunningham, to discuss their issues and raise concerns. There was also an open-door policy in my area where any member of staff could ask to come and see the manager if they wanted to discuss something on an individual or private basis. My managers also held team meetings with their staff.

11.4 The lead nurses for the wards and ED were based on the Admin Floor in close proximity with me and my ED and Ward Clerk manager, Sinead Corr. Any day to day issues were discussed informally and resolved. This meant that I was aware of Admin issues on the wards or with the ED staff and they were dealt with there and then.

11.5 Every morning the ward clerk would check to make sure that all patients on the ward were recorded on PAS with the correct details such as correct consultant, speciality, date of admission. The ward clerk would then compare this with the electronic FLOW board on the ward. The FLOW board would show which patient was in which bed, their consultant and specialty. It was the responsibility of the nursing staff to keep the FLOW board up to date when the ward clerk was not on duty, and make sure that any discharges were recorded, or if a patient was transferred to another ward that this was recorded on FLOW. This information would then be available to the Bed Management team to assist them with locating beds for patients in ED. In the morning the ward clerk would check that the information was correct and also matched the information they would have been given by the nursing staff following their handover. By checking all of this information it provided a clear picture of who was on each ward, under which consultant and specialty and on what date.

11.6 In Health Records tracking of a chart is very important as charts move from one location to another so it is the only way of determining where a chart could be located. If a chart is to be moved from one area to another it is tracked to the new area and PAS has to be updated so not only are you be able

to find the chart easily but it will also give an audit trail of where the chart has been. *Please see 28. Information/Guidance for Casenote Tracking*

11.7 Guidance regarding records management has been given to the Medical Directorate for including in doctors induction to provide them with information on good practice when dealing with a chart. *Please see 29. Doctor's Induction – Admin Process, and 30. Poster for Doctors Information A4*

11.8 Trust policies are in place to provide instruction and guidance on adhering to appropriate standards – as per 9.1. *Please see:*

16. Safeguarding the Transportation of Patient, Client, Staff files policy
17. 20201230_RecordsManagementProcedures_V4.0 (1)
18. 20210303_RecordsManagement Policy_V2.9_IG
19. SHSCT Information Technology Security Policy
20. Data Protection Policy
21. 20191121_InformationGovernanceFrameworkReport_V1.0_SHaughey
22. Data Quality Policy April 2021
23. PAS Technical Guidance for Recording Delayed Transfers of Care Definitions and Guidance - Feb 2021

12. **Have you experience of these systems being by-passed, whether by yourself or others? If yes, please explain in full, most particularly with reference to urology services.**

12.1 Quite frequently the FLOW board would not be updated during the evening/night time which meant when the ward clerk came in there was additional work to find out where patients were, who had been discharged or who transferred to another ward. This was applicable to all wards in Craigavon Area Hospital and Daisy Hill Hospital.

12.2 Charts would be moved from one location to another without being tracked on PAS, and in the case of Urology Mr O'Brien would frequently take

charts home and keep them there. The chart would be tracked to his office but when staff when to retrieve the chart it would not be there. They would then contact Mr O'Brien or ask his secretary to check with him, and ask if he had the chart at home, and if he did would he return the chart to the hospital. The earliest record I have of this is on 21 June 2012 when Health Records needed 3 charts all of which were in Mr O'Brien's house. I had emailed Martina Corrigan at the time to let her know about the 3 charts and to say that charts should not be removed from the hospital. *Please see 40. 20120621 Charts for Urology.* A Datix was also completed at the time (W[Irrelevant redacted by the USI]

13. What systems of governance do you use in fulfilling your role?

13.1 Datix - If there has been an incident I use Datix to record the incident, and inform those involved or associated with the incident, eg., a letter filed in the wrong chart. These incidents are then investigated, appropriate action taken and are discussed at the Assistant Director's Head of Service monthly meeting to ensure learning is cascaded through the team.

13.2 Risk Register – Risks are identified at local level and included in a Risk Register which I would review regularly discuss with my staff. *Please see 31. Risk Register 2020 Head of Health Records*. If the risks could not be dealt with at my level they are recorded on my Assistant Director Anita Carroll's Department Risk Register. *Please see 32. FSS Div HOS RR Nov 2019*

13.3 Complaints – complaints received in my area are investigated and replied to. If there is any learning this is discussed at my manager's meeting and also at my Head of Service meeting with my Assistant Director. As Head of Health Records I have very few complaints to deal with and any complaints that were received were of a minor nature and easily dealt with, eg., a patient not happy with the attitude of a receptionist.

13.4 Standard Operating Procedures as per 10.1(e), 10.7 and *27. Standard Operating Procedure Checklist*

13.5 Key Priorities – my manager, Anita Carroll and I developed and agreed a yearly workplan for me, as per 8.3 and *15. FSS Key Priorities 2019 – 2020***.** This provided the basis of the work which I was to take forward during the year. In turn I also developed and agreed a workplan with each of my managers – Pamela Lawson, Sinead Corr, Helen McCaul and Andrea Cunningham. *Please see 5. Workplan for HHR managers*

13.6 IEAP (Integrated Elective Access Protocol) see 10.1(c), 10.5 and 7.1

13.7 Information Governance Framework. Please see 21. *20191121_InformationGovernanceFrameworkReport_V1.0_SHaughey*

13.8 Data Protection. Please see 20. *Data Protection Policy*

14. Have you been offered any support for quality improvement initiatives during your tenure? If yes, please explain and provide any supporting documentation.

14.1 There is a Quality Improvement Team who are available for advice and guidance regarding any quality improvement initiative you would like to carry out in your area – this resource is available to all staff.

14.2 Extension of Ward Clerk Hours – I provided a paper requesting additional ward clerk hours to be provided in Craigavon Area Hospital and Daisy Hill Hospital to ensure there would be cover on the wards in the evenings and at weekends which would assist the nursing staff by having admin support for longer periods and would also help the ward clerks deal with their workload.

This was approved and additional hours were implemented in June 2016. *Please see 33. Extension of Ward Clerk Provision V06 – 5 April 2016*

14.3 Storage of records was a huge problem with the Trust having to send charts to a private off site storage facility. It was agreed that a facility on the St Luke's site would be given to Health Records for their chart storage with the proviso that the charts would be taken back from the off site storage facility thus providing a cost savings. *Please see 34. Proposal for the additional storage of Health Records in Craigavon Area Hospital*

15. During your tenure, who did you understand was responsible for overseeing the quality of services in urology?

15.1 My understanding was that the responsibility fell under the following structure:

a. Director of Acute Service
b. Assistant Director for Surgery and Elective Care
c. Associate Medical Director
d. Head of Service for ENT and Urology

15.2 My services came under the Assistant Director of Functional Support Services (Anita Carroll).

16. In your experience, who oversaw the clinical governance arrangements of urology and, how was this done?

16.1 In my experience this structure for overseeing the clinical governance was:

a. Director of Acute Services
b. Medical Director
c. Associate Medical Director

d. Clinical Director
e. Assistant Director of Surgery and Elective Care
f. Head of Service for ENT and Urology

16.2 I have no clear understanding of how the clinical governance arrangements were put in place or overseen and am unable to answer this part of the question.

17. Did you feel able to provide the requisite service and support to urology services which your role required? If not, why not? Did you ever bring this to the attention of management and, if so, what, if anything, was done? What, if any, impact do you consider your inability to properly fulfill your role within urology had on patient care, governance or risk?

17.1 I was able to provide the requisite service required.

17.2 I would have been able to provide an enhanced service which would have included more validating of charts tracked to offices had I had more staffing. My staffing levels were such that we carried out the core business and the staffing levels were exacerbated by the short notice clinics as mentioned in 10.8.

17.3 If we had had more staff to provide validation services we would have been able to check the charts tracked to Mr O'Brien's office and present the Head of Service, Martina Corrigan, with a list of charts not in the office and so be aware of the extent of the situation. However, management were aware that this was a problem, without this validation taking place, as I would have spoken to the Head of Service, Martina Corrigan about this, and also sent emails, completed Datix and escalated to my Assistant Director, Anita Carroll, who in turn escalated to the Assistant Director for Acute Services. *Please see:*

35. 20150127 Aob and charts at home

36. 20110114 Triage of Urology outpatient letters

37. 20111007 Escalation Process or issues/concerns from the Booking Centre

38. 20161123 Mr O'Brien and charts

39. 20120621 Charts for Urology

40. 20150304 MR AOB

41. 20150105 AOB chart

43. 20201204 Datix for Missing charts

18. Did you feel supported by staff within urology in carrying out your role? Please explain your answer in full.

18.1 My service played a support role in that we provided a service which supported the directorates in acute in the delivery of their service. While I felt supported in any discussion with the Head of Service, Martina Corrigan, in that Martina would agree to raise the issue of charts being held at home with Mr O'Brien, however there was no change in the working practices. So my request for support was not dealt with. I cannot quantify how often this would have happened but it would have been over several years, with the first email that I have written being in June 2012. *Please see 39. 20120621 Charts for Urology*. Due to proximity of our offices we would have had conversations about the fact that there were charts at home and this caused Records additional problems as it took up more of their time chasing up the chart. Unfortunately, I cannot give more detail on frequency or times.

18.2 I did raise these concerns with my Assistant Director, Anita Carroll and she escalated them to the Assistant Director Heather Trouton. *Please see;*

35. 20150127 Aob and charts at home

44. 20131014 Chart with AOB

Urology services

19. Please explain those aspects of your role and responsibilities which are relevant to the operation, governance or clinical aspects of urology services.

19.1 My role and responsibilities were to provide a service to the directorates in acute by providing:

A} A records function, so a patient chart would be available for a clinic, an admission, a day case, ward attender, or for dealing with a complaint or datix.

B} Providing reception cover at the main reception areas to check patients in to the clinic, update their details and make a review appointment for the patient.

C} To provide a ward clerk service on the ward, ensuring filing was up to date, PAS was updated and making review and follow-up appointments as required.

20. With whom do you liaise directly about all aspects of your job relevant to urology? Do you have formal meetings? If so, please describe their frequency, attendance, how any agenda is decided and how the meetings are recorded. Please provide the minutes as appropriate. If meetings are informal, please provide examples.

20.1 I liaised directly with the Head of Service, Martina Corrigan regarding urology issues. Due to the proximity of our offices on the admin floor I could call in with any issues and discuss. This would have been an informal verbal discussion and on an ad hoc basis. There would have been no record taken of this discussion.

20.2 If the issue was about staffing I would raise with my own Assistant Director, Anita Carroll, although staffing issues would not have been solely related to urology but would be in general.

20.3 I did escalate issues to Anita Carroll regarding the charts at home and she in turn escalated to the Assistant Director at the time – Heather Trouton. *Please see:*

35. 20150127 Aob and charts at home

44. 20131014 Chart with AOB

21. In what way is your role relevant to the operational, clinical and/or governance aspects of urology services? How are these roles and responsibilities carried out on a day to day basis (or otherwise)?

21.1 Please see 19.1

21.2 On a day to day basis the staff in Health Records would know what charts to get for the urology clinic and they would pull these charts, and prepare them for the clinic or admission in the same ways as they pulled and prepped charts for all clinics and admissions.

21.3 The ward clerk would file charts, update PAS and make follow-up appointments in the same way as they would for every ward and specialty.

22. What is your overall view of the efficiency and effectiveness of governance processes and procedures within urology as relevant to your role?

22.1 Governance processes relevant to my role related to my staff completing a Datix when a chart required for a clinic was found to be in Mr O'Brien's house. From the period 08/05/13 – 1/8/14 there were 29 Datix completed relating to 63 charts. *Please see 43.* [Irrelevant redacted by the USI] *Datix for Missing*

charts. It had not been our practice to complete a Datix when the chart was at Mr O'Brien's home but as the problem continued we started to complete a Datix each time a chart was in Mr O'Brien's house commencing in May 2013, and continuing until we were told not to complete any more Datix by the Director of Acute Services at the time, Debbie Burns. (see 22.3)

22.2 My view regarding the effectiveness of this process would be that it was not effective as no change in working practices were ever made, and I was not made aware of what action was taken in the management of the Datix.

22.3 We were asked to stop completing the Datix related to Mr O'Brien having charts at home by the Director of Acute Services at that time, Debbie Burns. This was a conversation on the corridor. I cannot recall the date of this conversation but our Datix stopped on 1/8/14 (with only one in 2016 an one in 2019) and Debbie Burns moved from Acute in approximately April 2015, so I would put the date in the region of August 2014 – April 2015. Debbie Burns stated that Mr O'Brien was being helpful to her and she did not want him annoyed I had mixed feelings about this as my staff were annoyed about having to search for charts to find that they were not in the office, and therefore their time was wasted in the search by having to chase up to get the chart the next day from Mr O'Brien and the situation did not improve. However, my manager was filling in a Datix each time this occurred but nothing was being achieved, and so her time was being wasted. It felt as if there was no point in us highlighting this concern as nothing was going to be done about it.

23. Through your role, did you inform or engage with performance metrics or have any other patient or system data input within urology? How did those systems help identify concerns, if at all?

23.1 I used Data Quality reports to check recording of information but there were no issues with my data quality reports in urology as per 10.1(a) and 10.2. *Please see 24. Validation Reports run by Head of Health Records and Team*

23.2 Health Records used the Casenote Tracking function on the Patient Administration System to record the location of charts. This did show a large volume of charts tracked to Mr O'Brien but we did not follow this up as no action was taken when we identified issues with Mr O'Brien's working practices, therefore I felt it was not practical to ask our very busy staff to carry out additional work which, in my opinion, and based on the fact that nothing had changed with our escalation and Datix reporting, would not change anything with regard to the charts being taken home.

24. Do you have any specific responsibility or input into any of the following areas within urology? If yes, please explain your role within that topic in full, including naming all others with whom you engaged:

(i) **Waiting times**

(ii) **Triage/GP referral letters**

(iii) **Letter and note dictation**

(iv) **Patient care scheduling/Booking**

(v) **Prescription of drugs**

(vi) **Administration of drugs**

(vii) **Private patient booking**

(viii) **Multi-disciplinary meetings (MDMs)/Attendance at MDMs**

(ix) **Following up on results/sign off of results**

(x) **Onward referral of patients for further care and treatment**

(xi) **Storage and management of health records**

(xii) **Operation of the Patient Administrative System (PAS)**

(xiii) **Staffing**

(xiv) **Clinical Nurse Specialists**

(xv) **Cancer Nurse Specialists**

(xvi) **Palliative Care Nurses**

(xvii) **Patient complaints/queries**

24.1(ii) Triage/GP referrals – up to 2013 I was responsible for the Referral and Booking Centre and the manager Katherine Robinson. At that time there were issues with Mr O'Brien not triaging referral letters. The Referral and Booking Centre (RBC) manager, Katherine Robinson, brought this to the attention of the Head of Service for Urology, Martina Corrigan and the Director of Acute Services, Gillian Rankin, at the weekly Tuesday performance meetings. The RBC manager, Katherine Robinson took forward this issue with the Head of Service for Urology, Martina Corrigan directly. *Please see:*

36.20110114 Triage of Urology outpatient letters

37. 20111007 Escalation Process or issues/concerns from the Booking Centre

24.2 (x) Onward referral of patients for further care and treatment **–** I am responsible for the ward clerks who are responsible for making review appointments or referring a patient to a new service following their discharge from hospital. This duty was carried out following the guidance as per the SOP and in line with IEAP guidance. There were no issues with regard to the urology service and this area. *Please see 27. SOP FOR CHECKLIST FOR E-DISCHARGES ON WARD 211115*

24.3 (xi) Storage and management of health records. I have responsibility for the storage, issue and retrieval of patient charts. My two Health Records Managers – Pamela Lawson and Andrea Cunningham are responsible for the day to day management of the service. The role of Health Records is to provide

safe and secure storage of charts, ensure they are available as required and to manage the life cycle of the chart in line with Good Management Good Records framework.

24.4 (xii) Operation of the Patient Administration System (PAS). I am responsible for my staffs input of data into PAS – for the accuracy of information and the correct use of the system. This is governed by the Technical Guidance of PAS and also in line with IEAP guidelines on booking appointments. I run monthly data quality reports which provide information on incorrect recording on PAS. This information is then corrected and the individual member of staff informed of the errors. Refresher training is provided if there is a persistent problem. *Please see 23. PAS Technical Guidance for Recording Delayed Transfers of Care Definitions and Guidance - Feb 2021*

Concerns

25. Please set out the procedure which you were expected to follow should you have a concern about an issue relevant to patient care and safety and governance.

25.1 I would gather all the information and if it is an issue that cannot be resolved within my own area then this should be raised with the Head of Service for the specific area, while also informing my own Assistant Director. A Datix would be raised detailing out the issue. Due to the formation of the Datix reporting system all those with responsibility for the concern would be notified for their input into the investigation of the issue, eg, if the Datix is coded as a breach of confidentiality this would trigger Datix to include the Information Governance team.

25.2 If the issue was a concern that could be addressed within my area I would add it to my Risk Register.

25.3 In addition to the formality of completing a Datix and adding to a Risk Register I would also alert the Head of Service and my AD either verbally or via email to ensure that everyone was aware of the issue in a timely manner.

26. Did you have any concerns arising from any of the issues set out at para 24, (i) – (xvii) above, *or any other matter* regarding urology services? If yes, please set out in full the nature of the concern, who, if anyone, you spoke to about it and what, if anything, happened next. You should include details of all meetings, contacts and outcomes. Was the concern resolved to your satisfaction? Please explain in full.

26.1 The only concern I had regarding urology services was the fact that Mr O'Brien kept a large volume of charts in his office and also took charts home without telling anyone. I do have to comment that when we needed a chart for an admission or for an outpatient clinic, and asked Mr O'Brien to bring the charts back to the hospital he always did so the following day. We were only aware of a chart being in Mr O'Brien's house if we went to retrieve it if we needed it for an admission or outpatient clinic and went to look for it in Mr O'Brien's office. After a search of his office, and his secretary's office, if the chart could not be found the Records staff or the secretary would contact Mr O'Brien to see if he had it in his house, and then he would be requested to bring the chart with him the next day. I can only comment on the charts that Health Records requested Mr O'Brien to return from home, and cannot comment on how often or how quickly Mr O'Brien would return charts not requested by Health Records to the hospital.

26.2 This concern was raised verbally and via e-mail with the Head of Service, Martina Corrigan and Martina Corrigan said she would raise this with Mr O'Brien. I see in one of my emails that I have commented that Simon Gibson was dealing with this – unfortunately due to the period of time that has passed I cannot remember what discussion took place with Simon Gibson but I think it was that Mr O'Brien was being investigated and this would be dealt with via that

investigation. I want to stress that I am not sure that this recollection is accurate, this is an assumption on my part. *Please see:*

38. 20161123 Mr O'Brien and charts
39. 20120621 Charts for Urology
40. 20150304 MR AOB

26.3 The issue was not resolved as Mr O'Brien did not return the charts back to the hospital.

27. Did you have concerns regarding the practice of any practitioner in urology? If so, did you speak to anyone and what was the outcome? Please explain your answer in full, providing documentation as relevant. If you were aware of concerns but did not report them, please explain why not.

27.1 Please see response to question 26

28. If you did have concerns regarding the practice of any practitioner in urology, what, in your view was the impact of the issue giving rise to concern on the provision, management and governance of urology services?

28.1 The issue giving rise to concern regarding the chart being at Mr O'Brien's house was that it could impact on all services not just urology, as the chart could be required for another service, eg general surgery, if the patient was attending a general surgery clinic and had been given a short notice appointment and the chart was at Mr O'Brien's house then it would not be available for the clinic.

28.2 A further concern was that I had no way of knowing how or where the charts were stored in Mr O'Brien's house and therefore could not tell if they were held safely and securely.

29. What steps were taken by you or others (if any) to risk assess the potential impact of the concerns once known?

29.1 I did not risk assess the impact as it was not my risk to assess, in that I could not control it or be in a position to make a change. I advised the Head of Service, Martina Corrigan of the concern and informed my Assistant Director Anita Carroll. Anita Carroll did raise the issue with the Assistant Director for Surgery and Elective Care – Heather Trouton to ask Heather if she had included this on her Risk Register. *Please see 35. 20150127 Aob and charts at home*

30. Did you consider that the concern(s) raised presented a risk to patient safety and clinical care? If yes, please explain by reference to particular incidents/examples. Was the risk mitigated in any way?

30.1 There could have been a risk to the patient if the chart contained specific information relating to the patient condition that would not be available electronically. The majority of clinical information is now available on NIECR with the exception of some investigations such as pulmonary function tests and cardiology investigations involving TOMCAT. If a consultant had made some handwritten notes in the chart which were not transcribed in the letter then this would not be available for the consultation. I do not recall there being an instance when the chart was not brought into the hospital by Mr O'Brien in time for the admission or the outpatient clinic.

30.2 When asked to bring a chart in from home Mr O'Brien always brought it in the next day, however, there was an instance where a patient was in the Emergency Department and the chart was requested. As it was in Mr O'Brien's house we had to contact him urgently, and fortunately he had not left the house at the time and was able to bring the chart in to the hospital with him. The Head of Service, Martina Corrigan was aware of this. This is the only example of an emergency request for a chart that was in Mr O'Brien's house. *Please see:*

41. 20150105 AOB chart

30.3 The risk of the chart not being available would be mitigated by the fact that we now have the Northern Ireland Electronic Care Record (NIECR) which provides a large amount of clinical information electronically. The risk is further mitigated by the fact that the patient's GP could be contacted during working hours to find any further information. (see 30.1)

30.4 It should be noted that due to the fact that the Southern Trust uses several facilities for outpatient clinics and surgery the chart may also not be available to someone in Majors as it could be in another facility at the time.

31. Was it your experience that once concerns were raised, systems of oversight and monitoring were put in place? If yes, please explain in full.

31.1 With regard to my one specific concern then it was not my experience that a system of oversight and monitoring was put in place.

32. In your experience, if concerns are raised by you or others, how, if at all, are the outcomes of any investigation relayed to staff to inform practice?

32.1 I was not aware of any outcome of an investigation. At one stage I was asked to attend an interview with Neta Chada and Siobhan Hynds to discuss my concerns as part of an investigation into the working practices of Mr O'Brien. I attended an interview and provided a statement but was never informed of any outcome of this investigation. *Please see:*

42. 20170515 STRICTLY CONFIDENTIAL – TO BE OPENED BY ADDRESSEE ONLY

33. Did you have any concerns that governance, clinical care or issues around risk were not being identified, addressed and escalated as necessary within urology?

33.1 I was not aware of any clinical care issues in urology so I did not have concerns, I just felt that Mr O'Brien's admin working practices were not being challenged.

33.2 I was aware of an issue with triage not being completed by Mr O'Brien which could affect the clinical care for a patient, as they would not be triaged by a consultant and therefore may not be seen in the correct timeframe. See point 38.2.

34. How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such Governance meeting minutes or notes, or in the Risk Register, whether at Departmental level or otherwise? Please provide any documents referred to.

34.1 I did not have access to Trust governance documents such as minutes or notes. With regard to the Risk Register I had access to my Risk Register and that of the Functional Support Services team, but the issue with regard to the charts being taken home would not be included in the FSS risk register, as I did not own that risk and was not in a position to manage the risk. If I had put this risk on my Risk Register it would have meant that I was able to either resolve the risk or reduce it. With regard to Mr O'Brien having charts at home I could do neither, I could not resolve or reduce the risk as Mr O'Brien was not under my management structure and so I had to go through the managerial chain of command with regard to my issue, and also I could not police what Mr O'Brien took home, and when. My Assistant Director, Anita Carroll, did ask the Assistant Director for Surgery and Elective Care, Heather Trouton, if she should put this risk on her departments Risk Register. *Please see:*

35. 20150127 Aob and charts at home

40. 20150304 MR AOB

35. What could improve the ways in which concerns are dealt with to enhance patient safety and experience and increase your effectiveness in carrying out your role?

35.1 Improvement could come in the way of having confirmation that the concern is raised and an outcome of the discussion provided, and to see a change in practice with the concern being resolved. I feel that concerns should be raised in a more formal platform withformal feedback being received regarding the concern rather than verbal conversations35.2 In hindsight I feel I should have been much more formal in my approach to this concern, detailing every conversation, asking for follow up, requesting a formal meeting to discuss when things did not change.

Staff

36. As relevant, what was your view of the working relationships between urology staff and other Trust staff? Do you consider you had a good working relationship with those with whom you interacted within urology? If you had any concerns regarding staff relationships, did you speak to anyone and, if so, what was done?

36.1 I had a good working relationship with the Head of Service, Martina Corrigan and due to the close proximity of our offices our interaction tended to be informal.

36.2 I had no working relationship issues with other staff in urology. I did not have contact with urology staff with the exception of Martina Corrigan, and I was not aware of any working relationship issues with urology staff and other Trust staff.

37. In your experience, did medical (clinical) managers and non-medical (operational) managers in urology work well together? Whether your answer is yes or no, please explain with examples.

37.1 I was not aware of any issues with clinical and operational staff in urology. The only observation I can make is that I would have heard Martina Corrigan talk about "my boys", meaning her consultants, and due to the close proximity of our offices I was aware of phone calls with her consultants and herself. During these phone calls I never heard anything that caused me to feel there were any issues. I would also have seen Mr Young, Consultant Urologist in Martina's office, and they seemed to have a good working relationship.

Learning

38. **Are you now aware of governance concerns arising out of the provision of urology services which you were not previously aware of? Identify any governance concerns which fall into this category and state whether you could and should have been made aware of the issues at the time they arose and why.**

38.1 Working in the Urology Lookback Review team I am now aware of concerns that I previously wasn't aware of such as inappropriate use of medication and delay in arranging treatment. As these are clinical issues I should not have been made aware of them at the time as I had no involvement in clinical issues.

38.2 I was aware of issues regarding the delay of triage associated with Mr O'Brien. These issues were taken forward with the Head of Service Martina Corrigan, and the Referral and Booking Centre manager, Katherine Robinson. *Please see 36. 20110114 Triage of Urology outpatient letters and 37. 20111007 Escalation Process or issues/concerns from the Booking Centre*. This was also discussed at the Performance Meeting with the Director of

Acute Services at that time - Dr Gillian Rankin. I was aware that it was agreed (have no knowledge of who made the decision) that for Mr O'Brien's referrals the GP categorisation of Red Flag, Urgent or Routine would be used as the triage to determine the urgency of the appointment.

39. **Having had the opportunity to reflect on these governance concerns arising out of the provision of urology services, do you have an explanation as to what went wrong within urology services and why?**

39.1 I have no input into the clinical areas/issues regarding urology services. My remit with regard to urology would have been in an admin role and the issues in my area that went wrong are associated with admin working practises.

40. **What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and, to the extent that you are aware, the concerns involving Mr. O'Brien in particular?**

40.1 I feel that the learning is that as an organisation we need to be more formal in how we approach concerns, then we gather the information, make informed decisions about what the outcomes need to be and then put into place a plan to address and resolve the issues. I feel that the fact someone is a consultant does not mean that you do not challenge their working practices. I believe that we have become an organisation that is so busy with bed pressures that we allow that busyness to take over from important issues that perhaps we do not want to tackle.

41. **Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. Your answer may, for example, refer to an individual, a group or a particular level of staffing, or a particular discipline.**

If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

41.1 I believe there was a failure to engage. I feel the issues should have been raised by the Head of Service, Martina Corrigan in a formal way alongside the lead urologist at the time (do not know who that was at that time). If there was no change/improvement then this should have been escalated to the Assistant Director – initially Heather Trouton and then Ronan Carroll, together with the Clinical Director. I was not aware of any clinical issues with his work but did know of the admin issues. I feel that as soon as issues were raised they should have been fully investigated, documented and an action plan put in place. As the issues of concern have had serious implications for the patient I feel that the investigation should have started immediately following them being raised, but as we work in a busy environment and several people would need to be involved I feel that initial steps should have been taken within a month to get a broad understanding of the situation and then a robust plan and timeframe in place to complete the investigation. However, as I have no input into the clinical concerns I do not know if this did take place. I am unclear as to whether engagement did not take place due to no-one wanting to challenge Mr O'Brien, or whether it was because everyone was so busy.

42. **Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?**

42.1 I do not believe that my team and I made mistakes but on reflection I would have carried out a full review of all the charts tracked out to tracking

codes associated with Mr O'Brien. Then, using this information I would have arranged a thorough search of his office and his secretary's office to validate which charts were actually in the offices. This would have produced a list of charts that were tracked out to Mr O'Brien but that were not actually in their tracked location. This would have given a clear picture of the extent of charts not in his office. However, I failed to do this, mainly because I felt that if I asked my staff to do this piece of work, which would take them some time, nothing would have been done, and nothing would change. I based this belief on the fact that although I raised the issue many times, and it was escalated through the service, and I could demonstrate that there were charts at Mr O'Brien's house that were required for admissions or clinics that no-one did anything. I had been told to stop completing Datixs by the Director of Acute Services, Debbie Burns, I had escalated the issue, my Assistant Director Anita Carroll had asked if it should be placed as a risk on the Risk Register – all of this and nothing was done. I felt it would have been wrong to ask my staff to do additional work when I did believe that there would be no change. Having reflected this is not a good enough reason not to have done this, but that was what I believed.

42.2 I believe that everyone is so busy with the day to day work and providing a service in difficult circumstances that important issues like governance can slip and loose its momentum.

42.3 There needs to be more of a focus on governance and the importance of it in the day to day running of the service.

42.4 I feel that the Head of Service, and Assistant Director did make a mistake in not addressing the chart issue – Datix was used to highlight the problem but nothing changed and I received no feedback as to what action was taken. There is nothing I could have done differently as I raised the concerns through the Trust's Datix system until I was told to stop by the Director of Acute Services, Debbie Burns. I also raised my concerns via conversation and email to the Head of Service, Martina Corrigan. I raised my

concerns with my Assistant Director, Anita Carroll, who escalated to the Assistant Director of Surgery and Elective Care, Heather Trouton.

43. **Do you think, overall, the governance arrangements were and are fit for purpose? Did you have concerns specifically about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?**

43.1 Having answered the questions I am conscious of a lack of knowledge of governance arrangements for clinical services, and the lack of information from governance meetings provided to staff, so in answer to this question I would say that the governance arrangements are not fit for purpose, and require some amendments to ensure all staff are aware of what the arrangements are and have access to governance information.

43.2 I had no concerns regarding governance arrangements during my tenure.

44. If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.

44.1 I have nothing else to add.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this

will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: _____Helen Forde_____

Date: _____21 October 2022_____

S21 78 of 2022

Witness statement of: Helen Forde

Table of Attachments

Attachment	Document Name
1	JD Head of Health Records and Admin Services Band 8a
2	Agenda of ED and WC Meeting on 19 Nov 2019
3	One to One Andrea 16 Oct 2019
4	One to One Pamela 13 Nov 2019
5	Workplan for HHR managers
6	KSF 19.6.20 Pamela Lawson
7	FSS HOS notes 23 11 2020
8	Departmental Induction June 2019
9	One to One with Helen Forde Nov 2020
9a.	doh-integrated-elective-access-
10	Information Governance Compliance Check Report – Medical Records – CAH
11	20160811 Patient Satisfaction Survey
12	KPIs Health Records
13	Ward Clerk Audit Spot Check
14	Helen PDP Part A and B June 2019
15	FSS Key Priorities 2019 – 2020
16	20190108_SafeguardingMovementTransportationofPatientClientStaffTrustRecordsFilesOtherMediaBetweenFacilities_Policy_V2_3

17	20201230_RecordsManagementProcedures_V4.0 (1)
18	20210303_RecordsManagement Policy_V2.9_IG
19	SHSCT Information Technology Security Policy
20	Data Protection Policy
21	20191121_InformationGovernanceFrameworkReport_V1.0_SHaughey
22	Data Quality Policy April 2021
23	PAS Technical Guidance for Recording Delayed Transfers of Care Definitions and Guidance - Feb 2021
24	Validation Reports run by Head of Health Records and Team
25	Validation Reports update from Megan
26	20191009 eEMS Validation
27	SOP FOR CHECKLIST FOR E-DISCHARGES ON WARD 211115
28	SOP – Casenote tracking
29	Doctor's Induction – Admin Process
30	Poster for Doctors Information A4
31	Risk Register 2020 Head of Health Records
32	FSS Div HOS RR Nov 2019
33	Extension of Ward Clerk Provision V06 – 5 April 2016
34	Proposal for the additional storage of Health Records in Craigavon Area Hospital

35	20150127 Aob and charts at home
36	20110114 Triage of Urology outpatient letters
37	20111007 Escalation Process or issues/concerns from the Booking Centre
38	20161123 Mr O'Brien and charts
39	20120621 Charts for Urology
40	20150304 MR AOB
41	20150105 AOB chart
42	20170515 STRICTLY CONFIDENTIAL – TO BE OPENED BY ADDRESSEE ONLY
43	20201204 Datix for Missing charts
44	20131014 Chart with AOB

Southern Health and Social Care Trust

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Head of Health Records and Admin Services

Southern Health and Social Care Trust

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JOB DESCRIPTION

JOB TITLE	Head of Health Records & Admin Services
BAND	8A
DIRECTORATE	Acute
INITIAL LOCATION	Craigavon Area Hospital
REPORTS TO	Assistant Director of Functional Support Services
ACCOUNTABLE TO	Director of Acute Services

JOB SUMMARY

The role of the Head of Health Records is to ensure the provision of a comprehensive, efficient and effective health records service which includes responsibility for Ward Clerks, Outpatient receptionists, Emergency Department and Minor Injuries Admin staff for the Acute Directorate in the Southern Health & Social Care Trust.

The Head of Health Records will strategically plan for the future of the health records service and will lead the implementation of the patient electronic record in the future.

The Head of Health Records will manage the budget for all admin staff employed in the Health Records Departments, Outpatients reception, Emergency Department and Ward Clerks.

The Head of Health Records will develop a culture of patient and client responsiveness, flexibility and quality. As a member of the Functional Support Services Senior Management Team, he/she will share corporate responsibility for achievement of Team objectives, be committed to multidisciplinary working in driving forward a culture of change, innovation, development and modernisation.

KEY DUTIES / RESPONSIBILITIES

1. Ensure the provision of a comprehensive, efficient and effective Health Records Service on a Trust-wide basis, within the resources available and in accordance with statutory requirements.

2. Provide leadership and professional advice on health records.

3. Plan and implement a single acute patient record for the Southern Health and Social care Trust and in the longer term, a patient electronic record.

4. Ensure that the Health Records Departments across the Trust comply with the Data Protection Act, Subject Access Requirements and the Access to Health Records (1990). Ensure compliance with Records Management Control Assurance standards.

5. Represent the Trust on external or regional committees regarding Health Records and associated Information systems, e.g. eEMS.

6. Manage contracts with external storage supplies.

7. Improve data quality and data recording through the development and implementations of procedures to help staff understand the importance of their data input and get it right at the source of entry.

8. Develop a culture of client and patient responsiveness, flexibility and quality. Involve patients and clients in setting performance indicators and ensure regular feedback on progress.

9. Strive to develop new ways of working to improve effectiveness and efficiency in service delivery, such as 'bank' staff to provide essential cover during staff absenteeism.

10. Ensure that health and social care records are available and accessible to meet the demands of patient on a 24-hour basis and will develop and implement a 'real time' service in the future.

11. Develop, implement and review a Health Records strategy, policies and procedures and monitor and evaluate implementation of these. This will ensure that all Acute Health Records are available for patient care at the appropriate time and place.

12. Manage and delegate the work of the various departments and groups of staff ensuring that duties are carried out to the required standard and within agreed deadlines.

13. Demonstrate strategic thinking in order to enable delivery of future changes to the service against the e-Health agenda. The postholder will play a leading role in the strategic planning and development of the electronic patient health records,

14. Plan and facilitate changes in workload, e.g. waiting list initiatives, clinical audit and research, peripheral clinics.

15. Keep abreast of the increasing legislative issues affecting the service and ensure that measures are devised and implemented and staff briefed accordingly across the diverse number of sites.

16. Develop and maintain work relationships with other colleagues to ensure achievement and objectives and effective team working. The postholder has the freedom to adapt, devise and implement policies and procedures regarding the health records service. If these policies or procedures affect other departments, this must be carried out in partnership with the other heads of service.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

The Trust supports and promotes a culture of collective leadership where those who have responsibility for managing other staff:

1. Establish and promote a supportive, fair and open culture that encourages and enables all parts of the team to have clearly aligned goals and objectives, to meet the required performance standards and to achieve continuous improvement in the services they deliver.

2. Ensure access to skills and personal development through appropriate training and support.

3. Promote a culture of openness and honesty to enable shared learning.

4. Encourage and empower others in their team to achieve their goals and reach their full potential through regular supportive conversation and shared decision making.

5. Adhere to and promote Trust policy and procedure in all staffing matters, participating as appropriate in a way which underpins Trust values.

RAISING CONCERNS – RESPONSIBILITIES

1. The post holder will promote and support effective team working, fostering a culture of openness and transparency.

2. The post holder will ensure that they take all concerns raised with them seriously and act in accordance with the Trust's 'Your Right to Raise a Concern (Whistleblowing)' policy and their professional code of conduct, where applicable.

3. The post holder will, in the event of a concern being raised with them, ensure that it is managed correctly under the Trust's 'Your Right to Raise a Concern (Whistleblowing)' policy and ensure feedback/learning is communicated at individual, team and organisational level.

EMERGENCY PLANNING & BUSINESS CONTINUITY RESPONSIBILITIES

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

PERSONAL AND PUBLIC INVOLVEMENT RESPONSIBILITIES (PPI)

Promote and support the implementation of the Trust's PPI Strategy and ensure all staff are aware of their responsibilities as appropriate to their job role.

GENERAL REQUIREMENTS

The post holder will be required to:

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

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

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

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

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

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

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

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

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

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

October 2020

Southern Health and Social Care Trust

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PERSONNEL SPECIFICATION

JOB TITLE AND BAND	**Head of Health Records & Admin Services Band 8A**
DEPARTMENT / DIRECTORATE	**Functional Support Services / Acute**
HOURS	**Full-time / 37.5 hours per week**

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

Notes to applicants:

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

ESSENTIAL CRITERIA

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

Factor	Criteria	Method of Assessment
Qualifications / Experience	A relevant degree or professional qualification in Records Management or Business/Management and have at least 2 years' experience working in a middle management role *(equivalent to NHS/HSC Band 5 level)* with responsibility for records management .**OR** have a HND/HNC in Business related subject and 3 years' experience working in a middle management	Shortlisting by Application Form

	role *(equivalent to NHS/HSC Band 5 level)* with responsibility for records management **OR** have at least 4 years' experience working in a middle management role (equivalent to NHS/HSC Band 5 level) with responsibility for records management. A minimum of 1 years' experience of managing a team of staff.	
Other	Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. *This criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post.*	Shortlisting by Application Form
SECTION 2: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage:		
Skills / Abilities	Have an ability to provide effective leadership and strategic direction Demonstrate evidence of managing priorities to achieve successful outcomes Demonstrate evidence of influencing and delivering improvement in service outcomes High level of verbal and written communication skills Able to establish effective working relationships Staff management and the ability to effectively motivate a team Must be a team player and have personal initiative and drive	Interview
Knowledge	In depth knowledge of Health records management and legislation affecting the Health Records function.	Interview

DESIRABLE CRITERIA		
SECTION 3: these will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these criteria. Failure to do so may result in you not being shortlisted		
Factor	**Criteria**	**Method of Assessment**
Experience	A minimum of one year's experience working in a middle management role (equivalent to NHS/HSC Band 5) in health records management.	Shortlisting by Application Form

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

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

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

THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER

Southern Health and Social Care Trust

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

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

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Agenda of Emergency Department and Ward Clerks Managers Meeting

Date : 20 Nov 2019 **Time : 9.30 am**
Venue : CAH

Agenda Item	Notes
Present	
SOP for timesheet	
eEMS *Standing item – for discussion if any matters arising*	
Health and Safety *Standing item – for discussion if any matters arising*	
Training *Standing item – for discussion if any matters arising*	
Data Quality / Validation/ Recording Issues *Standing item – for discussion if any matters arising*	Monthly check completed and recording very good
Departmental Work • Induction • SOPs • Training • New ways of working *Standing item – for*	None discussed

discussion if any matters arising	
Lessons Learnt *Standing item – for discussion if any matters arising*	
Managers Updates *Standing item – for discussion if any matters arising*	
AOB	
Date and Time of Next Meeting	

1 : 1 Meeting Andrea

Andrea	16 October 2019
Neurology chartless clinic any progress	Follow up with Dr Craig. Awaiting confirmation from Clinical Lead Dr Forbes. Pamela & Andrea to meet with Dr Forbes.TBC
Using FLOW for admission charts – any good?	Outstanding – AC to go through with PL
Location Database for records **(2 in circulation – need one copy only)**	WIP – Date in Diary for Villa to complete asap. Helen to email Managers to update Andrea with any changes.
DNA letters – any issues with process	None reported. Queries answered with updated SOP circulated & saved in J drive.
Oral Surgery charts	Met with Eimear beg Oct, Office procedure manual & J drive updated and any issues to be highlighted to AC.
e-triage letters DHH & ACH	DHH working well. AC went through checking PC (step by step process & how to guide) with ACH staff again Oct 19.
Standing Items (to be discussed as required) Staff in Post Vacancies Mandatory Training Work Plan Risk Register Data Validation Health and Safety Security and Confidentiality	Claire McAlister Personal Information redacted by the USI X3 WTE vacancies E-req completed x2 currently with Finance Ac spoke with Resourcing team – awaiting Finance sign off Unable to confirm block booking/perm post Kenan – declined 12-8pm shift – Resourcing team updated Verified Joe Bennett hrs – 9-5pm on E-req checked with HR/Resourcing No E-req to be approved unless 8am-8pm DHH 16,27 WTE (inc LTSL Estelle) B5 not inc ACH 1.53 WTE Villa 4 WTE (inc Laura on M/L) Health and Safety – update on First Aid in Villa. Louise - First Aid training SLH 3/12/19 SOP's/Review of processes/training templates. Storage space- hold on destruction. Options explored. Additional shelving, move charts up top shelf (across yard) 18 rows. AC advised H&S risk identified for anyone under 5'6 & risk of damage to charts (flood; no barrier) Pre-assessment reports – can't do anything with. Dating back to April 18. AC to link in with Caroline Barron. Storage space. Hold on destruction. Implemented internal weed/movement of charts. No destruction. Changes documented and circulated & displayed. Meeting with OPD SR arranged Thurs 24th Oct – to confirm arrangements on security of charts after hours and/or exiting Dept.

Andrea	16 October 2019
Records Management Issues Staffing Issues	
Any Other Business	T&O discharge filing. No room Aids& Appliances from NY. AC Proposal – scan documentation. Audits – recuperate costs. HOS approval.AC to send detail to HF. Duplication; time spent recording. HF joint meeting. Banding A&C. Datix – point of discovery v service area. Wards misfiling not HR Protected time for HRM. Clanrye works. Lifts/HR to remain unaffected. No requirement for contingency plan. Personal Information redacted (porter) query monthly pay. Give option to move to monthly. Float for HR/ED/Wards suggested – for further discussion @ HHRec meeting, Ambulance query – Checked with cashier office – nothing currently in place to reclaim costs for patients outside SHSCT boundaries. Orla backfill. HR B3 – backfill required if that were the case. Rena – SAR photocopying & Litigation scanning. Pharmacy request for notes. Go back to Sec.Look for notes. Consent. X-ray datix – storage space trolleys (x5 Surgical trolleys identified with cable ties). Trolleys not fit for purpose (external). Approval from HF for AC to look for something more suitable. Travel expenses submitted. Kilkeel Paed clinic paperless however Secretary requesting/requires charts. DHH Flexi – Meeting with Loughlin tbc. Start/finish time DHH Car parking - waiting list.
Date of Next 1 : 1	

1 : 1 Meeting Pamela

Pamela	10 Sept 2019
Jackie and Nursing	
MIU scanning	
Chartless clinic update re Derm and Paed – any progress?	No issues from Derm. Helen to check with Dr O'Hagan. Paed Diab going to Newry leisure centre. Records giving the clinic list and labels to S Millar who will take them to the leisure centre and bring them back in a tamperproof envelope. Responsibility of paeds to look after information. No filing to be done. Pamela to talk to Dr Forbes re neurology in CAH
Placement for student	
Filing awareness for doctors update	Complete the guidance and talk to HoS re meeting the doctors
Staff in Post Headcount of staff per site WTE of staff per site	Standing item
Vacancies	Still with BSO
Mandatory Training update including PDP	7 outstanding and all scheduled
Work Plan	Standing item
Risk Register	Standing item
Data Validation	Standing item
Health and Safety	Standing item
Security and Confidentiality	Standing item
Records Management Issues	

Pamela	10 Sept 2019
Staffing Issues	Pamela to let Helen know of next team meeting in STH and Helen will go to the start of the meeting to see the staff.
Any Other Business	
Date of Next 1 : 1	

Head of Health Records
Workplan Key Priorities 2019

Service	Objective	Responsibility	Completion Date	General Progress Update	Helen McC	Kate	Pamela	Sinead
Health Records CAH	missing chart database	Pamela	ongoing	all missing charts on database - work now ongoing to locate all missing charts. Barry put in charge of missing charts. Database updated to include all pages and labels. No pages and labels to go into filing cabinet except by Barry. Intensive search to be made for all charts when database is up to date.				
Health Records CAH	PDP and mandatory to be brought up to date	Pamela	ongoing	Backlog in PDPs - all to be updated starting Jan 19				
MIU STH								
MIU STH	new rota to replace Jacynth and to cover increased volume in MIU	Pamela	complete	Bernie Tiffney to start in MIU on permanent basis 30/04/18. Will look at using clinic prep staff to cover more hours if required. Figures to be shown to Helen Forde for comparison with ED CAH.				
A&E CAH	removal of typing log - coding department	Nicola	complete	No problems				
A&E CAH	removal of Doctor's Audit	Nicola	phasing out stage	currently monitored by Supervisors only - phasing out - review before removing				
A&E CAH	Rota's	Nicola		4 week coding rota in place & sent for 3 months ahead & ED rota out 4-5 weeks in advance for all staff - working well in department				
CAH Ward Clerks	4 Week Rota	Nicola	complete	5 weeks rota sent to staff				
A&E CAH	ED Workshop	Nicola	complete	next meeting 13.06.18				
Health Records staff DHH	Green and buff IS folders to be filed	Kate	completed 3rd May 2018	All green and buff coloured IS folders filed				
Health Records staff DHH	Loose IS filing to be completed	Kate	ongoing					

Health Records staff DHH	Weed started	Kate	ongoing	Aiden started 01.05.18				
Health Records staff DHH	CAH BF9's	Kate/Liam	ongoing	Completed May 2018				
Health Records staff DHH	Log of big charts updated	Kate	complete May 2018	Ramone updated list of big charts in lower libraries, forwarded misc R.I.P's to villa				
Health Records staff DHH	Tracking of charts ENT office	Kate	complete 15th May	All charts in ENT office tracked and validated				
Health Records staff DHH	Tracking of charts in medical offices	Kate	ongoing	Fiona, Eimear				
Health Records staff DHH	Tracking of charts Pain and Renal offices	Kate	complete 5th June	All charts in Pain and Renal offices tracked and validated				
WARD CLERKS	MFD moved to back wall and new extended work bench for ward clerk completed	Helen	Jun-18	completed June 2018				
RENAL UNIT	additional filing cupboards ordered for renal unit	Helen	June	Completed June 2018				
WARD CLERKS	To look at induction pack with ward clerks and amend as appropriate	Helen	to be arranged	ongoing				
ED	moving of records from lower ground store to car park store to make room for 2018 ed records move	Helen	on going	June 2018 to be completed				
Health Records staff DHH	Tracking of all dermatology/FOV charts	Kate	complete 8th June	Fiona				
Health Records staff DHH	All medical/derm offices charts tracked	Kate	complete 11th June	Fiona				
A&E CAH	Tea Breaks	Nicola	complete April 2018	No problems - tea breaks are not to be kept until end of shift to allow staff to leave early from shift				
A&E CAH	F.A.S.T Training	Nicola	complete May 2018	some staff were trained by Margaret O'Hagan in ED on FAST training - FAST booklet emailed to all remaining staff with instruction that should they wish any training to alert a supervisor or myself to facilitate.				

A&E CAH	Full-Time CDU Ward Clerk	Nicola	ongoing					
A&E CAH	Scanning & Quality Improvement Workshop	Nicola	Ongoing	Testing complete and move to live for under 4s in Dec 18				
A&E CAH	Registering of patients on eEMS using PAS numbers	Nicola	complete					
A&E CAH	Removal of Admission Slips & printer	Nicola	complete					
A&E CAH	ED induction	Nicola	complete	new general induction process updated - working well in the department and reduces induction talking time to allow for more hands-on training to commence at an earlier stage				
A&E CAH	PDP, Mandatory training updates for 2018	Nicola	complete					
CAH Ward Clerks	PDP, Mandatory training updates for 2018	Nicola	complete					
CAH Ward Clerks	Induction updated	Nicola	complete	new general induction process updated - working well in the department and reduces induction talking time to allow for more hands-on training to commence at an earlier stage				
A&E CAH	ED training spreadsheet	Nicola	ongoing	ED specific training spreadsheet for IOR & FAST and individual areas for all staff within ED department				
A&E CAH	ED Locum Rota	Nicola	complete	meetings held and complete - ED locum rota handover to commence by end of June 2018				
A&E CAH	X-ray request process	Nicola	complete	New x-ray request times have been implemented as per SOP - working well within department - reduces number of x-rays for audit				

A&E CAH	X-ray report process	Nicola	Implemented 21.05.18	updated SOP June 2018 - slight change to process to allow for disposal of more reports before sending on to wards/discharging Consultant & Secretary - *few issues raised from Consultants as to need for these being emailed to them - review in 1 month*				
A&E CAH	Diagnosis/Coding difficulties	Nicola	complete	emailed list of difficult codes - to be raised with BSO in regards to upadating eEMS to faciliate new codes to allow for easier coding process				
CAH Ward Clerks	MRI - bed/chair requests	Nicola	ongoing	Met with Gillian Reaney in regards to this process & streamlining the questions asked to the ward clerks in respect that these are medical question - Gillian to speak with Sharon Glenny re getting this from nursing staff - *await response*				
CAH Ward Clerks	Ward files	Nicola	Complete 04.06.18	All wards now have in place ward files for ward activity/replacing ward returns				
CAH Ward Clerks	Gastro forms	Nicola	Complete 01.06.18	all wards have been instructed to make the provision of gastro forms to be available for medical staff to complete - SOP updated and working well in department				
CAH Ward Clerks	Charts-Ward	Nicola	ongoing	admission charts process ongoing - audit in place for new process to reduce build-up of backfiling and charts not being available				
CAH Ward Clerks	Backfiling	Nicola	Ongoing	3ESU - backfiling large number of episodes outstanding. Tackled and process in place, there has been a good improvement but we will need to faciliate some *addditional hours to reduce backfiling further*				

CAH Ward Clerks	Datix Charts	Nicola	ongoing	issue raised re number of datix charts being requested from ward clerks - taking them from their duties at times - *ongoing review*				
CAH Ward Clerks	Access Clinic	Nicola	ongoing	Access Clinic - Steering group meeting held 30.05.18 - Lisa to attend sub-group meeting in relation to recording - *await further meeting*				
A&E CAH	DWA's - night shift	Nicola	ongoing	training being provided to night staff to complete DWA's at time of disposal for a more complete process				
CAH Ward Clerks	radiology red flags	Nicola	Complete 18.04.18	provided clarity on process for radiology red flags and provided generic email addresses for peace of mind where the ward clerk wanted to send referral on				
A&E CAH	Respiratory alerts - eEMS	Nicola	complete	124 backlog all complete and patient records updated - SOP completed and sent - working well in department				
A&E CAH	SOP Recording of Bloods	Nicola	updated 15.05.18	ongoing issue raised in relation to ward clerk taking down clinical information - *review*				
A&E CAH	Monthly timesheet guidance	Nicola	complete	new updated guidance sent to all staff - *review 1 month*				
CAH Ward Clerks	Monthly timesheet guidance	Nicola	complete	new updated guidance sent to all staff - *review 1 month*				
A&E CAH	Discharge Summaries	Sinead	ongoing	backlog of 62 discharge summaries as of 11.06.18 awaiting completion by Doctor - dating from 30.04.18 - *escalated 120618 - review*				
CAH Ward Clerks	Outstanding discharge letters	Nicola	ongoing	backlog on certain wards - *review*				

A&E CAH	Admissions not recorded	Nicola	ongoing	Nursing staff sending patients to wards without notifying admin staff so admissions are not being recorded - ward clerks are highlighting where patients are not being admitted, Majors Ward Clerk also highlighting - have escalated to Sharon but still an ongoing problem - *escalate & review again*				
CAH Ward Clerks	Admissions not recorded	Nicola	ongoing	patients arrivng on wards having not been admitted by ED - escalated to Sharon to raise with Nursing - ongoing issues				
Health Records DHH	Set up Sharepoint for SOP's	Orla	ongoing	Encourage staff to improve IT skills and to move to paperless. SOP's to be updated and put in same format before uploading				
			ongoing	reramone updated list of big charts in lower libraries, forwarded misc R.I.P's to villa				
WARD CLERKS DHH/CAH	programme for refresher training with IT for Ward clerks	Helen/ Nicola	ongoing	Refresher training sessions set up on alternate month basis. DHH commencing 12/11/18 and the CAH December				latest session held on 01/05/19, another date TBA
ED DHH	Installation of heat curtai	Helen	ongoing	minor works request raised, have been advised plans to build on porch to ED entrance.				
ED DHH	Pilot of DTA ward in ED	Helen/ Dr Muckian	ongoing	Pilot of DTA ward in ED. Staff trained on FLOW. Issues with incomplete discharges being addressed.				
ED & Ward Clerks dhh	Update all PDPS	Helen	ongoing	update all PDPS				
ED & Ward Clerks dhh	Update all mandatory tra	Helen	ongoing	encourage staff to complete all mandatory training asap.				
ED DHH	Move to new office	Helen	ongoing	order desks/pcs/phones for new office				
Health Records DHH	Changes to Destruction of charts	Orla/Pamela	ongoing	Create updated SOP's for the destruction of charts to include information about looking for a history of blood transfusion				
Health Records DHH	Rotation of Staff	Orla	ongoing	Getting staff trained in all areas so that there is more job rotation, and to ease pressures when staffing issues occur				
ED RECORDS VILLA 3	Storing of records in new	Helen	to be comp	Helen to take Conor and Tom over to Villa 3 to refile ED records correctly.				
ED STAFF DHH	Updated training on majc	Helen	to be arran	Helen to undertake updated training on major incident with all ED staff				
Health Records	APE charts look at merging in Villa weed	Pamela/Helen	Jan-19					

Health Records CAH	charts to be moved to Villa 3 from top of bays in Frist E library	Pamela	complete 1	Sean and Stephen pulled and tracked all charts and sent to Villa 3. Raymond released from CAH 17, 18 and 19 December to help interfile in Villa.				
Health Records CAH	large weed required in First E basement	Pamela	ongoing	to be sent over periodically and Raymond released to help in Villa				
ED CAH	DWA's							
ED CAH	Storage of records going to Villa	Sinead	completed	ED flimseys are to be taken to basement where they will be collected by transport, this is working well. New process of flimseys to be sent to STH on a weekly/fortnightly basis to try and keep the back office clear				start new process May 19
ED CAH	Breaking Paed Machine	Sinead	on going	Machine keeps breaking, has been reported, but keeps breaking.				
ED CAH	Zebra printer required for Green Area	Sinead	on going	Zebra printer was requested in Oct 18, still not assigned to the area, still waiting				
ED CAH	Flimseys being filled out correctly	Sinead	on going	HOS and AD to be sent issue log on a monthly basis to see if an improvement can be made, suggest a traning session from Admin to all Doctors and an explaination of the importance of filling out the forms correctly.				Continuous problem log is being kept
Ward Clerks	WEEKLY WARD WALKS	Sinead	on going	weekly ward walks to be completed by Sinead/Lisa to complete ward audit sheets which will be used to help with staff performance, Service Improvement and maintaining standards				
Ward Clerks	Introduction of Bloods	Sinead	On going	All ward clerks to be trained on the ordering of bloods, 2 new members of staff have been requisitioned slowly for this job but all ward clerks need to be shown.				

ED CAH	Training on FLOW	Sinead	ongoing	3 staff to be trained, just waiting on dates, will have completed training by the end of Jan 19.				All staff in ED have receive d their FLOW training
Ward Clerks								
Ward Clerks	Filing Protcol refresher	Sinead/Pamela	ongoing	Next refesher training due Nov 19.				
Health Records CAH	CAH weed 2019	Pamela	ongoing	First E's being weeded first and then B's as they are so badly overcrowded.				
Health Records CAH	T&O weed	Pamela	ongoing	all Es weeded - Bs started as at 30/01/19				
Health Records CAH	yellow process folders to each reception in CAH.	Pamela	complete	all complete before RQIA inspection. Noticeboards ordered - to be put up in each reception area				
ED RECORDS DHH	Move 2016 paeds to carpark store	Helen	ongoing	Plans in place to move records to car park store. Plans also in place to sort store and ensure all filing up to date. Helen and Orla to move records Thurs 2 May 2019				
DAU	new department DAU	Helen	ongoing	DAU opened in DHH 04/02/2019				
ED AND WARD CLERKS	SOPS TO BE UPDATED	Helen/Sinead	ongoing	to update all SOPs for ED and Ward clerks - room booked in Banbridge for away day on the 29/03/19 to complete. Helen and Sinead to arrange further day away to complete remaining sops. Need to meet with Helen to update Ward Clerk SOP just need to arrange a date				
ED AND WARD CLERKS	Incident log set up re technology issues	Helen/Sinead	ongoing	Log being kept of IT issues within departments				
ED AND WARD CLERKS	Delayed discharge coding	Helen/Sinead	ongoing	Weekly audits to be carried out for outstanding tracker forms on all wards, update to be given to Helen each week				

ED AND WARD CLERKS	ED Rota	Helen F/Sinead	ongoing	Met with John Creaney (unison)/ Loughlinn Duffy8th March to discuss potential change to rota - meeting arranged with staff 20/03/19 to discuss review, staff have forwarded on their rota, have made a few changes, just need to arrange to meet with Union Reps and staff to go through.				
ED AND WARD CLERKS	Back filing on wards	Sinead	ongoing	Discuss plan with each individual ward re their back filing and how to get cleared, get figures from each ward for the end of March. May 19 Have just received information from ward clerks, working on a plan to get all back filing cleared off the wards.				
Health Records DHH	MFD move	Andrea	complete					
Health Records DHH	Prep room move	Andrea	complete					
Health Records DHH	Structured Training program inc duties checklist (inc SOP ref)	Andrea	complete					
Health Records DHH	SOP's updated on log and referenced	Andrea	complete					
Health Records DHH	Complete swweep HR libraries DHH	Andrea	complete					
Health Records DHH	Daily stats database	Andrea	complete					
Health Records DHH	Other duties log	Andrea	complete					
Health Records DHH	Office procedure manual (yellow folder) in place for each area	Andrea	complete					
Health Records DHH	J drive set up; all staff to have access & folders for each area to include all relevant info	Andrea	complete					
Health Records DHH	Additional scanners for HR DHH	Andrea	complete					
Health Records DHH	Generic emails for DHH areas	Andrea	complete					
Health Records DHH	Broken locking mechanisms to be replaced	Andrea	complete					
Health Records DHH	Deep clean Health Records DHH	Andrea	complete					

Health Records DHH	Diary sign in/out for Health Records	Andrea	complete	Updated Access to HR including guidance 08.01.20 P&A				
Health Records DHH	Refresher training for HR DHH staff	Andrea	ongoing	Joe training in OPD Oct 19. Aiden desk. Vanessa training w/c 4.11.19 (Eimears area) & Sue x4 weeks Vanessa.				
Health Records DHH	NB info eg Transport box times for all sites on shared drive	Andrea	complete					
Health Records DHH	Separate Trolleys for Sec's & identified with coloured cable ties	Andrea (with Lauri)	complete Sept 19					
Health Records DHH	Staff only signage doors	Andrea	complete Sept 19					
Health Records DHH	MFD/Store Room cleared/tidied	Fiona/Damian	complete Sept 19					
Health Records DHH	Additional security measures D234	Andrea	complete C	key lock in addition to keypad				
Health Records DHH	Regular spots checks HRM & Supervisors	Andrea/Fiona/Dam	ongoing					
Health Records DHH	Utilise resources with SAR's Litigation photocopying/scanning from other Depts.	Andrea	complete S	SOP's & info provided to staff				
Health Records DHH	Meet with DR Craig re Pilot in Health Records	Andrea	complete	Dr Craig happy to trial pending confirmation from clinical lead Dr Forbes				
Health Records DHH	Issuedesk request log set up & access for staff	Andrea	complete					
Health Records Villa	Issuedesk request log set up & access for staff	Andrea	in progress	start with Sec's only, then CAH, DHH etc. ON HOLD DUE to S/L in VILLA OCT 19				
Health Records DHH	Routine library checks to be implemented/incorporated into Rota	Andrea/Fiona/Dam	ongoing					
Health Records DHH	KSF's	Andrea	complete	all HR staff completed up to Sept 19				
Health Records DHH	Training on FLOW	Andrea	complete	date in diary cancelled unforseen circumstances. Completed with Pamela 28.10.19.				
Health Records CAH &	Oasis new system training	Andrea/Pamela	complete					
Health Records CAH &	SOP for SAR (inc verbal req)	Andrea/Pamela	complete					

Health Records CAH &	Information Governance awareness sessions for staff	Andrea/Pamela	complete	IG booklet given to staff Dec 19				
Health Records CAH &	Meeting with Information Gov Managers	Andrea/Pamela	complete Sept 19					
Health Records CAH &	Datix training	Andrea/Pamela/Helen/Megan/Orla	complete Sept/Oct 19					
Villa 3	move Villa staff member (Laura Donnelly) from Pamela to Andrea cost centre	Andrea/Pamela	completed					
Helth Records DHH	Supervisors to move to same office	Andrea	complete	stock/stationary held in this area				
Health Records CAH &	SOP for processing state pathologist requests required	Andrea/Pamela	outstandin	see email 17.10.19				
Health Records CAH &	OCMT requests	Andrea/Pamela	outstandin	query Simon Gibson				
Health Records DHH & ED/Wards DHH	Careers Fair event - table/PC/uniform/freebies/posters	Andrea/Helen McC	complete	Meeting with Anita 09.10.19. Intersting Facts tba. Laptop. Met with Helen/Lauri 30.10.19. Items conf 31.10.19. Actions completed Nov 19.				
Health Records CAH &	Issue desk request log CAH&DHH	Andrea/Pamela/Cia	complete					
Health Records CAH &	Issue desk request access for staff	Andrea/Pamela/Cia	complete					
Health Records DHH	Removal of printer	Andrea	complete -	Issues with HCN not on labels. Staff reminder sent				
Health Records ACH	Removal of letter folding machine	Andrea	check with	ACH.				
Health Records ACH	PC training for Etriage	Andrea	complete					
Health Records CAH &	Meeting with Dr Forbes re Pilot for Health Records	Andrea/Pamela	outstandin	date to be confirmed. Dr Forbes to confirm availability. Pamela spoke to Elaine (Sec)				
Villa 3	Oasis moves	Andrea/Pamela	ongoing	met with H Forde 23.10.19. Figures/detail updated on Location database				
Health Records DHH/Villa/CAH/Ach	Location database	Andrea	ongoing	updates to be sent to Andrea as per email 16.10.19. Ongoing				
Villa 3	Issuesdesk request	Andrea/Pamela	outstandin	to set up & implement new process of ordering charts. ON hold due to s/l in Villa				

Health Records CAH	Ophthalmology - regional	Pamela/Kate	ongoing	all eye notes photocopied and sent to RVH - all known charts now phhotocopied - Sept 2019				
Health Records CAH	VV - regional	Pamela	ongoing	varicose vein information being photocopied and sent to Omagh				
Villa 3	64 boxes for Oasis - Chapel	Andrea	complete 2	request made for boxes to be lifted 23/10/19				
Villa 3	64 boxes for Oasis - ED 15's	Andrea	complete 2	request made for boxes to be lifted 23/10/19				
Villa, Ward 2, Chapel	Check heating on in Chapel daily	Andrea	complete	Davy confirm temp 18 degree x3 dail am/pm/night				
Villa, Ward 2, Chapel	Maintenance to check outlying buildings in sub zero temp	Andrea	complete C	Villa staff to alert Manintenace to any issues/concerns				
Health Records CAH &	Departmental Induction update	Andrea	complete J	Induction maual updated				
Villa 3	Electrical items to be replaced	Andrea	complete D	approval from HF 17.10.19. Items ordered				
DHH OPD	phase I - trolleys/notes/locking after hrs	Andrea	complete N	meeting with MM OPD Sr 24.10.19. Cnc'd. New date tbc. Met with Julie Neilly agreed process. Spoke to Jacqueline McPolan to confirm process Nov 19				
Health Records DHH	Move to Sharepoint		outstandin	roll out				
Health Records DHH	Staff performance	Andrea/Fiona/Dam	ongoing	Detail added to Supervisors folder J drive. Monitored & on going review.				
Health Records DHH	Additional storage solutions for charts - shelving to be added in main library & bench raised	Andrea	pending	assessment and Colin to seek advice from Patrick O'Donnell. Workmen to come back w/c 28.10.19 & to commence works shortly. **Hold - minor works request if to proceed. Benefit v cost so hold**				
Fractures DHH&CAH	CAH Fracture staff upgraded B3	Andrea	check with	To go through JD & duties with Ramone. Completed 30.10.19 & sent to Hforde. Email to HF 04.12.19				
DHH Health Records	Deep cleaning of DHH HR trolleys & Main Library including bay handles	Andrea	completed	Ramone completed deep clean trolleys Nov 19. Fiona completed deep clean of bay handles in main library Dec 19.				
DHH Health Records	Flexi	Andrea	complete N	Meet with [redacted] re flexi				

Health Records	risk register updated HR & Gen	Andrea & Pamela	completd 08.01.20					
Health Records	Tracking Notice	Andrea & Pamela		Emailed HF 08.01.20				
Health Records	Proposal for return chart info	Andrea & Pamela	to commer	Emailed Phyliss 08.01.20				
Health Records	Fratures - centralisation	Andrea & Pamela		Ramone duties - check				
Health Records	IG - guidance for accessing HR libaries	Andrea & Pamela	completed 08.01.19					
Health Records	H&S (risk assess) Documentation for staff	Andrea	completed	circulate to Managers				
Health Records	First Aid administered details sheet	Andrea	to be comp	circulate to Managers + add to First Aid boxes				
Health Records	Oasis - set up accounts DH02 & DH03 + streamline processes.	Andrea	completed	Meeting with Darren & Pamela 21.01.20				
Health Records	update First Aiders notice Villa	Andrea	completed 17.01.20					
Health Records	First Aid box proforma	Andrea	completed	saved to I & J drives				
Health Records	DHH 2020 weed	Andrea	completed					
Health Records	movement of charts	Andrea	on-going					
Health Records	cleared MFD top sheleves & some boxes	Andrea	mostly com	Oct/Nov 2020				
Health Records	Oasis - updating bridge	Andrea/Fiona/Dam	up to date as @ Oct 2020					
Health Records	Oasis - validation exercise/accounts/cost centres/reports to exclude destroyed records	Andrea (Darren - O	on-going					
Health Records	Staff training up to date	Andrea		completed & on-going. Rechecked 16.11.2020.				
Health Records	Prep - flexibility	Andrea/Fiona/Damian						
Health Records	Order new ladders	Andrea & Pamela		Ladders ordered July 2020. Order cancelled due to carriage costs & similar item recommended eproc & h&s approved. Ordered Aug 2020. 2-3 wk delivery. Delays chased with provider. Expected date of delivery 5th Oct 2020. Escalated. Ladders arrived, not suitable.				
Health Records	KSF's	Andrea	Nov-20	10-12 to complete @ 16.11.2020				

Health Records	ENT	Andrea & Pamela	to be confi	explore option of filing by Health Records staff				
Health Records	updating SOP's - sharepoint	Andrea & Pamela	on-going					
Health Records	Clanrye refurb	Andrea		move Hrecords equipment/cages/boxes w/c 16.11.2020 for works commencing				
Health Records	Trainnif staff in Villa for ACH	Andrea/Mary	on-going	David training Oct/Nov 2020. Plan Laura to train following return from M/L				

June 2020

Received from SHSCT on 24/10/2022. Annotated by the Urology Services Inquiry

Integrated Elective Access Protocol

Protocol Summary -

The purpose of this protocol is to outline the approved procedures for managing elective referrals to first definitive treatment or discharge.

Version	**2.0** This guidance replaces the Integrated Elective Access Protocol, 30th April 2008.
Status	Approved
Date	30 June 2020

Integrated Elective Access Protocol

Version

Version	Date of issue	Summary of change	Author
1.0	25 August 2006	New Regional Guidance: Integrated Elective Access Protocol	M Irvine M Wright S Greenwood
2.0	30 April 2008	Protocol refresh to encompass guidance on all aspects of the elective care pathway	M. Irvine, M. Wright, R. Hullat
3.0	30th June 2020	Update and relaunch IEAP to provide updated regional guidance on administration of patients on elective care pathways.	L. Mc Laughlin, Regional IEAP Review Group.

Integrated Elective Access Protocol Review Group

The Integrated Elective Access Protocol Review Group consisted of;

Marian Armstrong, BHSCT,
Roberta Gibney, BHSCT
Andrea Alcorn, NHSCT,
Christine Allam, SEHST,
Anita Carroll, SHSCT,
Paul Doherty, WHSCT,
Deborah Dunlop, WHSCT,
Sorcha Dougan, WHSCT,
Donagh Mc Donagh, Integrated Care
Geraldine Teague, PHA
Linus Mc Laughlin, HSCB

Integrated Elective Access Protocol

Document control

The current and approved version of this document can be found on the Department of Health website https://www.health-ni.gov.uk and on the Health and Social Care Board and Trusts intranet sites.

Document:	Integrated Elective Access Protocol 3.0
Department:	Department of Health
Purpose:	To advise and inform patients and clinical, administrative and managerial staff of the approved processes for managing patients access to outpatient, diagnostic, elective and elective Allied Health Professional (AHP) services.
For use by:	All clinical, administrative and managerial staff who are responsible for managing referrals, appointments and elective admissions.
This document is compliant with:	Northern Ireland Health and Social Care (NI HSCC) and Department of Health (DOH) Information Standards and Guidance and Systems Technical Guidance. https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Home.aspx
Screened by:	
Issue date:	
Approval by:	
Approval date:	
Distribution:	Trust Chief Executives, Directors of Planning and Performance, Directors of Acute Care, Department of Health.
Review date:	June 2022

Monitoring compliance with protocol

Monitoring compliance with the processes in this document should be part of Trusts internal audit processes.

Contents

Abbreviations

AHP	Allied Health Professional
CCG	Clinical Communication Gateway
CNA	Could Not Attend (appointment or admission)
DNA	Did Not Attend (appointment or admission)
DOH	Department of Health
CPD	Health and Social Care Commissioning Plan and Indicators of Performance Direction,
E Triage	An electronic triage system
GP	General Practitioner
HR	Human Resources (Trusts)
ICU	Intensive Care Unit
IEAP	Integrated Elective Access Protocol
IS	Independent Sector (provider)
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
IT	Information Technology
LOS	Length of Stay
MDT	Multidisciplinary Team
NI	Northern Ireland
PAS	Patient Administration System, which in this context refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting.
PTL	Primary Targeting List
SBA	Service and Budget Agreement
TCI	To Come In (date for patients)

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 1

CONTEXT

1.1 INTRODUCTION

1.1.1 This protocol has been developed to define the roles and responsibilities of all those involved in the elective care pathway and to outline good practice to assist staff with the effective management of outpatient appointments, diagnostic, elective admissions and allied help professional (AHP) bookings, including cancer pathways and waiting list management.

1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital and AHP services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations, elective inpatient or daycase treatment and AHP services is the responsibility of a number of key individuals within the organisation. General Practitioners (GPs), commissioners, hospital medical staff, allied health professionals, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time targets as defined in the Department of Health (DOH) Commissioning Plan Direction (CPD) and good clinical practice, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communication with patients is a core responsibility of the hospital and the wider local health community.

1.1.3 The purpose of this protocol is to outline the approved processes for managing referrals to outpatient clinics, diagnostic procedures, elective procedures and operations and AHP booking procedures, through to discharge, to allow consistent and fair care and treatment for all patients.

1.1.4 The overall aim of the protocol is to ensure patients are treated in a timely and effective manner, specifically to:

- Ensure that patients receive treatment according to their clinical priority, with routine patients and those with the same clinical priority treated in chronological order, thereby minimising the time a patient spends on the waiting list and improving the quality of the patient experience.

- Reduce waiting times for treatment and ensure patients are treated in accordance with agreed targets.
- Allow patients to maximise their right to patient choice in the care and treatment that they need.
- Increase the number of patients with a booked outpatient or in-patient / daycase appointment, thereby minimising Did Not Attends (DNAs), cancellations (CNAs), and improving the patient experience.
- Reduce the number of cancelled operations for non-clinical reasons.

1.1.5 This protocol aims to ensure that a consistent approach is taken across all Trusts. The principles can be applied to primary and community settings, however it is recommended that separate guidance is developed which recognises the specific needs of the care pathway provided in these settings.

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

1.1.7 This protocol will be reviewed regularly to ensure that Trusts' policies and procedures remain up to date and that the guidance is consistent with good practice and changes in clinical practice, locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.

1.2 METHODOLOGY

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

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

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

1.2.4 For the purposes of this protocol, the term;

- outpatient refers to a patient who has a clinical consultation. This may be face to face or virtual,
- elective admissions refer to inpatient and daycase admissions,
- inpatient refers to inpatient and daycase elective treatment,
- diagnostic refers to patients who attend for a scan / test or investigation,
- AHP refers to allied health professionals who work with people to help them protect and improve their health and well-being. There are thirteen professions recognised as allied health professions in Northern Ireland (NI),
- partial booking refers to the process whereby a patient has an opportunity to agree the date and time of their appointment,
- fixed booking refers to processes where the patient's appointment is made by the Trust booking office and the patient does not have the opportunity to agree/confirm the date and time of their appointment,
- virtual appointment refers to any appointment that does not involve the physical presence of a patient at a clinic, (see also 1.5 Virtual Activity).
- PAS refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting and those used in diagnostic departments such as NIPACS and systems used for other diagnostics / physiological investigations.

1.2.5 Trusts must maintain robust information systems to support the delivery of patient care through their clinical pathway. Robust data quality is essential to ensure accurate and reliable data is held, to support the production of timely operational and management information and to facilitate clinical and clerical training. All patient information should be recorded and held on an electronic system (PAS). Manual patient information systems should not be maintained.

1.2.6 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on electronic hospital/patient administration systems and the waiting times for treatment.

1.2.7 Trusts should provide training programmes for staff which include all aspects of this Integrated Elective Access Protocol (IEAP). It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts. Trusts will provide appropriate information to staff so they can make informed decisions when delivering and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.

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

1.3 UNDERPINNING PRINCIPLES

1.3.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined and agreed at specialty / procedure / service level.

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

1.3.3 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority.

1.3.4 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be “fit, ready, and able” to come in (TCI).

1.3.5 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures and that daycase is promoted. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving daycase surgery to outpatient care and outpatient care to primary care or alternative clinical models where appropriate.

1.3.6 Referrals into Trusts should be pooled where possible as the norm within specialties.

1.3.7 Trusts will maintain and promote electronic booking systems aimed at making hospital appointments more convenient for patients. Trusts should move away from fixed appointments to partially booked appointments.

1.3.8 Trusts should also promote direct access services where patients are directly referred from primary and community care to the direct access service for both assessment and treatment. Direct access arrangements must be supported by clearly agreed clinical pathways and referral guidance, jointly developed by primary and secondary care.

1.3.9 For the purposes of booking/arranging appointments, all patient information should be recorded and held on an electronic system. Trusts should not use manual administration systems to record and report patient’s information.

1.3.10 In all aspects of the booking processes, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. It is essential that patients who are considered at risk for whatever reason have their needs identified

and prioritised at the point of referral and appropriate arrangements made. Trusts must have mechanisms in place to identify such cases.

1.3.11 Trusts have a responsibility to ensure that children and adults at risk who DNA or CNA their outpatient, inpatient, diagnostic or AHP appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

1.3.12 Trusts must ensure that the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.4 BOOKING PRINCIPLES

1.4.1 These booking principles will support all areas across the elective and AHP pathways where appointment systems are used.

1.4.2 Offering the patient choice of date and time where possible is essential in agreeing and booking appointments with patients through partial booking systems. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them.

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

1.4.4 All booking principles should be underpinned with the relevant local policies to provide clarity to operational staff.

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

1.4.6 The definition of a booked appointment is:

a) The patient is given the choice of when to attend or have a virtual appointment.

b) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment.
c) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within two weeks if cancer is suspected.
d) The patient may choose to agree a date outside the range of dates offered or defer their decision until later.

1.4.7 Principles for booking Cancer Pathway patients:

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

1.4.8 Principles for booking Urgent Pathway patients:

a) Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff.
b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation.
c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the referrers's classification of urgency.

d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.
e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.4.9 Principles for booking Routine Pathway patients:

a) Patients should be booked to ensure appointment (including virtual appointment) is within the maximum waiting time guarantees for routine appointments.
b) Referrals will be received, registered within one working day at booking teams and forwarded to consultants for prioritisation.
c) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified.
d) Patients should be selected for booking in chronological order from the Primary Targeting List (PTL).
e) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment.

1.4.10 Principles for Booking Review Patients;

a) Patients who need to be reviewed within 6 weeks will agree their appointment (including virtual appointment) before they leave the clinic, where possible.
b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list.
c) Patients will be added to the review waiting list with a clearly indicated date of treatment and selected for booking according to this date.
d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment.

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

1.5 VIRTUAL ACTIVITY

1.5.1 Virtual Activity relates to any planned contact by the Trust with a patient (or their proxy) for healthcare delivery purposes i.e. clinical consultation, advice, review and treatment planning. It may be in the form of a telephone contact, video link, telemedicine or telecommunication, e.g. email.

1.5.2 The contact is in lieu of a face-to-face contact of a patient/client, i.e. a face-to-face contact would have been necessary if the telephone/video link/etc. had not taken place.

1.5.3 The call/contact should be prearranged with the patient and /or their proxy. Patients should not be disadvantaged where a decision is made to assess their clinical need through the use of virtual clinics.

1.5.4 The contact must be auditable with a written note detailing the date and substance of the contact is made following the consultation and retained in the patient's records.

1.6 COMPLIANCE WITH LEAVE PROTOCOL

1.6.1 It is essential that planned medical and other clinical staff leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments.

1.6.2 There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.

1.6.3 The protocol should require a **minimum** of **six** weeks' notification of intended leave, in line with locally agreed HR policies, in order to facilitate Trusts booking teams to manage appointment processes **six** weeks in advance.

1.6.4 The booking team should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

1.7 VALIDATION

1.7.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis. This is essential to ensure the efficiency of the elective pathway at all times. In addition, Trusts should ensure that waiting lists are regularly validated to ensure that only those patients who want or still require a procedure are on the waiting list.

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

1.7.3 A New Technical Guidance has been drafted to facilitate Trusts in the recording of the validation work which can be found on the Data Standards Share Point site. Clinical Coding & Information Standards - StandardsandGuidance (hscni.net)

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 2

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

2.1 INTRODUCTION

2.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of outpatient services, including those patients whose referral is managed virtually.

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

2.1.3 There will be dedicated booking offices within Trusts to receive, register and process all outpatient referrals.

2.1.4 Fixed appointments should only be used in exceptional circumstances.

2.1.5 In all aspects of the outpatient booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking polices should be developed accordingly.

2.2 KEY PRINCIPLES

2.2.1 Referrals into Trusts should be pooled where possible within specialties.

2.2.2 All new referrals, appointments and outpatient waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in three priorities, i.e.

1. Red flag (suspect cancer),
2. urgent and
3. routine.

No other clinical priority categories should be used for outpatient services.

2.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order.

2.2.4 Patient appointments for new and review should be **partially booked.**

2.2.5 The regional target for a maximum outpatient waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

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

2.2.7 Patients should not be disadvantaged where a decision is made to assess their clinical need through virtual activity.

2.2.8 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.

2.2.9 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

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

2.2.11 Trusts should **not** use manual administration systems to record and report patients who have been booked.

2.2.12 Trusts should provide training programmes for staff which include all aspects of IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

2.3 NEW REFERRALS

2.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.

2.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.

2.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

2.3.4 All referrals will be prioritised (including those prioritised via E-Triage) within **a maximum of three** working days of date of receipt of referral. Note; Red flag referrals require **daily** triage.

2.3.5 Following prioritisation, referrals must be actioned on PAS and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.

2.3.6 Inappropriate and inadequate referrals should be returned to the referral source immediately and the referral closed and managed in line with the PAS technical guidance.

2.4 CALCULATION OF THE WAITING TIME – STARTING TIME

2.4.1 The starting point for the waiting time of an outpatient new referral is the date the referral is received by the booking office/department.

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

2.5 REASONABLE OFFERS

2.5.1 For patients who are partially booked, a reasonable offer is defined as:

- an offer of appointment, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and **two** appointment dates, and
- at least **one** offer must be within Northern Ireland (NI), except for any regional specialties where there are no alternative providers within NI.

2.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

2.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

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

2.5.5 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

2.5.6 Providers should have robust audit procedures in place to demonstrate compliance with the above.

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

2.6 REVIEW APPOINTMENTS

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

2.6.2 Patients must be recorded on PAS as requiring to be seen within a clinically indicated time. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative time of treatment.

2.6.3 Review patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and PAS updated.

2.6.4 Patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

2.6.5 Virtual review appointments, e.g. telephone or video link, should be partially booked. If the patient cannot be contacted for their virtual review they should be sent a partial booking letter to arrange an appointment.

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

2.7.1 DNAs – New Outpatient

If a patient DNAs their new outpatient appointment the following process must be followed:

2.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they

are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

2.7.1(b) Under exceptional circumstances a clinician may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with clinicians, regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should always be offered.

2.7.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.

2.7.1(d) *Where patients are discharged from the waiting list (ref. 2.7.1(a)) they should be advised to contact the Trust booking office within* ***four*** *weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the* ***four*** *week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the* ***four*** *week period they cannot be reinstated*.

2.7.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

2.7.1(f) Where a patient DNAs a fixed new appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.

2.7.1(g) If the patient DNAs this second fixed appointment they will be removed from the waiting list and the steps in 2.7.1(d) should be followed.

2.7.1(h) If a patient DNA's a virtual outpatient appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

2.7.2 DNAs – Review Outpatient

If a patient DNAs their review outpatient the following process must be followed:

2.7.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.

2.7.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.

2.7.2(c) Where the clinical decision is that a second appointment should **not** be offered, Trusts should contact patients advising that as they have failed to attend their appointment they have been discharged from the waiting list. The referring clinician (and the patient's GP, where they are not the referring clinician) should also be informed of this.

2.7.2(d) *Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the review waiting list with a revised clinically indicated date at the date they make contact with the Trust.*

2.7.2(e) If the patient DNAs the second review appointment which has been partially booked then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

2.7.2(f) Where a patient DNAs a fixed review appointment where they have not had the opportunity to agree/ confirm the date and time of their

appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.

2.7.2(g) If a patient DNA's a virtual outpatient review appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

2.7.2(h) There may be instances for review patients where the clinician may wish to review notes prior to any action to remove a patient because of a DNA or failure to respond to a partial booking letter. Trusts should ensure that there are locally agreed processes in place to administer these patients.

2.7.3 CNAs – Patient Initiated Cancellations of Outpatient Appointments

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

2.7.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.

2.7.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

2.7.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.

2.7.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.

2.7.3(e) If a patient CNA's a virtual outpatient appointment this should follow the above protocol.

2.8 CNAs – HOSPITAL INITIATED CANCELLATIONS

2.8.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, including a virtual appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

2.8.2 The patient should be informed of the cancellation and a new appointment partially booked.

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

2.8.4 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

2.9 CLINIC OUTCOME MANAGEMENT

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

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

2.10 CLINIC TEMPLATE CHANGES

2.10.1 Clinic templates should be agreed between the consultant and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).

2.10.2 Templates will identify the number of slots available for red flag, urgent, and routine and review appointments; specify the time each clinic is scheduled to

start and finish; and identify the length of time allocated for each appointment slot.

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

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

2.11 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

2.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to independent sector (IS) providers.

2.11.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with PAS technical guidance, (see also Reasonable Offers, ref. 2.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

2.12 OPEN REGISTRATIONS

2.12.1 Registrations that have been opened on PAS should **not** be left open. When a patient referral for a new outpatient appointment has been opened on PAS, and their referral information has been recorded correctly, the patient will appear on the waiting list and will continue to do so until they have been seen or discharged in line with the earlier sections of this policy.

2.12.2 When a patient has attended their new outpatient appointment their outcome should be recorded on PAS within **three** working days of the appointment. The possible outcomes are that the patient is:

- added to appropriate waiting list,
- discharged,
- booked into a review appointment or

- added to a review waiting list.

If one of the above actions is not carried out the patient can get lost in the system which carries a governance risk.

2.13 TIME CRITICAL CONDITIONS

2.13.1 All referrals for new patients with time critical conditions, should be booked in line with the agreed clinical pathway requirement for the patient and within a maximum of the regionally recognised defined timescale from the receipt of the referral (e.g. for suspect cancer (red flag) and rapid access angina assessment the timescale is 14 days).

2.13.2 Patients will be contacted by phone and if telephone contact cannot be made, a fixed appointment will be issued.

2.13.3 If the patient does not respond to an offer of appointment (by phone and letter) the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.4 If the patient refuses the first appointment they should be offered a second appointment during the same telephone call. This second appointment should be offered on a date which is within **14** days of the date the initial appointment was offered and refused. In order to capture the correct waiting time the first appointment will have to be scheduled and then cancelled on the day of the offer and the patient choice field updated in line with the technical guidance. This will then reset the patient's waiting time to the date the initial appointment was refused.

2.13.5 If the patient cancels **two** agreed appointment dates the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.6 If the patient has agreed an appointment but then DNAs the relevant clinical team should be advised before a decision is taken to discharge. Where a

decision is taken to discharge the patient, the patient's GP should be informed.

2.13.7 Where the patient DNAs a fixed appointment they should be offered another appointment.

2.13.8 If the patient DNAs this second fixed appointment the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.9 With regard to 2.13.4 to 2.13.8 above, it is the responsibility of each individual Trust to agree the discharge arrangements with the clinical team.

2.13.10 If the patient is not available for up to **six** weeks following receipt of referral, the original referral should be discharged a second new referral should be opened with the same information as the original referral and with a new date equal to the date the patient has advised that they will be available and the patient monitored from this date.

2.14 TECHNICAL GUIDANCE

2.14.1 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re;

- Acute activity definitions.
- Effective Use of Resources policy.

2.14.2 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- ICATS waiting times and activity (including paper triage)
- Biologic therapies activity.
- Cancer related information.
- Centralised funding waiting list validation.

- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Obstetric and midwifery activity.
- Outpatients who are to be treated for Glaucoma.
- Management of referrals for outpatient services.
- Rapid angina assessment clinic (RAAC).
- Regional assessment and surgical centres.
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.
- Recording Consultant Virtual Outpatient Activity (June 2020)

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 3

GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

3.1 INTRODUCTION

3.1.1 A diagnostic procedure may be performed by a range of medical and clinical professionals across many different modalities, including, diagnostic imaging, cardiac imaging and physiological measurement services. These may have differing operational protocols, pathways and information systems but the principles of the IEAP should be applied across all diagnostic services.

3.1.2 The principles of good practice outlined in the Outpatient and Elective Admissions sections of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.

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

3.1.4 It is recognised that diagnostic services are administered on a wide range of information systems, with varying degrees of functionality able to support full information technology (IT) implementation of the requirements of the IEAP. Trusts should ensure that the administrative management of patients is undertaken in line with the principles of the IEAP and that all efforts are made to ensure patient administration systems are made fit for purpose.

3.1.5 In all aspects of the diagnostic booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language as well as associated legislative requirements such as Ionising Radiation (Medical Exposure) Regulations.** Local booking polices should be developed accordingly.

3.2 KEY PRINCIPLES

3.2.1 Referrals into Trusts should be pooled as the norm where possible.

3.2.2 All diagnostic requests, appointments and waiting lists should be managed according to clinical priority. Priorities must be identified for each patient on a waiting list and allocated according to urgency of the diagnostic procedure. Trusts will manage patients in four priorities, i.e.

1. Red flag (suspect cancer),
2. urgent,
3. routine and
4. planned.

No other clinical priority categories should be used for diagnostic services.

3.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order.

3.2.4 Trusts should work towards an appointment system where patient appointments are **partially booked** (where applicable)**.** Where fixed appointments are being issued, Trusts should ensure that the regional IEAP guidance is followed in the management of patients.

3.2.5 The regional target for a maximum diagnostic waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

3.2.6 Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated and capacity issues are quickly identified and escalated.

3.2.7 The outcome of the diagnostic test must be available to the referrer without undue delay and within the relevant DoH targets / standards.

3.2.8 Trusts should ensure that specific diagnostic tests or planned patients which are classified as daycases adhere to the relevant standards in the Elective Admissions section of this document.

3.2.9 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.

3.2.10 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

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

3.2.12 Trusts should **not** use manual administration systems to record and report patients who have been booked.

3.2.13 Trusts should provide training programmes for staff which include all aspects of this IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

3.3 NEW DIAGNOSTIC REQUESTS

3.3.1 All diagnostic requests will be registered on the IT system within **one** working day of receipt. Referrer priority status must be recorded at registration.

3.3.2 Trust diagnostic services must have mechanisms in place to track all referrals (paper and electronic) at all times.

3.3.3 All requests must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

3.3.4 All referrals will be prioritised (including those prioritised via E Triage) within **three** working days of date of receipt of referral.

3.3.5 Following prioritisation, requests must be actioned on the IT system and appropriate correspondence (including electronic) issued to patients within **one** working day.

3.3.6 Inappropriate and inadequate requests should be returned to the referral source and the referral closed and managed in line with the PAS/relevant technical guidance, where appropriate.

3.4 CALCULATION OF THE WAITING TIME – STARTING TIME

3.4.1 The starting point for the waiting time of a request for a diagnostic investigation or procedure is the date the request is received into the department.

3.4.2 All referral letters and requests, emailed and electronically delivered referrals, will have the date received into the department recorded either by date stamp or electronically.

3.5 REASONABLE OFFERS

3.5.1 For patients who are partially booked, a reasonable offer is defined as:

- an offer of appointment, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and **two** appointments, and
- at least **one** offer must be within Northern Ireland (NI), except in those cases where there are no alternative providers within NI.

3.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

3.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less

than three weeks' notice) and refuses it they will not have their waiting time reset.

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

3.5.5 Providers should have robust audit procedures in place to demonstrate compliance with the above.

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

3.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

3.6 FOLLOW UP APPOINTMENTS

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

3.6.2 Patients must be recorded on the IT system as requiring to be seen within a clinically indicated time. Trusts should actively monitor follow up patients on the review list to ensure that they do not go past their indicative time of treatment.

3.6.3 Follow up patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and the IT system updated.

3.6.4 Follow up patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with management guidance for follow up pathway patients.

3.7 PLANNED PATIENTS

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

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

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

3.7.4 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs.

3.8 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

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

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

3.8.3 Where a patient requires more than one test carried out on separate occasions the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.

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

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

3.9.1 DNAs – Diagnostic Appointment

If a patient DNAs their diagnostic appointment the following process must be followed:

3.9.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

3.9.1(b) Under exceptional circumstances a clinician may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with clinicians, regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should be offered.

3.9.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.

3.9.1(d) *Where patients are discharged from the waiting list (ref. 3.7.1(a) above) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated*.

3.9.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

3.9.1(f) Where a patient DNAs a fixed diagnostic appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.

3.9.1(g) If the patient DNAs this second fixed diagnostic appointment they will be removed from the waiting list and the above steps in 3.7.1(d) should be followed.

3.9.2 DNAs – Follow up Diagnostic Appointment

If a patient DNAs their follow up diagnostic appointment the following process must be followed:

3.9.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.

3.9.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.

3.9.2(c) Where the clinical decision is that a second appointment should **not** be offered, Trusts should contact patients advising that as they have failed to attend they have been discharged from the waiting list. The referring clinician (and the patients GP, where they are not the referring clinician) should also be informed of this.

3.9.2(d) *Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the review waiting list with a revised clinically indicated date at the date they make contact with the Trust.*

3.9.2(e) If the patient DNAs the second follow up appointment which has been partially booked then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

3.9.2(f) Where a patient DNAs a fixed follow up appointment, including virtual appointments, where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.

3.9.2(g) There may be instances for follow up patients where the clinician may wish to review notes prior to any action to remove a patient because of a DNA or failure to respond to a partial booking letter. Trusts should ensure that there are locally agreed processes in place to administer these patients.

3.9.3 CNAs – Patient Initiated Cancellations of Diagnostic Appointment

If a patient cancels their diagnostic appointment the following process must be followed:

3.9.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.

3.9.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

3.9.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.

3.9.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.

3.10 CNAs - HOSPITAL INITIATED CANCELLATIONS

3.10.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

3.10.2 The patient should be informed of the cancellation and the date of the new appointment.

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

3.10.4 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

3.11 SESSION OUTCOME MANAGEMENT

3.11.1 Changes in the patient's details must be updated on the IT system and the medical record on the date of the session.

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

3.12 SESSION TEMPLATE CHANGES

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

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

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

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

3.13 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

3.13.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to independent sector (IS) providers.

3.13.2 Transfers to alternative providers must always be with the consent of the patient and the receiving clinician and be managed in line with PAS technical guidance (see also Reasonable Offers, ref. 3.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

3.14 TECHNICAL GUIDANCE

3.14.1 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re acute activity definitions.

3.14.2 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- Diagnostic waiting time and report turnaround time.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Rapid angina assessment clinic (RAAC).
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 4

GUIDANCE FOR MANAGEMENT OF ELECTIVE ADMISSIONS

4.1 INTRODUCTION

4.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of elective inpatient and daycase admissions.

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

4.1.3 In all aspects of the elective admissions booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking polices should be developed accordingly.

4.2 KEY PRINCIPLES

4.2.1 To aid both the clinical and administrative management of the waiting list, lists should be sub-divided and managed appropriately. Trusts will manage patients on one of three waiting lists, i.e.

1. active,
2. planned and
3. suspended.

4.2.2 All elective inpatient and daycase waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in four priorities, i.e.

1. Red flag (suspect cancer),
2. urgent,
3. routine and
4. planned.

No other clinical priority categories should be used for inpatient and daycase services.

4.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order, taking into account planned patients expected date of admission.

4.2.4 The regional targets for a maximum inpatient and daycase waiting times are outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

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

4.2.6 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.

4.2.7 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

4.2.8 Trusts should **not** use manual administration systems to record and report patients who have been booked.

4.2.9 Trusts should provide training programmes for staff which include all aspects of IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

4.3 PRE-ASSESSMENT

4.3.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-assessment. This can be provided using a variety of methods including telephone, video link, postal or face to face assessment.

4.3.2 Pre-assessment may include an anesthetic assessment or guidance on how to comply with pre-procedure requirements such as bowel preparation. It will be the responsibility of the pre- assessment team, in accordance with protocols developed by the relevant clinical teams, to authorise fitness for an elective procedure.

4.3.3 Only those patients that are deemed fit for their procedure may be offered a TCI date.

4.3.4 If a patient is assessed as being unfit for their procedure, their To Come In (TCI) date may be cancelled and decision taken as to the appropriate next action.

4.3.5 Pre-assessment services should be supported by a robust booking system.

4.4 CALCULATION OF THE WAITING TIME

4.4.1 The starting point for the waiting time of an inpatient/daycase admission is the date the appropriate clinician agrees that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is clinically and socially fit to undergo such a procedure.

4.4.2 The waiting time for each patient on the elective admission list is calculated as the time period between the original decision to admit date and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

4.5 REASONABLE OFFERS - TO COME IN (TCI) OFFERS OF TREATMENT

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

4.5.2 All patients must be offered reasonable notice. Patients should be made reasonable offers to come in (TCI) on the basis of clinical priority. Within

clinical priority groups offers should then be made on the basis of the patient's chronological wait.

4.5.3 A reasonable offer is defined as:

- an offer of admission, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and a choice of **two** TCI dates, and
- at least **one** of the offers must be within N. I., except for any regional specialties where there are no alternative providers within NI.

4.5.4 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the admission was refused.

4.5.5 This does not prevent patients being offered earlier appointment dates. If the patient is offered an admission within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

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

4.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

4.5.8 Providers should have robust audit procedures in place to demonstrate compliance with the above.

4.5.9 To ensure the verbal booking process is auditable, the Trust should make and cancel a TCI date using the date of the second admission date offered and refused for this transaction.

4.6 INPATIENT AND DAYCASE ACTIVE WAITING LISTS

4.6.1 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be “fit, ready, and able” to come in.

4.6.2 To ensure consistency and the standardisation of reporting with commissioners and the DoH, all waiting lists are to be maintained in the PAS patient information system.

4.6.3 Details of patients must be entered on to the computer system (PAS) recording the date the decision was made to admit the patient or add the patient to the waiting list within **two** working days of the decision being made. Failure to do this will lead to incorrect assessment of waiting list times.

4.6.4 Where a decision to add to the waiting list depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure a decision is made in relation to the result of the investigation and the clinical patient pathway agreed.

4.7 SUSPENDED PATIENTS

4.7.1 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or personal reasons. These patients should be suspended from the active waiting list until they are ready for admission.

4.7.2 A period of suspension is defined as:

- A patient suspended from the active waiting list for medical reasons, or unavailable for admission for a specified period because of family commitments, holidays, or other reasons i.e. a patient may be suspended during any periods when they are unavailable for treatment for personal or medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc.).

- A recommended maximum period not exceeding **three** months.

4.7.3 No patient should be suspended from the waiting list without a suspension end date.

4.7.4 Suspended patients should be reviewed one month prior to the end of their suspension period and a decision taken on their admission.

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

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

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

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

4.7.9 Recommended practice is that no more than 5% of patients should be suspended from the waiting list at any time. This indicator should be regularly monitored.

4.8 PLANNED PATIENTS

4.8.1 Planned patients are those patients who are waiting to be admitted to hospital for a further stage in their course of treatment or surgical investigation within specific timescales.

4.8.2 These patients are not actively waiting for treatment, but for planned continuation of treatment. A patient is planned if there are clinical reasons that determine the patient must wait set periods of time between

interventions. They will not be classified as being on a waiting list for statistical purposes.

4.8.3 Trusts must have systems and processes in place to identify high risk planned patients in line with clinical guidance.

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

4.8.5 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs, with particular focus on high risk surveillance pathway patients.

4.9 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

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

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

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

4.10 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR ADMISSION

DNAs – Inpatient/Daycase

4.10.1 If a patient DNAs their inpatient or daycase admission, the following process must be followed:

4.10.1(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second date should be offered or whether the patient can be discharged.

4.10.1(b) Where the clinical decision is that a second admission should be offered, the admission date must be agreed with the patient. Trusts should put in place local agreements with clinicians regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should always be offered.

4.10.1(c) Patients who DNA and are not discharged but offered a second date will have their waiting time clock reset to the date of the DNA.

4.10.1(d) Where the clinical decision is that a second date should not be offered, Trusts should contact patients advising that as they have failed to attend they have been discharged from the waiting list. The referring clinician (and the patient's GP, where they are not the referring clinician) should also be informed of this.

4.10.1(e) *Patients being discharged from the list should be advised to contact the Trust if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original date, a clinical decision may be made to offer a second date. Where this is the case, the patient should be added to the waiting list at the date they make contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated*.

4.10.1(f) If the patient DNAs the second admission offered then the above steps should be followed.

4.10.1(g) Where a patient DNAs a fixed admission date (i.e. they have not had the opportunity to agree/ confirm the date and time of their admission), they should be offered another date.

4.10.1(h) If the patient DNAs this second fixed admission, they will be removed from the waiting list and the steps in 4.10.1(e) should be followed.

4.10.1(i) Where a patient DNAs a pre-assessment appointment they will be offered another date. If they DNA this second pre-assessment appointment, they will be removed from the waiting list and the above steps in 4.10.1(e) should be followed.

4.10.2 CNAs – Patient Initiated Cancellations of inpatient/daycase admission

If a patient cancels their inpatient/ daycase admission the following process must be followed:

4.10.2(a) Patients who cancel an agreed reasonable offer will be given a second opportunity to book an admission, which should ideally be within **six weeks** of the original admission date.

4.10.2(b) If a second agreed offer of admission is cancelled, the patient will not be offered a **third** opportunity.

4.10.2(c) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second admission, the Trust may exercise discretion to offer a third admission - this should include seeking a clinical review of the patient's case where this is appropriate.

4.10.2(d) Where a decision is taken not to offer a further admission, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.

4.10.2(e) Where a patient CNAs a pre-assessment appointment they should be offered another date. If they CNA this second pre-assessment appointment, the above steps should be followed, as per 4.10.1(h).

4.10.2(f) Patients who cancel their procedure (CNA) will have their waiting time clock reset to the date the Trust was informed of the cancellation.

4.11. CNAs - HOSPITAL INITIATED CANCELLATIONS

4.11.1 No patient should have his or her admission cancelled. If Trusts cancel a patient's admission the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

4.11.2 The patient should be informed of the cancellation and the date of the new admission booked.

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

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

4.11.5 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of admission a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

4.12 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

4.12.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trust sites or to independent sector (IS) providers.

4.12.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with PAS technical guidance, (see also Reasonable Offers, ref. 4.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

4.13 TECHNICAL GUIDANCE

4.13.1 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re acute activity definitions.

4.13.2 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- Recording inpatients who need to be added to the 28 day cardiac surgery waiting list.
- Recording paediatric congenital cardiac surgery activity.
- Centralised Funding waiting list validation.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Obstetric and midwifery activity.
- Patients who are added to a waiting list with a planned method of admission.
- Pre-operative assessment clinics.
- Rapid angina assessment clinic (RAAC).
- Regional assessment and surgical centres.
- Patients waiting for a review outpatient appointment.
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 5

GUIDANCE FOR MANAGEMENT OF ELECTIVE ALLIED HEALTH PROFESSIONAL (AHP) SERVICES

5.1 INTRODUCTION

5.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of the elective booking processes for elective Allied Health Professionals (AHP) services, including those patients whose referral is managed virtually.

5.1.2 Allied Health Professionals work with people of all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors.

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

5.1.4 For the purposes of this section of the protocol, the generic term ‘clinic’ will be used to reflect AHP activity undertaken in hospital, community (schools, daycare settings, leisure and community centres) or domiciliary settings (people’s own home or where they live e.g. residential or nursing homes) as AHPs provide patient care in a variety of care locations.

5.1.5 AHP services are administered on a wide range of information systems, with varying degrees of functionality able to support full IT implementation of the requirements of the IEAP. Trusts should ensure that the administrative management of patients is undertaken in line with the principles of the IEAP and that all efforts are made to ensure patient administration systems are made fit for purpose.

5.1.6 There will be dedicated booking offices within Trusts to receive, register and process all AHP referrals.

5.1.7 Fixed appointments should only be used in exceptional circumstances.

5.1.8 In all aspects of the AHP booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking polices should be developed accordingly.

5.2 KEY PRINCIPLES

5.2.1 All referrals, appointments and AHP waiting lists should be managed according to clinical priority. A clinical priority must be identified for each patient on a waiting list and allocated according to urgency of the treatment. Trusts will manage new patients in two priorities, i.e.

1. urgent and
2. routine.

No other clinical priorities should be used for AHP services.

5.2.2 Patients of equal clinical priority will be selected for booking in strict chronological order.

5.2.3 Patient appointments for new and review should be **partially booked.** Where fixed appointments are being issued, Trusts should ensure that the IEAP guidance is followed in the management of patients.

5.2.4 The regional target for a maximum AHP waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

5.2.5 Maximum waiting times for urgent patients should be agreed locally with AHP professionals and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the professional and capacity issues are quickly identified and escalated.

5.2.6 Patients should not be disadvantaged where a decision is made to assess their clinical need through virtual activity.

5.2.7 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.

5.2.8 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

5.2.9 Trusts should **not** use manual administration systems to record and report patients who have been booked.

5.2.10 Trusts should provide training programmes for staff which include all aspects of this IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

5.3 NEW REFERRALS

5.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.

5.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.

5.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

5.3.4 All referrals will be prioritised (including those prioritised via E Triage) within **three** working days of date of receipt of referral.

5.3.5 Following prioritisation, referrals must be actioned on PAS or the relevant electronic patient administration system and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.

5.3.6 Inappropriate and inadequate referrals should be returned to the referral source immediately and the referral closed and managed in line with the PAS technical guidance.

5.4 CALCULATION OF THE WAITING TIME

5.4.1 The starting point for the waiting time of an AHP new referral is the date the clinician's referral or self-referral is received by the booking office or, for internal referrals, when the referral is received by the booking office/department. All referrals, including emailed and electronically delivered referrals, will have the date the referral received into the organisation recorded either by date stamp or electronically.

5.4.2 In cases where referrals bypass the booking office, (e.g. sent directly to an allied health professional), the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the booking office/department and registered at the date on the date stamp.

5.4.3 The waiting time for each patient is calculated as the time period between the receipt of the referral and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

5.4.4 The waiting time clock stops when the first definitive AHP treatment has commenced.

5.5 REASONABLE OFFERS

5.5.1 For patients who are partially booked, a reasonable offer is defined as:

- an offer of appointment, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and **two** appointment dates, and
- at least **one** offer must be within Northern Ireland (NI), except for any regional specialties where there are no alternative providers within NI.

5.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

5.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

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

5.5.5 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

5.5.6 Providers should have robust audit procedures in place to demonstrate compliance with the above.

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

5.6 REVIEW APPOINTMENTS

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

5.6.2 Patients must be recorded on PAS as requiring to be seen within a clinically indicated time. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative time of treatment.

5.6.3 Review patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and PAS updated.

5.6.4 Patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

5.6.5 Virtual review appointments, e.g. telephone or video link, should be partially booked. If the patient cannot be contacted for their virtual review they should be sent a partial booking letter to arrange an appointment.

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

5.7.1 DNAs – New AHP Appointments

If a patient DNAs their new appointment, the following process must be followed:

5.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referrer (and the patients GP, where they are not the referrer) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

5.7.1(b) Under exceptional circumstances the AHP professional may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with AHP professionals, regarding those referrals or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should always be offered.

5.7.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.

5.7.1(d) *Where patients are discharged from the waiting list (ref. 5.7.1(a)) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated*.

5.7.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer (and the patients GP, where they are not the referrer) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

5.7.1(f) Where a patient DNAs a fixed new appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.

5.7.1(g) If the patient DNAs this second appointment the above steps should be followed.

5.7.1(h) If a patient DNA's a virtual outpatient appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

5.7.2 DNAs – Review Appointments

If a patient DNAs their review appointment the following process must be followed:

5.7.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.

5.7.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.

5.7.2(c) Where the clinical decision is that a second appointment should **NOT** be offered, Trusts should contact patients advising that as they have failed to attend their appointment they will be discharged from the waiting list. The referrer (and the patient's GP, where they are not the referrer) should also be informed of this.

5.7.2(d) Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the waiting list at the date they make contact with the Trust.

5.7.2(e) If the patient DNAs the second appointment offered then the patient should **NOT** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they will be discharged from the waiting list.

5.7.2(f) Where a patient DNAs a fixed review appointment where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.

5.7.2(g) If a patient DNA's a virtual outpatient review appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

5.7.3 **CNAs –** Patient initiated cancellations (new and review)

If a patient cancels their AHP appointment the following process must be followed:

5.7.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.

5.7.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

5.7.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring professional (and the patient's GP, where they are not the referrer) should also be informed of this.

5.7.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.

5.7.3(e) If a patient CNA's a virtual outpatient appointment this should follow the above protocol.

5.7.4 Trusts have a responsibility to ensure that children and adults at risk who DNA or CNA their outpatient, inpatient, diagnostic or AHP appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

5.8 CNAs – SERVICE INITIATED CANCELLATIONS

5.8.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, including a virtual appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

5.8.2 The patient should be informed of the cancellation and a new appointment partially booked.

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

5.8.4 Service initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

5.9 CLINIC OUTCOME MANAGEMENT

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

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

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

5.10 CLINIC TEMPLATE CHANGES

5.10.1 Clinic templates should be agreed between the relevant AHP professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).

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

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

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

5.11 TRANSFERS BETWEEN TRUSTS or to INDEPENDENT SECTOR

5.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trusts or to independent sector (IS) providers.

5.11.2 Transfers to alternative providers must always be with the consent of the patient and the receiving AHP professional, (see also Reasonable Offers, ref. 5.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

5.12 TECHNICAL GUIDANCE

5.12.1 See also Public Health Agency; https://www.publichealth.hscni.net/publications/ahp-services-data-definitions-guidance-june-2015 re Guidance for monitoring the Ministerial AHP 13 week access target.

5.12.2 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re acute activity definitions.

5.12.3 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- ICATS waiting times and activity (including paper triage).
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.
- Recording Consultant Virtual Outpatient Activity (June 2020).
- AHP Virtual Consultation Guidance (to be issued).

INFORMATION GOVERNANCE COMPLIANCE CHECK REPORT

TEAM: Medical Records

FACILITY: Craigavon Area Hospital

DATE OF CHECK: 19/01/17

REPORT FINDINGS:

Good physical security in building and office area

- Swipe card access into main records department
- Department area secured at the end of the day
- Office area not accessible to public – Visitors checked by staff

Good awareness of IG policies and procedures

All mandatory Data Protection training is up to date. Spreadsheet record is kept of training completion and refresher requirements

Confidential waste collected as and when required. Tagged by cleaner

Staff access rights to systems reviewed. Access only granted on need to know basis

High level windows in office. No risk of screens being viewable from outside

RECOMMENDATIONS:

Raise awareness of 'Who Does What' document within the team to ensure that requests are passed to the correct departments.

Promote the use of the IG SharePoint site within team for access to IG related topics and awareness.

http://sharepoint/pr/ig/SitePages/NewHome.aspx

Forde, Helen

From: Forde, Helen <Personal Information redacted by the USI>
Sent: 15 August 2016 13:24
To: Gishkori, Esther
Subject: FW: Patient Satisfaction Survey

Esther – we hear of complaints, but not always the good news – so I thought I would share this with you - sometimes we do get it right!

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

From: Forde, Helen
Sent: 15 August 2016 13:22
To: Watters, Kate; Lawson, Pamela
Cc: Lappin, Aideen; Conway, Barry; Hughes, Sinead; Rocks, Cathy; Mulligan, Marilyn; McAlinden, Jacinta
Subject: Patient Satisfaction Survey

We carried out a Patient Satisfaction Survey in CAH, DHH, STH, BPC and ACH to get some patient feedback on the outpatient reception service. This is something we do as part of our public engagement.

Cathy, Marilyn and Jacinta – I've copied you in too for information.

Survey

119 questionnaires returned

We asked 4 questions –

1. Were you happy with the check in facilities. (Every patient replied – yes they were happy)
2. Was there anything that you found helpful/useful or anything that you were not happy with.
3. Have you any suggestions on how to improve the reception service.
4. Any additional comments you may like to make regarding the reception.

Every comment made for questions 2 – 4 regarding the reception cover was positive, here is just a selection of them but there are more in the same vein –

- *Staff are always very friendly*
- *Staff polite, efficient, pleasant, helpful*
- *Reception is such an important part of this facility and is often not appreciated by patients*
- *Attentive staff and friendly receptionist*
- *Everything was good*
- *Staff were very helpful*
- *Happy all the time we attend*
- *The staff are always helpful and kind*

- *Staff always very helpful and able to answer any questions I have*
- *Everything is good*

10 patients mentioned the self check in kiosks – with 5 in favour of them and 5 not in favour of them.

Would you share this with our reception staff and thank them for the work that they do to make the patient's visit to our clinics as pleasant and welcoming as it can be.

Our patients come here and they can be worried about their condition, in pain, feeling vunerable, and some may have driven round for a time to get a parking space so they may be cross – so it's very important that when they are come to reception they are welcomed and treated in a professional and friendly manner– this can make a great difference to the rest of their time in outpatients. This survey shows that the patients are happy with the service they receive so keep up the good work.

So once again thanks to you and your staff. Best wishes.

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

TRUST VIEW

FISCAL YEAR	CODED / NOT CODED	APRIL	MAY	JUNE	JULY	AUGUST	TOTAL:
2022/2023	NO	275	161	121	1193	5825	7575
		2.2%	1.2%	0.9%	9.5%	45.2%	11.8%
2022/2023	YES	12082	13224	12701	11341	7056	56404
		97.8%	98.8%	99.1%	90.5%	54.8%	88.2%

SITE VIEW

				Coded with UDDA		Coded with UDDA	
FISCAL YEAR	Department Name	Department Code	MONTH	YES		NO	
2022/2023	CRAIGAVON AREA HOSPITAL	CAH	APRIL	5866	96.4%	222	3.6%
2022/2023	CRAIGAVON AREA HOSPITAL		MAY	6589	98.8%	78	1.2%
2022/2023	CRAIGAVON AREA HOSPITAL		JUNE	6397	98.9%	72	1.1%
2022/2023	CRAIGAVON AREA HOSPITAL		JULY	6115	96.5%	224	3.5%
2022/2023	CRAIGAVON AREA HOSPITAL		AUGUST	4055	63.9%	2287	36.1%
		CAH		**29022**	**91.0%**	**2883**	**9.0%**
2022/2023	DAISY HILL	DHH	APRIL	4409	99.9%	5	0.1%
2022/2023	DAISY HILL		MAY	4709	99.8%	8	0.2%
2022/2023	DAISY HILL		JUNE	4527	99.8%	8	0.2%
2022/2023	DAISY HILL		JULY	3537	79.4%	916	20.6%
2022/2023	DAISY HILL		AUGUST	1167	25.5%	3415	74.5%
		DHH		**18349**	**80.8%**	**4352**	**19.2%**

2022/2023	**SOUTH TYRONE HOSPITAL**	**STH**	**APRIL**	1807	97.4%	48	2.6%
2022/2023	**SOUTH TYRONE HOSPITAL**		**MAY**	1926	96.3%	75	3.7%
2022/2023	**SOUTH TYRONE HOSPITAL**		**JUNE**	1777	97.7%	41	2.3%
2022/2023	**SOUTH TYRONE HOSPITAL**		**JULY**	1689	97.0%	53	3.0%
2022/2023	**SOUTH TYRONE HOSPITAL**		**AUGUST**	1834	93.7%	123	6.3%
		STH		**9033**	**96.4%**	**340**	**3.6%**
				56404	**88.2%**	**7575**	**11.8%**

Ward Audit - Spot Check

Ward: **Date:**

Clerical

	ADMISSIONS						DISCHARGES								Filing Protocol	
Casenote Number	Admission	Chaplain Recorded	PN /RES Home	Chart on the ward and tracked	Number of missing charts today	Comments	Discharge	Tracker	Follow Up	Discharge patient list	Number of Large Charts	Outstanding discharges	Outstanding backfilling	Comments	Clinical and Nursing Section filed correctly	Comments
	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐			Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐					Y ☐ N ☐	
	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐			Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐					Y ☐ N ☐	
	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐			Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐					Y ☐ N ☐	
	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐			Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐					Y ☐ N ☐	
	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐			Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐					Y ☐ N ☐	
	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐			Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐					Y ☐ N ☐	

Infection Control

Trollies cleaned	Work Area	Hand Hygiene	Comments
Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	

Dress Code

Uniforms i.e. Tunic, Trousers	Nail Polish	Long hair tied back	Bare below the elbows	No jewellery - only wedding ring	Comments
Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	Y ☐ N ☐	

Ward Activity Files:	Comments and Issues:

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

Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: Helen Forde – Head of Health Records **Staff Number:** Personal Information redacted by the USI

Is Professional Registration up to date? _____

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? **Post Outlines can be accessed via Trust Intranet (KSF link)** YES ☐ NO ☐ **Have Post Outline levels been achieved:** YES ☐ NO ☐ **If no, record below what action to be taken:**	Personal Information redacted by the USI
Objectives for Next Year: Personal Information redacted by the USI	

Reviewee Staff Name (Print) Helen Forde Signature Personal Information redacted by the USI Date 19/6/19.

Reviewer Manager/Supervisor (Print) A Carson Signature Personal Information redacted by the USI Date 19/6/19.

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

Scanned to Vocational Assessment Centre

Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: Personal Information redacted by the USI

Training type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Personal Information redacted by the USI		
Corporate Mandatory Training ROLE SPECIFIC			
Essential for Post			
Best practice Development (Coaching/Mentoring) (Relevant to current job role)			

Reviewee Staff Name (Print) Helen Forde Signature [redacted] Date 19/6/19.

Reviewer Manager/Supervisor (Print) A CARLIN Signature [redacted] Date 19/6

PLEASE SEND COMPLETED PART B TO: KSE DEPARTMENT, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ OR EMAIL TO:

Helen - Key Priorities 2019/20

Service	SMART Objective	Responsibility	Completion Date
[redacted]			

Progress Update
Personal Information redacted by the USI

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Southern Health and Social Care Trust

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

Lead Policy Author & Job Title:	Catherine Weaver – Head of Information Governance
Directorate responsible for document:	**Performance & Reform**
Issue Date:	9th January 2019
Review Date:	**January 2021**

Policy Checklist

Policy name:	Policy for the safeguarding, movement and transportation of Patient/Client/Staff/Trust Records, Files and other media between facilities.
Lead Policy Author & Job Title:	Catherine Weaver – Head of Information Governance
Director responsible for Policy:	Aldrina Magwood
Directorate responsible for Policy:	**Performance & Reform**
Equality Screened by:	Claire Graham
Trade Union consultation?	Yes ☒No ☐
Policy Implementation Plan included?	Yes ☐ No ☒
Date approved by Policy Scrutiny Committee:	8th January 2019
Date approved by SMT:	
Policy circulated to:	Directors and Information Governance Committee
Policy uploaded to:	Sharepoint

Version Control

Version:	Version 2.3
Supersedes:	Version 2.2

Version History

Version	Notes on revisions/modifications and who document was circulated or presented to	Date	Lead Policy Author
V2.3	Amendments to include GDPR	09012019	Catherine Weaver

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

1.0 INTRODUCTION

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

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

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

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

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

2.0 GUIDING PRINCIPLE

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

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

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

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

3.0 TRACKING / TRACING RECORDS

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

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

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

4.0 MOVEMENT OUTSIDE THE WORK BASE

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

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

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

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

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

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

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

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

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

5.7 If it appears that security seals have been tampered with, this should be reported to your Line Manager immediately and must be reported as per Adverse Incident reporting procedure. If a loss of data occurs, this must also be reported immediately to Catherine Weaver, Head of Information Governance, Ferndale, Bannvale Site, Gilford Tel: 028 Personal Information redacted by the USI

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

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

6,1 TRANSPORTATION OF RECORDS FOR CLINICS

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

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

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

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

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

6.1.6 Staff preparing records for transport must ensure:

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

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

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

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

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

7.0 TRANSPORTATION OF ORIGINAL RECORDS OUTSIDE OF THE SOUTHERN TRUST

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

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

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

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

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

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

8.0 TRANSPORT AND STORAGE FOR DOMICILIARY VISITS

- Client records are to be transported in a secure transport briefcase/bag.
- During transport client records are to be kept in the boot of the car and out of sight in a briefcase or a secure transport bag.
- Professional to decide with Line Manager on individual case whether it is best to bring only records pertaining to the client into their home and other client records to be kept in a secure transport briefcase/bag in the boot of car.

- Records should be returned to base when visit is complete as soon as possible.
- Staff should not leave portable computers, medical notes or mobile data devices (e.g. Dictaphones, PDAs, digital cameras) that are used to store patient records/patient identifiable information in unattended cars or in easily accessible areas. staff should store all files and portable equipment under lock and key, when not actually being used.
- Staff should not normally take health/client records home and where this cannot be avoided, procedures should be place to safeguard that information effectively. If records are being held by staff member's home overnight then they must be kept in a secure place. The responsibility for the records is held by the staff member.

9.0 RELATED POLICIES/MANUALS INCLUDE:

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

2. Records Management Policy, Southern Health & Social Care Trust (September 2013).

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

4. Records Retention and Disposal Schedule, DHSSPSNI November 2011. http://www.dhsspsni.gov.uk/gmgr.htm

5. Data Protection Requests Flowchart (GDPR) Southern Health & Social Care Trust (May 2018).

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

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

7. Data Protection Guidance Note: Subject Access Requests for Social Services Records, Southern Health & Social Care Trust 01/06/09.

Southern Health and Social Care Trust

Records Management Procedures

Version: 4. December 2020

Name of Policy:	Records Management Procedures
Directorate responsible for this Document	Performance & Reform
Author(s) by Title(s):	Head of Information Governance
Date:	30 December 2020

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1.0 Records Management Procedures

1.1 Introduction

It is a statutory requirement for the HPSS to implement records management as set out in the Public Records Act (Northern Ireland) 1923 Act and in the Disposal of Documents (Northern Ireland) Order (1925).

The international standard of managing records, ISO 15489 defines a record as *"information created, received and maintained as evidence and information by an organisation or person, in pursuance of legal obligations or in the transaction of business."*

1.2 Purpose

The purpose of these procedures is to ensure that the Southern HSC Trust adopts best practices in the management of its records so that reliable records are created, they can be found when needed, and are destroyed or archived, when no longer required.

It is the responsibility of all staff including those on temporary contracts to comply with this procedure

1.3 Scope

The Freedom of Information Act 2000, Lord Chancellor's Code of Practice (S.46), Data Protection Act 1998 and Good Management, Good Records all have implications for Records Management processes.

This guidance has been developed as a minimum standard and should be read in conjunction with the Trust Records Management Policy and relevant professional standards from regulatory bodies e.g. Nursing and Midwifery Council.

HPSS records are public records as defined in the Public Records Act (Northern Ireland) 1923. A "public" record is a record of information created by the activities of the Trust and conveyed by any means (manuscript, typescript, email, film, magnetic tape, map, plan, drawing, account and ledger).

In the context of these procedures, a record is any thing which contains information in any media which has been created or gathered as a result of any aspect of the work of HPSS employees including:

- Administrative/Information Governance (including personnel, estates, financial and accounting records)
- Patient health records (electronic or paper based)
- X-ray and imaging reports, and other images microform/microfiche/film
- Audio and videotapes, cassettes, CD-ROM etc

- Computer data bases, output and disks etc and all other electronic records

This list is not exhaustive.

Section 2 – Records Creation

2.0 Records Creation

Records are created so that information is available in the Trust to:

i. Deliver the services offered by the Trust to the community.
ii. Ensure that appropriate records are kept of the operation of the Trust business and are correctly identified and managed.
iii. Support day-to-day business, which underpins decision-making and the delivery and continuity of care.
iv. Support evidence based practice.
v. Meet legal requirements including requests under the Data Protection Act 2018 and Access to Health Records (NI) Order 1993, requests for information under the Freedom of Information Act 2000 and Environmental Information (Amendments) Regulations 1998.
vi. Assist in the auditing process.
vii. Support archival functions by taking account of the historical importance of material and the needs for future research.
viii. Ensure whenever, and wherever there is a justified need for records to be created for use in the authority, community, and wider public it is done effectively and in line with appropriate legal requirements and recognised good practice.
ix. Assist the Trust in defending any legal claims against it or its staff.

2.1 Filing of Legal Papers and Complaints

Correspondence generated from legal cases and complaints must not be filed within the clinical record. These papers are not relevant to clinical care and are often not disclosable unlike the clinical record.

2.2 Version Control Certificate

Policy documents frequently undergo changes and it is vital that the Trust adopts a ‘version control certificate’, which should be attached to all approved policy documents (Appendix 1). This certificate will demonstrate that the policy is in force and is current, as it will give a revision date for the policy. It will be reasonable to assume that if a policy is being referred to after the revision date on the 'Version Control Certificate’, such policy will no longer be in force.

('Guidance on Version Control of Documents' (Appendix 2) and 'Guidance on Naming Convention' (Appendix 3) has been produced by the Regional Records Management Working Group in 2006).

2.3 Records Registration

Determining which records require registration is a decision that should be made by the Departmental Records Officer and the Records Manager. Registration is a system which allocates a unique identifier (number or alphabetical prefix) to each item. The kinds of records, which are most likely to be placed on a registered file, include:

- Trust records re: functions and procedures
- Trust minutes of meetings
- Personnel, Financial and Estates records
- Contractual information
- Care/clinical records re: patient care or treatment
- Mandatory patient activity returns
- Performance monitoring
- Policy papers (reports, correspondence etc)
- Complaints papers and correspondence
- Research and development papers
- Papers relating to the preparation of legislation
- Relates to the decision-making process, success or failure, of any work or project associated with the file e.g. success or failure to meet targets, standards or other criteria.

Registration will depend on the Trust business need to maintain accountable records of particular activities.

The best practice principles of registration are:

- The file title must be unique and accurately reflect the contents of the file (exclude terms e.g. general or miscellaneous)
- Acronyms and abbreviations used in the title must be those in common use in the organisation
- Both must be relevant to and easily understood by all users
- The reference assigned to each patient file must be unique e.g. PAS or Health & Care Number
- Details should be recorded both on the register and on all associated papers

Types of registered file systems include:

- Alphabetical
- Numerical
- Alpha-numeric
- Keyword

Registration systems should be monitored regularly and reviewed at least once every two years to ensure that they continue to operate effectively and efficiently.

2.4 Electronic Records

With the development of electronic patient records, there will be a need to identify every item which is patient/client related with the relevant Health & Care Number to provide the necessary links through all electronic records.

An Electronic and Document and Records Management System (EDRMS) is a computerised information system that captures, maintains and provides access to documents and records. An EDRMS allows levels of access and security to be set and offers strict and auditable version control. An EDRMS with a functional fileplan in place supports the Trust's obligations under the Freedom of Information Act by facilitating access to information. Within the Trust there is an EDRM (WinDip) which is linked to the Paris Community Information System and can be used to store addition documents from external sources.

(The Regional Records Management Working Group has developed a regional Fileplan which can be adopted by HPSS organisations - Appendix 4).

2.5 Protective markings

There must be sufficient space on the file cover to indicate the protective marking (if any e.g. Confidential, Restricted). Protective markings must be consistent with the accepted system used in the Trust.

2.6 File Covers

The cover of every file should include:

- File title
- Year in which it was opened
- Date of closure

- Marked ‘closed’ if appropriate
- Date of the first paper
- Date of last paper
- Identification of precedent cases (Glossary)

(The Public Record Office, Northern Ireland, (PRONI) has agreed a file cover for use within the HPSS).

2.7 Record Keeping

Records of all types are valuable because of the information they contain and that information is only useful if it is:

- correctly and legibly recorded in the first place;
- is kept up to date; and
- is easily accessible when needed.

To ensure quality and continuity of services all records should be accurate and up to date. Procedures should be developed to ensure and maintain data quality for both manual and electronic records. These procedures should be passed on to staff who are responsible for recording such information. It is also essential that these procedures are reviewed and updated regularly.

2.7.1 Information Governance

The Trust records are its corporate memory, providing evidence of actions and decisions and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision making, protect the interests of the Trust and the rights of patients, staff and members of the public. They support consistency, continuity, efficiency and productivity and help deliver services in a consistent and equitable way. Information is a corporate asset. The Trust records are important sources of administrative, evidential and historical information. They are vital to the Trust to support its current and future business, including meeting the requirements of Freedom of Information legislation, for the purpose of accountability, and for awareness and understanding of its history, policies and procedures.

Examples of Information Governance :

<u>Minutes of meetings</u>

Transcript of important work related telephone conversations – providing advice, instructions or recommendations, giving permissions and consent and making decisions, commitments and agreements.
Correspondence – letters, email, faxes, internal memos

Draft documents – drafts submitted for comment or approval by others and drafts containing significant annotations.

Integrity of Records

It is the responsibility of each Trust to ensure that all records are complete and authentic and in addition, to be satisfied that all correspondence is present and kept in correct order. The records must:

- provide adequate evidence of the conduct of business to account for a financial transaction including reasons for any decision necessary for that transaction to take place;
- contain verifiable evidence that the transaction was properly authorised;
- provide complete information to document the transaction;
- comply with record keeping requirements arising from the regulatory and accountability directions of the Trust; and
- be comprehensive and document the complete activity i.e. contain a full audit.

2.7.2 Health Care Records

The purpose of the clinical record is to facilitate the care, treatment and support of a particular client.

Patient and client records should be:

- Factual
- Consistent and accurate
- Written in black ink only
- Written as soon as possible after an event has occurred, preferably within 24 hours (Refer to professional guidelines and 'Generic medical record-keeping standards prepared by Royal College of Physicians, see References). Such records should provide current information on the care and condition of the patient (if the date and time of the event differs from that of when the records are written up, this should be clearly noted under the signature, printed name and position/grade)
- Written clearly, legibly and in such a manner that cannot be erased. Erasers, liquid paper, or any other obliterating agents should never be used to cancel errors. A single line should be used to cross out and cancel mistakes or errors and this should be signed and dated by the person who has made the amendment (See References: 'How does the Data Protection Act apply to professional opinions?')

- Accurately dated, timed (24 hour clock) and signed along with the authors printed name and designation. These details should be entered beneath each record entry in the case-notes
- Written, wherever possible, with the involvement of the service user or carer and in terms that the service user or carer will be able to understand
- Bound and stored so that loss of documents is minimised
- The client will be identifiable on each sheet of paper within the notes using prepared labels, or with the minimum of patient's full name, patient ID No. (e.g. H&CN No., Hospital Number), date of birth and their location in the hospital
- All hand-written entries will be in permanent ink
- Healthcare professionals name and designation should be printed and Bleep/Radiopager Number (as appropriate) will be noted against the signature at least once
- Any referrals to multidisciplinary team are documented
- Verbal consent should be recorded in clients' notes together with discussion and explanations given
- No inappropriate personal or offensive comments should be included

Relevant and useful

- Identifying problems that have arisen and the action taken to rectify them
- Providing evidence of the care planned, the decisions made, the care delivered and the information shared
- Providing evidence of action agreed with the patient (including consent to treatment and/or consent to share)

And include

- Medical observations, examinations, tests, diagnoses, prognoses, prescriptions, other treatments
- Relevant disclosures by the patient – pertinent to understanding cause or effecting cure/treatment
- Facts presented to the patient
- Correspondence from the patient or other parties

Patient records should not include

- Unnecessary abbreviations, jargon, meaningless phrases, irrelevant speculation and offensive subjective statements
- Personal opinions regarding the patient (restrict to professional judgements on clinical matters)
- The name(s) of third parties involved in a serious incident. The name should be included on a separate incident form for cross referencing
- Correspondence generated from legal papers and complaints

Use of Year Stickers on Health Care Records

All departments which use Health Care records should ensure that they hold sufficient stocks of year stickers and apply these on an annual basis to patient records as follows:

- Each patient being seen in a calendar year i.e. between 1st January and 31st December should have a year sticker for that year applied to the edge of the case-note folder. This sticker should be applied only once to each volume and each consecutive year that the patient is seen a New Year sticker for that year should be applied to the case-note folder and all corresponding volumes for that patient.

The purpose of the year stickers is to ensure that it is easy to identify if a patient was seen in a particular year or not. This system also enables fast effective weeding of case-notes each year when it is necessary to weed the records stores for old case-notes for archiving or destruction.

2.7.3 Continuity of recording in Health Records where services are devolved or patients are transferred.

Where services are devolved to a Trust, the original Trust needs to remain accountable for the service it provided, and may need to be capable of resuming treatment again in the future. The Trust taking over the service needs to be able to provide continuity of care and to account both to patients and possibly to the transferring Trust for the services it is providing. Therefore, both Trusts need to keep records of the service they provide and any relevant information about transfers of responsibility between them.

CREST Guidelines must be followed in relation to the transfer of patient records (see References).

Both Trusts should then apply their own retention and disposal arrangements to the records they hold. As far as the transferring Trust is concerned, the patient episode ends at the point of transfer.

If the service provided is a small part of an ongoing care process then a transfer of care/discharge summary should be sent back to the original Trust at the end of the care spell. If both Trusts are involved in providing ongoing but different services, which have relevance to each other, they should devise appropriate approaches to more regular communication.

Section 3 – Storage of Records

3.0 Storing Paper Records

3.0.1 Current records

When a record is in constant or regular use, or is likely to be needed quickly, it makes sense to keep it within the area responsible for the related work. Storage equipment for current records will usually be adjacent to users i.e. their desk drawers or nearby cabinets, to enable information to be appropriately filed so that it can be retrieved when it is next required. Records must always be kept securely and when a room containing records is left unattended, it should be locked. A sensible balance should be achieved between the needs for security and accessibility.

There is a wide range of suitable office filing equipment available. The following factors should be taken into account:

- Compliance with Health & Safety regulations (must be the top priority)
- Security (especially for confidential material)/the user's needs
- Type(s) or records to be stored, their size and quantities
- Usage and frequency of retrievals
- Suitability, space efficiency and price

3.0.2 Records Stored in the Patient's Home

In some circumstances records may be stored at the patient's home e.g. maternity notes and Community Trust Homecare records. Confidentiality of the record stored in the client's home is the responsibility of the client and they should be informed of their responsibility. Records should be returned to the Trust, when they are no longer required in the Service User's Home.

3.0.3 Closed/Archived records

As the need for quick access to particular records reduces, it may be more efficient to move the less frequently used material out of the work area and into archive storage.

When transferred into an archive, semi-current paper records should be stored on shelves in a way that facilitates retrieval. The records need not be boxed, although boxing may be required where, for example, there are risks from damage by excessive light or by flooding. Records should be stored off the floor, and away from dampness and dust.

The width of aisles and general layout of storage areas must conform to fire, health and safety, and similar regulations.

Large documents, such as maps, should be housed in special storage equipment to ensure that they are not damaged and are readily accessible.

3.1 Storing Non-paper Records

Microfilm and fiche have been used for many years and courts will accept them as evidence in most cases. (Ref BSI BIP 008 Code of Practice on Legal Admissibility and Evidential Weight of Information Stored Electronically). Microfilming is a relatively cost-efficient way to capture and store images of otherwise bulky or deteriorating archival material:

Photograph and film collections assembled by medical and other staff through their work, should be regarded as Public Records and subject to these guidelines. Note that the provisions of the Data Protection Act 1998 on registration of records and restriction of disclosure, relate to photographs of identifiable individuals as well as to other personal records.

The Trust is currently piloting the use of electronic scanning of records and other types of documents within the organisation. Whilst there is obviously a large outlay of financial resources to undertake such a large project there are significant benefits to be gained for the organisation. Some of these benefits are;

- Less storage space is required
- Documents are instantly available to more than one individual at any one time
- There are no associated transport costs to make the document available at various locations
- There is a lesser risk of damage to the documents by way of fire, flood or theft
- Production costs of new documents and pages to a record via a PC is minimal
- There is no risk of loss of a document through misfiling or removal of a document from a central file without the tracking system being updated

Section 4 – Records in Transit

4.0 Records in Transit

Accurate recording of all record movements is essential if information is to be located quickly and efficiently. One of the main reasons why records are misplaced is because record movements are not recorded.

If records are being delivered to another location they should be enclosed in envelopes and sealed for transfer. Any records that may be damaged in transit should be enclosed in suitable padding or containers.

For larger quantities, records should be boxed in suitable boxes or containers for their protection.

Each box or envelope should be addressed clearly and marked confidential with the senders name and address on the reverse.

There are various options if records are to be mailed, such as recorded delivery, registered mail etc. When considering options staff should consider the following:

- Will the records be protected from damage, unauthorised access or theft?
- Is the level of security offered appropriate to the degree of importance, sensitivity or confidentiality of the records?
- Does the mail provider offer 'track and trace' options and is a signature required on delivery?

The records must not be left unattended in transit at any time. When carried in a car they must be locked in the boot.

4.1 Handling and transporting records

- No one should eat, drink or smoke near the records.
- Clinical records being carried on site e.g. from archive to the department, should be enclosed in an envelope.
- Records should be handled carefully when being loaded, transported or unloaded.
- Records should never be thrown.
- Records should be packed carefully into vehicles to ensure that the movement of the vehicle will not damage them.
- Vehicles must be fully covered so that records are protected from exposure to weather, excessive light and other risks such as theft.
- No other materials that could cause risks to records (i.e. chemicals) should be transported with records.
- Records should not be left in unattended vehicles.
- Records of any type should NOT be left in vehicles overnight.

(Please refer to the Trust Policy for the Safeguarding, Movement & Transportation of Patient/Client/Staff/Trust Records, Files and Other Media between facilities and the Policy for the Transfer of Electronic Data).

4.2 Tracking / Tracing Records

Managers must ensure that effective systems are in place for tracking the location of files containing confidential information.

Section 5 – Retention of Records

5.0 Retention of Records

Records Closure
A file is closed when:

- Determined by the Trust PRONI approved Disposal Schedule
- Depth of paper reaches 2.5 cm (A continuation file should be opened if required and should be cross referenced)
- The subject matter is finished
- No new papers have been added to the file for two years

Action on Closure

- Complete a Yellow closure sheet (Appendix 5)
- The word 'CLOSED' should be marked/stamped on the outside of the file. If when a file is being closed, the subject to which it relates remains 'live' a continuation file should be opened
- Update records management system
- Consider review process – see review section

Other Practical Points

- Paper clips and pins should be removed from papers before filing, as these will damage the paper and when rusted can be a health hazard. Particular attention to this must be given to those records, which, according to the Disposal Schedule, are to be preserved permanently.
- Flags, either adhesive tabs or strips of paper attached to a page with cellotape, should be avoided – instead use card dividers.
- File covers should provide adequate protection for the papers and preferably have a flap which should be used to prevent papers becoming dog-eared. If they become tatty or torn, new covers should be prepared and the front of the older covers retained inside the new ones. Old covers form part of the original record.
- Files should not be filled too full – they should not be more than 2.5cm thick. Bulky files should be closed and a continuation file opened and cross-referenced with the old part.
- Files must not contain any loose papers.
- Do not use metal tags – instead use the readily available plastic-ended ones.
- Avoid the duplication of papers – only one copy of any piece of information should normally be filed on any one file.
- Papers to be filed should be punched 2.5 cm/one inch in and 2.5 cm/one inch down from the edge to minimize the danger of detachment.
- All papers received for filing should bear a file reference number.
- Papers should be filed in date order with the most recent papers on top. This is very important as the review and access dates are calculated from the date of the last paper on the file and, if the latest document is not on the top, it is likely that the wrong terminal date will be assumed.

- All papers should be filed on the right hand side of the file. Bulky or outsize items can be stored in a pocket or envelope inside the cover on the left hand side.

The length of the retention period depends on the type of record and its importance to the business of the organisation. The destruction of records is an irreversible act, whilst the cost of keeping them can be high and continuing.

The Trust 'Retention & Disposal Schedule' (Appendix 6) takes account of legal requirements and sets out the minimum retention periods for clinical and administrative (both paper and electronic) records.

Records categorised for permanent preservation will need to be initially placed in long term storage with a view to them then being moved to a suitable archive as agreed with Public Records Office, Northern Ireland (PRONI).

Section 6 – Review/Disposal of Records

6.0 Paper records

The Trust Disposal Schedule outlines retention periods and final potential action for all records.

Closed records not selected for destruction, permanent preservation or transfer to PRONI will be subject to a review process. Senior Management should ensure that procedures are in operation within the organisation to review files at the appropriate time.

6.1 Records Review

A Records Review group should be set up at local level and allocated the task of reviewing records.

Trust records are examined or reviewed in order to determine if they are worthy of destruction, retention and permanent preservation. This is because their full value cannot be determined at an earlier stage.

Each record needs to be assessed individually to

- Determine its value as a source of information about the Trust, its operations, relationships and environment
- Assess its importance as evidence of business activities and divisions and
- Establish whether there are any legal or regulatory retention requirements

Where there are records which have been omitted from the Disposal Schedule, consultation should be undertaken with the Records Manager for further clarification.

The procedure for disposal of confidential waste is as follows:

6.1.1 Non-sensitive files/records

I.e. non-confidential waste

Information in public domain:

- Dispose of waste in a black bag

Files/records not normally available to the public:

- Torn into small pieces and disposed in a white Hessian sack (Confidential Waste) for collection by the approved waste management company

6.1.2 Sensitive records

Restricted: Strip - shredded

- Bagged for collection by approved waste management company

Confidential: Cross-cut shredded

- Bagged for destruction by approved waste management company

Secret and Top Secret: Cross-cut shredded

- Bagged for destruction by approved waste management company

When records are destroyed by an external service provider, i.e. an approved waste management company, a Certificate of Destruction must be obtained from the company destroying the records and kept on file at the site of the collection.

The disposal of confidential waste is subject to change by the Environmental Manager. Please contact the Trust Environmental Manager for further guidance.

(A Regional Contract is in place in the Trust for the collection, shredding/destruction and safe disposal of confidential paper and optical/magnetic (audio tapes, CD's, video tapes, films etc) waste).

6.2 Electronic Records

An email message constitutes an official record when the document is made or received in connection with the transaction of Trust business. Email should be retained for the same period of time as the Trust would need to retain such a record if it were in paper format. Under the Freedom of Information Act 2000 certain emails and their content may be 'discoverable' and would therefore be liable to disclosure.

It is good practice to destroy all emails that do not need to be retained for specific business purposes.

Under the Freedom of information Act 2000 it is a criminal offence for any member of staff to deliberately and knowingly destroy information (including emails) under the control of the Trust, which is required for the purposes of disclosure pursuant to a pending application seeking such information. Destruction of such information under these terms may lead to criminal prosecution of the individual responsible for the destruction of the information.

(Please refer to the Trust ICT Security Policy, Internet Policy and Email Policy).

Section 7 – Access to Records

7.0 Access to Records

The improper disclosure of information may be in breach of the law, Trust guidelines/or policy such as on confidentiality and other professional guidelines and may result in legal action by others and/or disciplinary action by the Trust.

As a public body, the Trust's information is held on the basis of need and where information is not required for performing the business of the Trust it will be destroyed in line with retention and disposal schedules.

The Trust will publish or provide information to interested applicants under the Freedom of Information Act 2000, The Data Protection Act 2018 and the Environmental Information Regulations 1998 where the application is correctly presented, any prescribed fee has been paid and information requested is not subject to an exemption.

Both Trust staff and associated professionals are required to ensure they maintain the quality and consistency of records they create and follow the correct local procedures to allow both local and central access as appropriate.

Certain information held by the Trust is exempt from disclosure to the public. Examples of exemptions include information that relates to an individual and information provided in confidence.

Staff who have queries regarding requests for access to records/information should contact the Head of Information Governance in the first instance who will advise on the Trust' s process and where applicable, relevant exemptions.

Section 8 – Audit

8.0 Records Management is ongoing work that is the responsibility of all staff in the Trust and is a fundamental part of their normal duties. It is important to operate in an environment of effective records management which contributes to an improved quality in the services provided the organisation. The Trust will be expected to self-assess and report compliance annually, against the Records Management Controls Assurance Standard. The Trust will undertake regular audit of its records management systems which will include compliance with the Trust's Records Management Policy and this procedures document.

GLOSSARY OF RECORDS MANAGEMENT TERMS

Access. The availability of or permission to consult records.

Active Record. Those records which are retrieved and consulted frequently, or which contain information of immediate relevance to the current activities of the organisation.

Appraisal. The process of evaluating business activities to determine which records need to be captured and how long they need to be kept to meet business needs and the requirements of organisational accountability.

Business Activity. An umbrella term covering all the functions, activities and transactions of an organisation and its employees.

BCS. See Business classification scheme

Business classification scheme (BCS). A conceptual representation of the functions and activities performed by an organisation. The scheme is derived from the analysis of business activity. The BCS contains scope notes and 'terms' that represent and describe functions, activities, transactions or other elements and shows their relationships. The structure of the scheme is hierarchical, moving from the general to the specific. The business classification scheme is used to link records to their business context. This is a key requirement for making and capturing 'full and accurate' records.

Classification.
1. The systematic identification and arrangement of business activities and/or records into categories according to logically structured conventions, methods and procedural rules represented in a classification system.
2. Classification includes determining document or file naming conventions, user permissions and security restrictions on records.

Control. The physical and/or intellectual management established over records by documenting information about their physical and logical state, their content, their provenance, and their relationships with other records. The systems and processes associated with establishing control include registration, classification, indexing and tracking.

Create (a record). The act of making a record (evidence) of business transactions.

Controlled vocabulary. See Thesaurus

Disposal. The implementation of appraisal and review decisions. These comprise the destruction of records and transfer of selected records to the Public Record

Office. They may also include movement of records from one system to another (for example paper to electronic) or the transfer of custody of the records.

Disposal Schedule. A list of the record series of an organisation with directions for how the records are to be disposed of (see Disposal) after their creation and initial use. The schedule is a written statement of how long each series (or group of series) is to be retained (e.g. a period of years or indefinitely), and may also include instructions on when records are to be transferred to secondary storage of archives, or destroyed.

Documents. These are recorded communication with recognisable structure regardless of medium. Not all documents are records in the archival or legal sense.

Documentation. Written facts about a recordkeeping system including its component parts and a manual of instruction detailing rules for use and maintenance of the system.

Electronic Document Management (EDM) helps organisations to exploit their information more effectively by providing better access to stored information. EDM supports the immediate operational requirement for business information.

Electronic Document and Records Management System (EDRMS) ensures that all records are retained and managed within the context in which they were originally created i.e. electronically.

Electronic Records. These are records where the information is recorded in a form that is suitable for retrieval, processing and communication by a digital computer.

File In records management sense, a file (or folder) groups associated records in a logical structure that shows the position of one record in relation to others. By means of a file/folder, a whole group of records can be managed together. Also refers to a set of data held on computer.

Fileplan. A category of electronic records grouped together in a file within a classification scheme.

'The full set of classes and the folders, which re allocated to them, together make up a fileplan. The fileplan is a full representation of the business of the organisation within a structure, which is best suited to support the conduct of that business and meet records management needs'. (PRO 2002)

Folder. A container for records. Folders are located in the fileplan by being allocated to a category.

Inactive Records. Those records which are seldom accessed, but must be retained for occasional reference, or for legal or archival reasons. See also Active and Semi-active records.

Lifecycle. The life of a record is viewed as consisting of five phases: creation, distribution, use, maintenance and disposal.

Notation. A numbering or coding system.

Precedent Case. The first time a procedure or a certain product or piece of equipment was used on certain groups of patients or individuals in Northern Ireland regardless of the professional who carried it out. 'Precedent case' implies a unique situation, and one which is innovative in nature. (Craigavon & Banbridge Community HSS Trust with approval of PRONI, 2006).

Record. Information created, received & maintained as evidence and information by an organisation or person, in pursuance of legal obligations or in the transaction of business.

Records retention and disposal schedule. See Disposal Schedule.

Records Series. A collection of records having a common subject or theme usually identified by a specific lettercode or number.

Record Audit. Complete and accurate listing of records resulting from a survey Register. A list of records, usually in simple sequence such as date and reference number, serving as a finding aid to the records.

Retention. The continued storage and maintenance of records for as long as they are required by the creating or holding organisation until their disposal, according to their administrative, legal, financial and historical evaluation.

Review. The examination of records to determine whether they should be destroyed, retained for a further period or transferred to the Public Record Office.

Scheduling. The production of a schedule or list of public records for which pre determined periods of retention have been agreed between the Departmental Record Officer of the Organisation concerned, and the Public Record Office.

Scope note. Defines the meaning of a term or combination of terms in a business classification tool and guides user on how such terms should be applied. It facilitates

consistency in usage by discouraging personal interpretations by different people across the organisation.

Semi-active records. A category of records in between active and inactive records. Previous year records which are needed for reference when the current year's work is being done, are an example of semi-active records.

Series. See Record Series.

Thesaurus

An alphabetical presentation of a controlled list of terms, linked together by semantic, hierarchical, associative or equivalence relationships. Such a tool acts as a guide to allocating classification terms to individual records (AS/ISO 15489, Part2, Clause 4.2.3.2.) Source - National Archives of Australia; Overview of Classification Tools – July 2003

Thesaurus
1. In a thesaurus, the meaning of the term is specified and relationships to other terms are shown. A thesaurus should provide sufficient entry points to allow users to navigate from non-preferred terms to preferred terms adopted by the organisation.
2. Classification tool comprising an alphabetical presentation of a controlled list of terms linked together by semantic, hierarchical, associative or equivalence relationships.

Tracking. Capturing and maintaining information about the movement, use and transaction of records.

Transaction.

1. The smallest unit of business activity. Uses of records are themselves transactions
2. The third level in a business classification scheme

("Records Management: Standards for the management of Government Records; Information Surveys, 1999, Public Record Office")

(Kennedy, J. & Schauder, C. Records Management, a guide to corporate recordkeeping. Longman, 1998.)

Glossary of Recordkeeping Terminology. National Archives of Australia. 2004. ISBN1920807268
www.naa.gov.au/recordkeeping/rkpubs/recordkeepingglossary.html

PRO/The National Archives Requirements for Electronic Records Management Systems 3: Reference Document 2002)

References

Generic medical record-keeping standards. Prepared by the Health Informatics Unit of the Royal College of Physicians, 2007 (includes 12 generic record keeping standards which are applicable to any patient's medical record).
http://hiu.rcplondon.ac.uk/clinicalstandards/GenericRecordKeepingStandards.pdf

Policy on the Transfer of patients/clients and their records to another hospital or in-patient facility
http://intranet/HTML/PandP/documents/PolicyonTransferofPatientsclientsandtheirrecordstoanotherhospitalorinpatientfacility.pdf

How does the Data Protection Act apply to professional opinions?
Data Protection Good Practice Note, 2006. Information Commissioner's Office - www.ico.gov.uk

Southern Health and Social Care Trust Policy for the Safeguarding, Movement & Transportation of Records and Files Link

Records Management Strategy 2019, Southern Health & Social Care Trust
Records Managemetn Strategy

Records Retention and Disposal Schedule, Southern Health & Social Care Trust (January 2011) http://sharepoint/pr/ig/RM/good-mamagement-good-records_2011.pdf

APPENDIX 1 – Version Control Certificate

POLICY DOCUMENT – VERSION CONTROL SHEET	
Title	Title: Version: Reference number/document name:
Supersedes	Supersedes:
Originator	Name of Author: Title:
Scrutiny Committee & SMT approval	Referred for approval by: Date of Referral: Scrutiny Policy Committee Approval (Date): SMT approval (Date):
Circulation	Issue Date: Circulated By: Issued To:
Review	Review Date: Responsibility of (Name): Title:

APPENDIX 2 – Guidance on Version Control of Documents

1.0 Introduction

Using Version Control helps to identify where changes have been made to a document and to ensure that everyone is using the most recent version of a document. This is particularly useful when a document is being produced or reviewed collaboratively, for example, by a project team, committee, etc.

The content of a document under Version Control is never overwritten. However, each time modifications are made to a document a new version is created which then becomes the current version. Every version number for a given document shall be unique.

The guidance outlined in Section 2.0 of this section will assist in the application of Version Control of all Trust documents, for example policies, procedures etc. To assist in the application of Version Control, a flow diagram has been developed (See Appendix 2a).

1.0 Applying Version Control to Documents

Each version of a document shall be given an issue number, in the format of 'Version X_Y', where 'X' and 'Y' are numbers.

2.1 Initial Draft of a Document

When a document is initially produced, prior to formal organisation approval, it shall be versioned as 'Version 0_1 Draft'. Subsequent versions of the initial document shall be described as 'Version 0_2 Draft', 'Version 0_3 Draft' etc.

Where documents are in draft, a 'DRAFT' watermark should be incorporated into the document.

1.2 First Approval of a Document

When a document is formally approved for the first time by the Trust, it shall be issued as 'Version 1_0'.

2.3 Initial Review of an Approved Document

Good practice suggests that documents should be reviewed regularly to ensure that they are up-to-date, relevant and not obsolete.

During the review of the formally approved document 'Version 1_0', if an amendment is required a new version of the document should be created incorporating the amendment. This will be versioned as 'Version 1_0 Draft1'.

Subsequent changes during the review of document 'Version 1_0', will be versioned as 'Version 1_0 Draft2', 'Version 1_0 Draft3' etc.

How a document will be versioned following formal approval for the second time will depend upon the significance of the changes since the issue of 'Version 1_0':

- If the changes are considered to be **minor** e.g. spelling, grammar, 1 line change, then the document will be issued as 'Version 1_1'; or
- If the changes are considered to be major e.g. Addition/Removal of a section, legislative changes, change in processes, then the document will be issued as 'Version 2_0'.

2.4 Subsequent Reviews of a Document

If further changes are to be made to document 'Version 1_1', the draft version will be described as 'Version 1_1 Draft1', 'Version 1_1 Draft2', 'Version 1_1 Draft3' etc.

If further changes are to be made to document 'Version 2_0', the draft version will be described as 'Version 2_0 Draft1', 'Version 2_0 Draft2', 'Version 2_0 Draft3' etc.

3.0 The Change Log

A Change Log should be created which will detail the changes made during the lifecycle of a document and allow a reader to identify where modifications have been made within each version of a document. Therefore, the Change Log should contain an entry for every version of a document.

Each entry should include details of the following:
- The version number;
- The date the version number was assigned;
- The author of the changes; and
- A brief description of the modifications associated with the version. This should be no more than a few concise phrases but sufficient enough to outline the changes.

The Change Log should appear at the beginning of a formally approved document and should describe the changes between the first formally approved version and subsequent approved versions.

The author should retain the more detailed Change Log of a document between draft versions. An example of a Change Log for a document is contained in Appendix 2b.

APPENDIX 2a

Example Flow Diagram on the application of Version Control

First draft of 'Version Control of Documents Guidance' produced.	Document is issued as: **Version 0_1 Draft**
Version 0_1 Draft reviewed by the Project Team and amendments made to document.	Document is issued as: **Version 0_2 Draft**
Version 0_2 Draft reviewed by the Project Assurance Team and amendments made to document.	Document is issued as: **Version 0_3 Draft**
Version 0_3 Draft reviewed by Project Team and Information Services Department and amendments made to document.	Document is issued as: **Version 0_4 Draft**
Version 0_4 Draft reviewed by Project Assurance Team and final amendments made to document.	Document is issued as: **Version 0_5 Draft**
Version 0_5 Draft 'Version Control of Documents Guidance' formally approved by the Senior Management Team.	Document is issued as: **Version 1_0**
Version 1_0 reviewed by Project Manager and **minor** amendments made.	Document is issued as: **Version 1_0 Draft1**
Version 1_0 Draft1 formally approved by the Senior Management Team	Document is issued as: **Version 1_1**

APPENDIX 2b

The Change Log

Version	Date	Author(s)	Notes on Revisions/Modifications
Version 1_0	10 February 2005	Information Services	
Version 1_1	30 September 2005	Information Services	Updated Contact Details
Version 2_0	31 March 2006	Information Services	New section added on Communication Channels

APPENDIX 3 - Guidance on Naming Convention

Yearmonthdate_title_documenttype_version_originator

Example: **20180104_InformationGovernanceQuarterly_Report_V1_PMcManus**

8.0 Guidance: Best Practice

Year: Use 4 digits for the year and two for the month and date for example yyyymmdd_

Title: Include enough keywords to identify the document. Up to four may be used. Do not Include 'and', it', etc. Do not use abbreviations.

Capitals: Use a capital letter at the start of each word. Do not place a space in between words.

Underscore: The purpose of the underscore is to break up each part of naming convention and to assist the search facility.

Full stops and dashes: Should not be used.

Document type: Refers to a report, minutes, agenda, circular, email, letter (letterin; emailin for a letter or email message which has been received/scanned).

Addressee Name: It is best practice if the name of addressee makes up part of a title.
Example: 20180515_ComplaintResponseBloggsJ_letter_V1_IG

Version: Use
V0_1 for a document which you are working on
V0_2 for a document you are working on (second draft prior to approval)
V0_3 for a document you are working on (third draft prior to approval)
V1_0 for a document which has been approved
V1_1 for a document which has undergone minor amendments
V2_0 for a document which has undergone major amendments

Draft: Only include if a document is a draft, otherwise leave out.

Originator/Author: Use either of the following;

1. surname in full and initial. Example GrahamC; or;
2. abbreviations denoting Department or Team as know in the corporate environment. Example CA (Corporate Affairs); RM (Records Management); HR (Human Resources)

APPENDIX 4 – Fileplan by The Regional Records Management Working Group

FILEPLAN – LEVELS ONE & TWO

Level One

CORPORATE MANAGEMENT
ESTATE SERVICES
FINANCIAL MANAGEMENT
HUMAN RESOURCE MANAGEMENT
INFORMATION & COMMUNICATION
INFORMATION MANAGEMENT & TECHNOLOGY
SERVICE DELIVERY
SUPPORT SERVICES

Levels One & Two

CORPORATE MANAGEMENT
- AUDIT
- BUSINESS CONTINUITY PLANNING
- BUSINESS PERFORMANCE
- BUSINESS PLANNING
- EQUALITY PLANNING & MONITORING
- GOVERNANCE
- LEGAL SUPPORT
- MEETINGS
- OFFICIAL FUNCTIONS & VISITS
- ORGANISATIONAL DEVELOPMENT
- STATUTORY RESPONSIBILITIES
- STRATEGY

ESTATE SERVICES
- PREMISES
- PROGRAMMES & PROJECTS
- STATUTORY RESPONSIBILITIES
- SUPPLIES & EQUIPMENT
- TELEPHONE SYSTEMS
- VEHICLES

FINANCIAL MANAGEMENT
- ACCOUNTING FOR INCOME & EXPENDITURE
- ASSET MANAGEMENT
- FINANCIAL GOVERNANCE
- FINANCIAL PLANNING & CONTROL
- PAYROLL
- STATUTORY RESPONSIBILITIES

HUMAN RESOURCE MANAGEMENT
- ATTENDANCE MANAGEMENT
- GRIEVANCE & DISCIPLINE
- INDUSTRIAL RELATIONS
- PERSONNEL FILES
- SECURITY MANAGEMENT
- STAFF PERFORMANCE MANAGEMENT
- STAFFING
- STATUTORY RESPONSIBILITIES
- TRAINING & DEVELOPMENT
- WORKFORCE PLANNING

INFORMATION & COMMUNICATION
- BRIEFINGS
- CONTACTS
- GOVERNMENT ENQUIRIES
- INFORMATION ACCESS REQUESTS
- MARKETING
- MEDIA RELATIONS
- PUBLICATIONS & REFERENCE MATERIAL
- RECORDS MANAGEMENT
- STATUTORY RESPONSIBILITIES
- WEBSITE CONTENT MANAGEMENT

INFORMATION MANAGEMENT & TECHNOLOGY
- ASSETS & SERVICES
- PROGRAMMES & PROJECTS
- SECURITY MANAGEMENT
- STATUTORY RESPONSIBILITIES
- SYSTEMS MANAGEMENT
- USER SUPPORT

SERVICE DELIVERY
- COMMISSIONING
- CONSULTATION
- MONITORING
- NEEDS ASSESSMENT
- PLANNING
- STATUTORY RESPONSIBILITIES

SUPPORT SERVICES
- COMMISSIONING
- MONITORING
- STATUTORY RESPONSIBILITIES

APPENDIX 5 (Print on a yellow sheet of paper)

Southern Health and Social Care Trust

CLOSED RECORDS FORM

PLEASE ENSURE THAT YOU READ THE CLOSED RECORD PROCEDURE BEFORE COMPLETING THIS FORM

COMPLETE ALL SECTIONS IN BLOCK CAPITALS

Record/Client Name: _____

Record/Client Unit Number (if applicable):_____

Address of Patient (if applicable): _____

Record Type: _____

Date of Birth (if applicable): _____

Date Record Created (if applicable)_____

Date Record Closed:_____

Team Name: _____

Team Address:_____

Retain to: _____

Final Outcome (as per GMGR):_____

APPENDIX 6 – Retention & Disposal Schedule

The Retention & Disposal Schedule is on the Department of Health's website at https://www.health-ni.gov.uk/topics/good-management-good-records/disposal-schedule-work-areas

Southern Health and Social Care Trust

Version: 2_9 March 2021

Records Management Policy

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

Policy Checklist

Policy name:	**Records Management Policy**
Lead Policy Author & Job Title:	Catherine Weaver – Head of Information Governance
Director responsible for Policy:	Aldrina Magwood
Directorate responsible for Policy:	**Performance & Reform**
Equality Screened by:	Claire Graham
Trade Union consultation?	Yes ☒No ☐
Policy Implementation Plan included?	Yes ☐ No ☒
Date approved by Policy Scrutiny Committee:	TBC
Date approved by SMT:	
Policy circulated to:	Directors and Information Governance Committee
Policy uploaded to:	Sharepoint

Version Control

Version:	Records Management Policy Version: 2_9
Supersedes:	Records Management Policy Version 2_8 January 2019

Version History

Version	Notes on revisions/modifications and who document was circulated or presented to	Date	Lead Policy Author
V2.9	Amended to include updated Good Management, Good Records (GMGR) 2021	TBC	Catherine Weaver

Contents ***Page Number***

1.0 Introduction to Policy

It is a statutory requirement for the HPSS to implement records management as set out in the Public Records Act (Northern Ireland) 1923 Act and in the Disposal of Documents (Northern Ireland) Order (1925).

This policy gives the basis for good records management, and will contribute to the foundation of the Trust's Information Governance Strategy.

2.0 Purpose and Aims

The purpose of this policy is to ensure that the Trust adopts best practices in the management of its records so that reliable records are created, they can be found when needed, and are destroyed or archived, when no longer required.

Compliance with this policy will ensure that the Trust can provide evidence of performance and demonstrate accountability, as well as providing information about its decisions and activities.

3.0 Policy Statement

It is the policy of Southern Health and Social Care Trust that authentic, reliable and useable records are created, which are capable of supporting business functions and activities for as long as they are required. Adherence to this policy will ensure consistency and conformity of approach. The policy applies to all records of the Trust, and will be achieved by creating a procedural framework, which ensures that:

- records are made accessible to enable well-informed and proper judgments to be made;
- records are kept securely and protected from accidental loss, destruction and unauthorised access;
- records are kept for no longer than is necessary, in accordance with legal and professional obligations and with due regard to the Trust's Records Retention and Disposal Schedule;
- members and employees are made aware of and trained in the management of records within their sphere of work or responsibility.

4.0 Scope of the Policy

The international standard of managing records, ISO 15489 defines a record as *"information created, received and maintained as evidence and*

information by an organisation or person, in pursuance of legal obligations or in the transaction of business."

In the context of this policy a record is any recorded information that contains information, electronic or in paper, in any media which is created, collected, processed, used, stored and/or disposed of by Southern Health and Social Care Trust employees, as well as those acting as its agents in the course of Trust business.

This policy applies to all directors and employees of the Southern Health and Social Care Trust. Non-compliance with this policy may result in disciplinary action by the Trust or legal action by others.

5.0 Responsibility for Trust Records

5.1 Managerial responsibility

5.1.1 Trust Board

The role of the Trust Board is to oversee the effective records management by officers of the Trust.

5.1.2 Chief Executive and Directors

The Chief Executive and Directors are personally accountable for the quality of records management within the Trust and have a duty to make arrangements for the safekeeping and eventual disposal of those records under the overall supervision of the Deputy Keeper of Public Records Office, Northern Ireland.

5.1.3 Assistant Director of Informatics

The Assistant Director of Informatics is lead officer for records management within the Trust. Responsibilities include:

- co-ordinating, publicising and monitoring implementation of the records management strategy and reporting on a regular basis to the Senior Management Team;
- determining the type of system appropriate to allow effective and efficient discharge of functions while meeting the statutory duty of records management;
- ensuring that the systems in place for records management are monitored and reviewed by the Senior Management Team and the Board at least annually in order to make improvements to the system;
- promotion of and overseeing of the Information Governance Strategy; and

- ensuring that records management functions are supported in their work in terms of commitment and resources.

5.1.4 Senior Managers

The role of Senior Managers is to ensure that records are managed effectively in each service area in accordance with the Trust Records Management Policy (this document). Senior Managers are responsible for ensuring staff are aware of the appropriate records management policies and procedures and that they have been trained in the operational procedures required by the Trust. Responsibilities of Senior Managers include:

- ensuring that any policies, procedures or protocols agreed by Records Management/Policy Committee are implemented within their area;
- ensuring that appropriate employees are designated to assist with the implementation of records management procedures within their area;
- ensuring that employees are supported in terms of training and development in their adherence to the Records Management Policy and procedures;
- ensuring that personal information (e.g. about a patient/member of staff) is not kept longer than is necessary. (Information about individual patients may not be passed on to others without the individual's consent except as permitted under Schedule 2 and 3 of the Data Protection Act 2018);
- ensuring that an inventory of records is maintained which shows the nature and type of records within service function, activity and directorate, is accessible to users and indicates the specific retention periods for those records; and
- ensuring that staff who record, handle, store or otherwise comes across patient information is aware that they may have a common law duty of confidence to patients. Such a duty will continue even after the death of a patient.

5.1.5 Head of Information Governance

The role of the Head of Information Governance is to support the Trust, its directorates and employees in the development, implementation and review of the records management, policies and procedures and to ensure that the Trust has a modern innovative and fully effective records management system. The Head of Information Governance oversees the implementation of the integrated framework, policy, strategy and processes on behalf of the Trust. Responsibilities include:

- ensuring the statutory requirements as laid down in the Disposal of Documents (Northern Ireland) Order 1925 (made under the Public Records Act (Northern Ireland) 1923 for the destruction and preservation of records), are fulfilled;
- providing advice and support of the Information Governance strategy, policy, framework and processes;
- providing training in Records Management, Freedom of Information, Data Protection and Environmental Information;
- providing advice on appropriate low cost storage for departmental records;
- developing procedures for the permanent preservation of selected records with the Public Records Office, Northern Ireland;
- co-ordinating requests for information in compliance with Data Protection and Freedom of Information legislation;
- preparing draft reports for the Senior Management Team to issue to stakeholders on the Trust's Information Governance framework, policy, strategy ;
- undertaking information audits to develop appropriate retention schedules and classification schemes (corporate and health);
- undertaking compliance audits of records management programmes (policies, procedures and systems) to ensure statutory obligations are met including the Freedom of Information Act 2000 and Data Protection Act 2018; and
- providing the Trust, in accordance with the Governance framework, details of records management process to enable internal controls to be monitored.

5.1.6 Head of Health Records

The responsibilities of the Head of Health Records include:

- ensuring the provision of a comprehensive, efficient and effective Acute Health Records Service on a Trust-wide basis.

- providing professional advice on health records.

- ensuring the Health Records Departments comply with the Data Protection Act, Subject Access requirements and Access to Health Records Order (1993).

- ensuring compliance with Information Management Controls Assurance standards.

- ensuring the statutory requirements as laid down in the Disposal of Documents (Northern Ireland) Order 1925, made

under the Public Records Act Northern Ireland 1923 regarding the destruction and preservation of acute health records are fulfilled.

- auditing availability of acute health records for patient attendances.

5.1.7 Personal Data Guardian

The Personal Data Guardian has a particular responsibility for safeguarding patients' interests regarding the use of patient identifiable information. The Trust's Personal Data Guardian is the Medical Director. The Director of Children and Young People's Services is the Data Guardian for Social Services Records.

5.1.8 Information Governance Forum

The Information Governance Forum will ensure that the Trust has effective policies, systems and processes in place for record keeping and information handling in accordance with statutory, legal and good practice requirements. The Forum's remit is specific to patient and client information governance. The Information Governance Forum will be chaired by the Medical Director (Personal Data Guardian) and will steer the work of the following groups:

- Information Governance Committee;
- Data Protection Sub Group;
- Research Governance Committee;
- Data Quality Working Group;
- Technology Enabled Change Group;
- Cyber Security Task & Finish Group
- Technical Design Authority
- Clinical Coding Sub Group; and
- Corporate Governance
- Clinical & Social Care Governance

5.1.9 Information Governance Committee

A group has been established under the Chairmanship of the Assistant Director of Informatics (Directorate of Performance and Reform). The Head of Information Governance and a representative from each Directorate serve on the committee. The role of the committee is to;

- assist with and oversee Trust compliance in Information Management Controls Assurance Standards and the Freedom of Information Act 2000;
- facilitate consultation and the development of coherent responses on all Records Management issues;
- promote records management and provide support to staff in line with 'Good Management, Good Records; Guidelines for managing records in Health and Personal Social Services organisations in Northern Ireland', (Jan 2021);
- assist with the implementation of a training programme for Records Management, FOI and Data Protection;
- assist with the development of performance indicators and implement benchmarking with other Trusts;
- support the development and population of the Trust Publication Scheme; and
- facilitate the networking, collaborating and sharing of information between those responsible for record keeping.

5.1.10 Individual members of staff

All Trust staff, whether administrative or clinical are responsible for any records, which they create or use in the performance of their duties. They are responsible for documenting their actions and decisions and for maintaining the records in accordance with good records management practice and professional guidelines. This responsibility is established at, and defined by, the law for example, Public Records Act 1958, Data Protection Act 2018 and other professional guidelines covering the handling of public records. Therefore everyone working for or with the Trust who records, handles, stores or otherwise comes across patient information has a personal common law duty of confidence to patients and to his/her employer. The duty of confidence continues even after the death of the patient or after an employee or contractor has left the NHS.

Individuals need to ensure that:

- the record can be accessed;
- the record can be interpreted;
- it is possible to establish who created the document, during which operational process and how it relates to other records;
- the record can be trusted;
- the record can be maintained through time;
- the record is disposed of in accordance with Good Management, Good Records (GMGR 2021);

- the record is accessible and meaningful, in the right format, to those who need to use it;
- there is no unnecessary duplication between the paper and electronic record collections; and
- there is no distinction made between the electronic documents that are printed, printed records that reside in paper record systems and other original documents that are retained as records.

5.1.11 Designated Accountability

The person accountable for overseeing the implementation of this Policy and Guidelines is the Assistant Director of Informatics.

The Head of Information Governance will ensure that staff operating in the Trust is made aware of developments in law, NHS and/or professional guidelines and recognised good practice.

The Trust's Records Management Policy is required to be reviewed every 2 years.

6.0 Legislative Compliance, Relevant Policies, Procedures and Guidance

The Lord Chancellor's Code of Practice on the management of records, which can be found under Section 46 of the Freedom of Information Act, requires the Trust to have in place a policy statement endorsed by senior management and made readily available to staff at all levels in the Trust on how it manages its paper and electronic records. Other relevant documents are the Trust's Records Management Procedures and Information Governance Strategy.

7 Sources of Advice and Further Information

Related Policies/Manuals Include:-

1. Code of Practice on Protecting the Confidentiality of Service User Information.

2. Southern Health & Social Care Trust Records Management Procedures

3. Southern Health and Social Care Trust Safeguarding, Movement & Transportation of Records Policy

4. Record Management Strategy, Southern Health & Social Care Trust (V2.1 2019-2021)

5. ‘Good Management, Good Records; Guidelines for managing records in Health and Personal Social Services organisations in Northern Ireland’, (Jan 2021).

Southern Health and Social Care Trust

Quality Care - for you, with you

Information Technology Security Policy 1.3 March 2021

Lead Policy Author & Job Title:	Stephen Hylands, Head of Information Technology
Directorate responsible for document:	Performance & Reform
Issue Date:	01 March 2021
Review Date:	01 March 2023

Policy Checklist

Policy name:	Information Technology Security Policy
Lead Policy Author & Job Title:	**Stephen Hylands, Head of Information Technology**
Director responsible for Policy:	Mrs Aldrina Magwood
Directorate responsible for Policy:	Performance & Reform
Equality Screened by:	**Head of Information Technology**
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Date approved by SMT:	Click here to enter a date.
Policy circulated to:	Eg Directors, Assistant Directors, Heads of Service for onward distribution to line managers, Global email, Staff Newsletter
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Version 3.3	Update to previous Policy and Procedure	01/05/2017	Stephen Hylands

Contents

1. INTRODUCTION

Health and Social Care (HSC) and Northern Ireland Fire and Rescue Service (NIFRS) (herein HSC will refer to all HSC and NIFRS organisations) Information and Information Communication Technology (ICT) (herein Information Assets and Systems), is vital to the successful operation and effectiveness of HSC organisations. It is, however, vulnerable to risk and so there is a need to develop a culture within which our Information Assets and Systems can operate efficiently, effectively and securely. The management of these risks is referred to as Information Security which is used herein to describe the management of risks relating to Information Assets and Systems.

HSC take a risk-based approach to the management of Information Security risk, and objectives outlined in this policy and the supporting Information Security Standards aim to target and treat the highest risks to the organisation. An example of this is malicious or accidental insider threat, which remains a big risk to HSC - so effective Information Security management requires the participation of all employees in the organisation.

Information Security can be achieved in part through technical means but should be supported and enhanced by appropriate management and procedures. The main principle is that the data and information that HSC information systems process (particularly personally identifiable and business sensitive data) must only be seen by those who are entitled to see it.

HSC is committed to the continuous improvement of Information Security across our organisations and commit to satisfy the applicable requirements ethically, regulatory and legally applicable to us. To enable this, the objectives set within this Information Security Policy is complimented by two sets of Information Security Standards, for non-technical users and technical users, that should be read for detail into specific areas of Information Security, these areas are as follows:

Standard Reference Number	**All User Standards**
1.01	Email Communications
1.02	Removeable Media
1.03	Use of Internet Services
1.04	Asset Management
1.05	Clear Desk and Screen
1.06	Cloud Security
1.07	Data Transfer
1.08	Encryption
1.09	Incident Identification and Reporting
1.10	Remote and Mobile Working
1.11	Accounts and Passwords

Standard Reference Number	**Technical User Standards**
2.01	Asset Management
2.02	Cloud Services and Security
2.03	Encryption
2.04	Incident Management
2.05	Remote and Mobile Working
2.06	Privileged Account Management
2.07	Patch Management
2.08	Vulnerability Management
2.09	Incident Response
2.10	Network Discovery
2.11	Anti-Virus and Endpoint Protection
2.12	Public Key Infrastructure
2.13	Wireless
2.14	Joiners, Movers, Leavers

There are a number of relevant pieces of legislation (see section 9) that must be adhered to if HSC organisations are to remain legally compliant when using, storing and handling information. The Data Protection Act 2018 (DPA) and the General Data Protection Regulation (GDPR) define a legal basis for UK organisations to take steps to ensure that personal data is adequately protected by placing a legal obligation on them to do so. HSC are also required to abide by the regulation set out in the Network and Information Systems

(NIS) Regulation (2018) that aims to improve the cyber security and resilience of key systems.

As the risk to HSC or the regulatory/legal landscape changes, policies and the applicable standards, processes, procedures and guidance will be updated as is appropriate.

2. PURPOSE

This Information Security Policy details the regional approach to Information Security Management across HSC and NIFRS, including the overall management structure and key principles which apply to each HSC and NIFRS organisation.

This policy, and the associated Information Security standards, lay down high-level principles and expectations, from which each HSC and NIFRS organisation must develop their own local policies, standards, guidelines, and working practices to ensure compliance.

This is to ensure a consistent and high standard of Information Security management across the entire HSC and NIFRS community from all significant threats whether internal, external, deliberate or accidental.

3. SCOPE

The Information Security Policy applies to:

- All parties who have access to, or the use of, Information Assets and Systems belonging to, or under the control of, HSC or NIFRS [1], including:
  - HSC and NIFRS employees
  - Temporary Staff including agency and students
  - Voluntary Health Sector organisations / Volunteers
  - Third Party Contractors
  - Any other party making use of HSC ICT resources
- HSC information stored, or in use, on HSC or externally hosted systems;
- Information in transit across the HSC networks;
- Information leaving HSC networks;
- ICT Systems belonging to or under the control of HSC.

This policy applies throughout the entire information lifecycle from acquisition/creation through utilisation to storage and disposal.

4. MANAGEMENT FRAMEWORK

4.1. STRATEGIC DIRECTION

4.1.1. The Department of Health in Northern Ireland (DoHNI) is responsible for setting

[1] Northern Ireland Health & Social Care organisations include Health & Social Care Board (HSCB), Public Health Agency (PHA), Health & Social Care Trusts, NI Ambulance Service (NIAS), Business Services Organisation (BSO), Patient & Client Council (PCC), Regulation & Quality Improvement Authority (RQIA), NI Guardian Ad Litem Agency (NIGALA), NI Blood Transfusion Service (NIBTS), NI Social Care Council (NISCC), NI Practice and Education Council for Nursing and Midwifery (NIPEC), NI Medical and Dental Training Agency (NIMDTA), GP Practices and other Independent Contractors to HSC, and Northern Ireland Fire and Rescue Service (NIFRS).

policy and legislation which directs Information Security Management across the HSC.

4.1.2. The Health and Social Care Board (HSCB) is responsible for the effective commissioning of Information Systems across the HSC estate, the provision of delegated funding to meet agreed objectives in line with ministerial and departmental policy and the implementation of performance management and service improvement to monitor objectives, targets and standards and their achievement.

4.2. CO-ORDINATION

4.2.1. HSC co-ordinates Information Security management across the region through the Cyber Programme Board. This group holds responsibility for considering and proposing amendments to Information Security management. Significant amendments will be approved by the Regional Director of eHealth and External Collaboration.

4.2.2. HSC co-ordinates Information Governance management across the region through an internal Information Governance Advisory Group, chaired by the Head of Information Management Branch of the DoHNI.

4.3. CORE INFRASTRUCTURE

4.3.1. The Business Services Organisation IT Services Unit provides and maintains the central ICT infrastructure and architecture for HSC. This includes providing Technical Design Authority support (which has representatives from across all HSC organisations and is chaired by Assistant Director of CNI) and General Medical Services ICT support to the HSCB.

4.4. COLLABORATION

4.4.1. All HSC organisations are expected to work together to ensure the successful implementation and development of Information Security across HSC.

4.5. OPERATIONAL MANAGEMENT

HSC Cyber Leads Group

4.5.1. Cyber Leads Group governs local implementation of Information Security management across the region through an internal working group of Information Security representatives from HSC organisations, chaired by the Cyber Leads Programme Manager.

Local Security Management

4.5.2. Each HSC organisation is responsible for implementing a local programme of Information Security management, including the provision of necessary skills, training and resource to ensure adherence to this policy.

4.5.3. Each HSC organisation is accountable to the HSCB, through their Executive and Non-Executive management framework, for the application of this policy.

4.6. ROLES AND RESPONSIBILITIES

Most Senior Officer (MSO) of each HSC Organisation

4.6.1. The MSO is responsible to the HSCB for Information Security within their organisation. This is typically the Chief Executive, General Manager or Senior General Practitioner (GP). This role is responsible for:

- Ensuring a nominated officer with sufficient authority is appointed to ensure security related matters are adopted throughout the organisation;
- Ensuring frameworks are in place to ensure information systems are appropriately assessed for security; and
- Ensuring the organisation maintains compliance with HSC Information Security Policy.

Senior Information Risk Owner (SIRO)

4.6.2. Responsible to the MSO of their local organisation, e.g. Chief Executive, advising on the information risk aspects of his/her statement on internal controls. Responsible for:

- Leading and fostering a culture that values, protects and uses information for the success of the organisation and benefit of its customers;
- Owning the organisation's overall information risk policy and risk assessment processes and ensuring they are implemented consistently by Information Asset Owners; and
- Owning the organisation's information incident management framework.

Data Protection Officer (DPO)

4.6.3. Reporting to the SIRO, the DPO is an independent Data Protection expert that is accountable for ensuing Data Protection regulations such as the DPA and GDPR are being successfully managed at HSC. The DPO is responsible for:

- Informing and advising HSC's data protection obligations, monitoring internal compliance, and demonstrating compliance where required;
- Providing support and advice to the business on Data Protection matters generally and also the Data Protection Impact Assessment (DPIA) process; and
- Being the point of contact for data subjects and the supervisory authority (Information Commissioner's Office (ICO).

Information Asset Owner (IAO)

4.6.4. Responsible to the SIRO of their local organisation providing assurance that information risk is being managed effectively in respect of the information assets that they 'own'. Responsible for:

- Knowing what information comprises or is associated with an asset, and understands the nature and justification of information flows to and from the asset;
- Knowing who has access to the asset, why they have access, ensuring access is compliant with all appropriate policies, procedures or standards; and
- Understanding and addressing risks to the information asset and providing assurance to the SIRO.

HSC ICT Security Manager

4.6.5. Responsible to the BSO ITS Assistant Director, providing assurance that appropriate HSC Information Security policies and procedures, standards and guidelines are in place. Responsible for:

- Co-ordinating Information Security matters across organisational and system boundaries within the HSC;
- Monitoring the effectiveness of Information Security Policy, procedures, standards, guidelines across the HSC;

- Taking a pro-active role in establishing and implementing an HSC-wide Information Security Programme including training, awareness and guidance;
- Promoting Information Security awareness across the HSC;
- Receiving and considering reports of Information Security incidents from ICT Security Managers/Officers, System Managers or others, ensuring the necessary corrective or preventative actions are implemented; and
- Liaising with ICT Security Manager/Officers on matters of Information Security which may impact multiple HSC organisations.

Cyber Lead

4.6.6. Responsible to the SIRO in their organisation providing a local focus on all Information Security matters. Responsible for:

- Co-ordinating Information Security matters across departmental and system boundaries within the organisation;
- Monitoring the effectiveness of Information Security Policy, procedures, standards, guidelines within the organisation;
- Taking a pro-active role in establishing and implementing an Information Security Programme including training, awareness and guidance;
- Promoting Information Security awareness across the organisation;
- Receiving and considering reports of Information Security incidents from System Managers or others, ensuring the necessary corrective or preventative actions are implemented; and
- Liaising with Cyber Programme Manager on matters of Information Security which may impact other HSC organisations.

System Managers

4.6.7. Responsible to the IAO in their organisation ensuring that Information Security requirements, expectations and limitations are mutually understood and agreed, and processes are in place to securely and effectively manage the day to day operations of HSC information systems. Responsible for:

- Day to day operational management of the information system including implementation of suitable measures to ensure system is secure;
- Working in conjunction with the ICT department to ensure core local processes are consistently applied across all information systems;
- Ensuring users of the systems are appropriately trained; and
- Reporting security matters to the ICT Security Officer/Manager.

Third Party Contractors

4.6.8. Responsible to the IAO/Business or Contract Owner/Manager ensuring compliance to regional and local Information Security policies. Responsible for:

- Complying with the terms of their Statement of Compliance.

Users of HSC Information Assets and Systems

4.6.9. Responsible for:

- Complying with all local and regional Information Security policies, procedures or standards;
- Ensuring attendance at, or completion of, all necessary Information Security awareness/training sessions; and
- Reporting incidents relating to Information Security in accordance with local policies, procedures or standards.
-

5. INFORMATION SECURITY POLICY STATEMENTS

5.1. CONTROLS ASSURANCE

5.1.1. All HSC organisations are required to achieve and maintain compliance with the NIS 2018 cyber assessment, and where necessary report to the Competent Authority, in order to provide routine assurance that Information Security is being effectively managed.

5.1.2. To support and underpin compliance, all HSC organisations shall have:

- Staff who are well trained to exercise good judgement, take responsibility and be accountable for the information they handle, including all partner information;
- Mechanisms and processes to ensure assets are properly classified and appropriately protected; and
- Confidence that security controls are effective, and that systems and services can protect the information they carry.

5.2. THIRD PARTY MANAGEMENT

5.2.1. HSC organisations must develop and implement a third-party risk management framework to ensure that strategic, business and budget objectives have rigour, and the selections of products and supplier services are based on an organisational acceptance and understanding of risk.

5.2.2. All HSC organisations must ensure that Information Security clauses, particularly with regards to the DPA 2018, NIS 2018 and The GDPR 2018, are built into all formal service contracts where required.

5.2.3. Where third parties have access to HSC networks, HSC organisations must document the standards and processes necessary to protect against supply chain threats to connected information systems, system components, or information system services. An adequate and proportionate monitoring and auditing capability is expected commensurate with Information Security based risks.

5.2.4. Where data is being hosted externally to the HSC networks (e.g. Cloud Services), information-based risk assessments must be carried out in line with the Information Security Technical Standards. These assessments must, as a minimum, consider legislation and implications with regards to:

- Processing of Personal Data;
- Hosting outside the EU (if applicable);
- Business continuity planning;
- Physical and logical access management;
- Information protection (at rest and in transit);
- Disposal of information;
- Audit logging and access to logs/reports; and
- Termination of contract.

5.3. DATA CLASSIFICATION

5.3.1. All HSC organisations must ensure that information assets and systems are classified appropriately, taking into account value, relevant legal requirements, sensitivity and criticality to the organisation.

5.3.2. The NHS Digital Risk Model should be used to help inform HSC organisations

ensure an appropriate and consistent set of processes and procedures are developed, including:

- Defining information;
- Classifying information;
- Accepting ownership for classified information;
- Labelling classified information;
- Storing and handling classified information;
- Managing network security;
- Categorising and labelling Personally Identifiable Information according to its sensitivity; and
- Making distinctions between ordinary personal data and special categories of personal data as required.

5.4. RECORDS MANAGEMENT

5.4.1. All HSC organisations must ensure that standards and processes are in place and compliant with the Department of Health "Good Management, Good Records" guidance to appropriately document, maintain and destroy HSC information throughout its lifecycle.

5.4.2. The integrity of HSC information relies on information being trusted, acceptable, useable and available. Information should be in a format that is accessible and easy to use, whether it is in electronic, photographic or paper form whilst being adequately protected from unauthorised modification or access.

5.5. ENCRYPTION

5.5.1. All HSC organisations must document the standards and processes necessary to ensure personally identifiable or business sensitive information which is held on devices (including laptops, mobile devices and removable media) and transmitted via the internet, is encrypted to the HSC approved standards, as mandated by the DoHNI.

5.5.2. All HSC organisations must ensure that standards and processes are in place to outline the appropriate requirements for protecting encryption keys against compromise, damage, loss and unauthorised access.

5.5.3. See the Information Security 1.08 Encryption Standard for more information. Technical users should see the Information Security 2.03 Encryption Standard and Information Security 2.12 Public Key Infrastructure Standard for more information.

5.6. INFORMATION ASSET AND SYSTEM MANAGEMENT

5.6.1. All HSC organisations must ensure that standards and processes are in place for the secure recording, monitoring, use, maintenance, decommissioning, redeployment and disposal of all information assets (including hardware and software).

5.6.2. All HSC organisations must ensure that standards and processes are in place to maintain software integrity and traceability. These should govern:

- Procurement of software;
- Risk management;
- The software installation process (and licensing requirements);
- Network management (where software utilises the network);
- Set standards and processes for updating software; and

- The end-of-life process for software (including the removal of software/licensing, and deletion/transfer of associated data).

5.6.3. See the Information Security 1.04 Asset Management Standard for more information. For more information, Technical users should see:

- Information Security 2.01 Asset Management Standard;
- Information Security 2.10 Network Discovery Standard;
- Information Security 2.13 Wireless Standard.

5.7. DATA PROTECTION

5.7.1. The legal requirement for the lawful and correct handling of personal data is set out in the DPA 2018. This Act makes provision for the regulation of the processing (collection, handling and storing etc.) of information relating to living individuals, including the obtaining, holding, use or disclosure of such information. HSC Organisations must have local a Data Protection Policy(s) to ensure the DPA 2018 requirements are met.

5.7.2. All HSC organisations must ensure standards and processes are in place to facilitate implementation of the local Data Protection policies and associated system/information integrity controls. These must include requirements on how personal data must be processed to meet the HSC's data protection standards and to comply with the law, see local policy for more information.

5.7.3. The Code of Practice on Protecting the Confidentiality of Service User Information document issued by DoHNI in April 2019 provides guidance on the handling of personal information and should be applied by HSC organisations.

5.7.4. HSC organisations must ensure that safeguards are in place for information assets and systems, especially those being removed from site for repair or replacement – for example HSC data or licensed software must be removed prior to disposal or re-use of an asset or system.

5.8. EMAIL COMMUNICATIONS

5.8.1. All HSC organisations must ensure that standards and processes are in place to manage email communications that use HSC organisation-controlled email services.

5.8.2. Personal use (any access which is unrelated to official duties) of HSC email services is only permitted in accordance with local security policies – however it shall be avoided where possible.

5.8.3. See the Information Security 1.01 Email Communications Standard for more information.

5.9. USE OF INTERNET SERVICES

5.9.1. All HSC organisations must ensure that standards and processes are in place to manage the use of internet services.

5.9.2. All staff must use internet services in a secure, ethical and legal manner. Staff shall only use internet services for reasonable personal use. Examples of prohibited Internet Services include but are not limited to:

- Attempts to gain unauthorised access to information resources;
- Accessing material that is pornographic, illegal, offensive, or discriminatory;

- Accessing non-approved file sharing services or software;
- Activities that could be damaging to the reputation of the organisation;
- Activities that interfere with business requirements; and
- Activities that violate copyright, license agreements or other contracts.

5.9.3. See the Information Security 1.03 Use of Internet Services Standard for more information.

5.10. INFORMATION FLOW CONTROL

5.10.1. All HSC organisations must ensure that standards and processes are in place to record, manage, regulate and control the flow of information within HSC systems and between HSC's interconnected systems.

5.10.2. To comply with the GDPR and DPA 2018, HSC organisations need to map their information flows in order to appropriately assess privacy risks.

5.11. DATA TRANSFER

5.11.1. All HSC organisations must ensure the parameters for secure and appropriate data transfers are set out. The Information Security content of any Data Access Agreement (DSA) should reflect the sensitivity of the business information involved.

5.11.2. Where formal service contracts are either absent or do not adequately cover the sharing of business sensitive or personally identifiable information between HSC organisations and/or outside organisations, the HSC Data Access Agreement procedure must be followed.

5.11.3. Before establishing any new form of data transfer process that involves personal data, a DPIA must be conducted as a requirement under the DPA 2018/GDPR.

5.11.4. Where an information asset(s) is being shared or transferred, for example a data set containing personal information is being shared with a third party.

5.11.5. See Information Security 1.07 Data Transfer Standard for more information.

5.12. ACCOUNTS AND PASSWORDS

5.12.1. All HSC organisations must ensure that standards and processes are in place to ensure access to systems, information and information processing facilities is limited to those with appropriate authority. These should be used to ensure correct user account provisioning, maintaining appropriate separation of duties between users and outline password best practices.

5.12.2. All HSC organisations must ensure that information systems use unique identifiers for information systems, users and the devices used to access information.

5.12.3. Security privileges and access rights must be allocated based on the requirements of a user's role, and use the principle of least privilege.

5.12.4. Processes must be in place and actioned as soon as is possible to in the event that a user joins the organisation, moves departments (including changing role, or requires different privileges) or leaves the employment of the organisation.

5.12.5. Strong authentication mechanisms must be in place to ensure authorised access.

5.12.6. All staff are responsible for setting passwords that meet the minimum requirements and not sharing their password with others.

5.12.7. See Information Security 1.11 Accounts and Passwords Standard for more information. Technical users should see the Information Security 2.06 Privileged Account Management Standard and Information Security 2.14 Joiners, Movers, Leavers Standard for more information.

5.13. ACCEPTABLE USE

5.13.1. All HSC organisations must ensure that standards and processes are in place to establish the acceptable use of computing equipment and facilities provided by HSC, both from the workplace and whilst using resources remotely. These must be consistent with overarching policies and legislation governing personally identifiable or business sensitive information.

5.14. REMOTE AND MOBILE WORKING

5.14.1. All HSC organisations must ensure that standards and processes are in place to establish secure connections to HSC networks or systems from any remote host using Multifactor Authentication (MFA) where possible.

5.14.2. Restrictions and configuration requirements for organisation-controlled devices should be established to minimise their potential exposure to compromise, which may result from unauthorised use of HSC resources.

5.14.3. All staff are responsible for the authorised and appropriate use of all remote resources, complying with HSC policies, standards, procedures, and legal responsibilities. Remote resources include, but are not limited to, laptops, smartphones, tablets, workstations, mobile devices, network resources, software and hardware.

5.14.4. Staff must ensure they safeguard remote devices from theft, loss or unauthorised access.

5.14.5. See Information Security 1.10 Remote and Mobile Working Standard for more information. Technical users should see the Information Security 2.05 Remote and Mobile Working Standard for more information.

5.15. MALWARE AND ENDPOINT PROTECTION

5.15.1. All HSC organisations must ensure that standards and processes are in place to establish requirements for the detection, prevention and recovery controls to protect against malware - the implementation (software, deployment, update schedule, proactive scanning etc.) and user awareness strategies should also be included.

5.15.2. Additional controls such as prohibiting unauthorised software install, malicious website deny lists, vulnerability/patch management, business continuity planning etc. should be considered to reduce the risk and impact of malware.

5.15.3. Technical users should see the Information Security 2.11 Anti-virus and Endpoint Protection Standard for more information.

5.16. EXTERNAL GATEWAYS

5.16.1. All HSC organisations must ensure that standards and processes are in place to ensure that external gateways to HSC networks are:

- Notified to the Regional Director of eHealth and External Collaboration;
- Controlled by a suitably configured firewall that is at least Common Criteria

EAL4 compliant;
- As a minimum, when new services are brought online, or when significant changes are made, the use of the CHECK scheme is recommended;
- Subject to annual health checks; and
- Remediated in line with agreed risk appetite and local policy where a vulnerability has been identified.

5.16.2. Where external gateways facilitate internet access, a suitable monitoring solution must be in place.

5.16.3. Consideration should also be given to installing Intrusion Prevention and SSL inspection systems on external gateways.

5.16.4. HSC shall consider additional security controls at connection points to the HSC network such as firewalls. This is especially important if inbound initiated connections are permitted at the external gateways, to give security assurance to the other HSC organisations on the HSC network.

5.17. VULNERABILITY/PATCH MANAGEMENT

5.17.1. All HSC organisations must ensure that standards and processes are in place to ensure the patching and vulnerability management of devices and software is in effective at reducing exposure and subsequent risk to known vulnerabilities. This should include at least:

- Roles and responsibilities;
- Response plans and timelines;
- Integration into change management processes;
- Escalation into Incident Response processes;
- Testing processes to ensure compatibility and integrity; and
- Other mitigating controls to take where a fix is not timely or available.

5.17.2. In addition to maintaining a complete inventory of information assets and systems, technical information should be recorded alongside to support the discovery and management of vulnerabilities, for example vendor, version number, and where it is installed.

5.17.3. Technical users should see the Information Security 2.07 Patch Management Standard and Information Security 2.08 Vulnerability Management Standard for more information.

5.18. SECURITY TRAINING AND AWARENESS

5.18.1. All HSC organisations must ensure that standards and processes are in place to ensure employees and contractors are aware and educated on their responsibilities for Information Security.

5.18.2. Security training and awareness should take place at least annually and tailored to Information Security risks, taking into consideration the employees' roles and access within the organisation.

5.18.3. The awareness programme should be updated regularly so it stays in line with current risks faced by HSC, organisational policies and procedures and should be built on lessons learnt from Information Security incidents.

5.19. CLOUD SECURITY

5.19.1. All HSC organisations must ensure that standards and processes are in place to support the secure implementation, risk management, and use of cloud services.

5.19.2. Use of cloud services must be agreed with ICT and approved by your local SIRO.

5.19.3. See the Information Security 1.06 Cloud Security Standard for more information. Technical users should see the Information Security 2.02 Cloud Security Standard for more information.

5.20. BUSINESS CONTINUITY

5.20.1. All HSC organisations must ensure that they develop and maintain business continuity and disaster recovery plans, based on business impact and risk assessments, to maintain adequate levels of HSC services in the event of any significant disruption to facilities or information services. These processes should be developed, tested and maintained in conjunction with data owners to ensure they are sufficient to provide an adequate level of service and recovery time.

5.21. INCIDENT IDENTIFICATION, MANAGEMENT AND REPORTING

5.21.1. All HSC organisations must ensure that standards and processes are in place to establish a consistent and effective approach to Information Security incidents, including identification, management and reporting. These are important in complying with legal and regulatory responsibilities, protecting the reputation of HSC organisations and protecting client confidentiality.

5.21.2. All Information Security Incidents or significant threats which may impact other HSC organisations should be shared promptly via agreed processes to assist in incident preparedness, response and recovery processes as appropriate.

5.21.3. All HSC organisations should provide incident statistics to the local Cyber Programme Manager, in order to share learning and inform discussions regarding operational matters.

5.21.4. All staff shall report suspected or confirmed incidents to their local ICT service desk immediately.

5.21.5. See the Information Security 1.09 Incident Identification and Reporting Standard or Regional Incident Response Plan for more information. Technical users should see the Information Security 2.04 Incident Management Standard and Information Security 2.09 Incident Response Standard for more information.

5.22. DATA BACKUP

5.22.1. All HSC organisations must ensure that standards and processes are in place to ensure backup copies of information are made and tested regularly. The requirement to backup will be determined based upon, but not limited to:

- What the information is, for example:
  - User storage;
  - File repositories;
  - Software files;
  - System configuration and master images.
- The Recovery Time Objective (RTO);
- The Recovery Point Objective (RPO);
- The risk to the information;
- Laws and regulations;

- Security controls;
- Information governance requirements:
  - Retention period
  - Classification and handling procedures

5.23. REMOVABLE MEDIA HANDLING

5.23.1. All HSC organisations must ensure that standards and processes are in place to govern the secure use, handling and destruction of removable media.

5.23.2. All staff should be aware that:

- Only organisation approved, and encrypted, removable media devices shall be used to store, download or transport organisation and client information; and
- Unknown removable media must not be connected to a HSC computer system (e.g. a USB Flash Drive found internally or externally to HSC premises) but should, instead, be handed to the ICT Service Desk.

5.23.3. See the Information Security 1.02 Removable Media Standard for more information.

5.24. SECURITY VETTING

5.24.1. All HSC organisations must ensure that standards and processes are in place to screen individuals prior to authorising access to information systems and to rescreen individuals according to defined conditions.

5.25. TERMS AND CONDITIONS OF EMPLOYMENT

5.25.1. All HSC organisations should ensure that all contracts of employment include statements requiring compliance with HSC and local Information Security policies, standards and procedures. HSC organisations must ensure:

- Contractual obligations are made clear and employees sign terms and conditions;
- Employees are aware of their responsibilities and liabilities;
- All employees receive security awareness, education and training;
- A formal disciplinary process for security breaches is in place;
- Employees exit the organisation in an orderly manner;
- Termination or change of employment if clearly defined; and
- That access rights are terminated at the end of employment. There are processes for changing or terminating employment.

5.26. PHYSICAL AND ENVIRONMENTAL SECURITY

5.26.1. All HSC organisations must ensure that standards and processes are in place to implement and monitor physical security controls to prevent unauthorised physical access, damage and interference to the organisation's information and information processing facilities.

5.26.2. The physical security and controls must be actioned in line with the Risk Management Policy, e.g. controls must be relative to the value and potential risk to Information Assets and Systems within those physical boundaries. As a minimum, the policy should set out access authorisations and controls, verification, ingress and egress.

5.26.3. Best practice (such as HMG Civil Contingencies Act 2004 guidance) on monitoring and emergency planning should be included within the policy.

5.26.4. Health and Safety legislation must be adhered to at all times and realised in local policies, standards, processes and guidance materials where applicable.

5.27. CLEAR DESK AND SCREEN

5.27.1. All HSC organisations must ensure that standards and processes are in place to establish the minimum requirements for a clear desk and screen environment. The policy must address security guidance on both the physical environment (e.g. locked areas, desks, printers, cupboards, desk drawers, multi-function devices and photocopiers) and computer equipment.

5.27.2. HSC recognises the importance of protecting our information, therefore, all staff must:

- Immediately collect printed media from printers, especially when printing sensitive information;
- Keep desk areas clear;
- Remove materials from meeting rooms;
- Dispose of any confidential materials in a secure manner;
- Lock sensitive documents in approved drawers and lockers when not in use and keep keys in a secure location;
- Secure PCs, Laptops etc. before leaving them unattended by locking the screen, logging off or shutting down; and
- Ensure on-screen or desk content cannot be overseen by unauthorised individuals, especially when in public places (e.g. use display screen protectors).

5.27.3. See the Information Security 1.05 Clear Desk and Screen Standard for more information.

5.28. RISK ANALYSIS AND MANAGEMENT

5.28.1. HSC organisations must ensure that standards and processes are in place to ensure the identification, assessment and management of Information Security risks to HSC information assets and systems in accordance with the HSC Risk Management Policy.

5.29. AUDIT AND ACCOUNTABILITY

5.29.1. All HSC organisations must ensure that standards and processes are in place to provide auditable evidence for system transactions and that key records are available for a sufficient amount of time (as determined and justified by the Information Asset Owner in line with legal requirements, such as Data Retention).

5.29.2. Audit records, review, analysis and reporting shall be protected from unauthorised access, modification, and deletion.

6. COMPLIANCE (LEGAL/CONTRACTUAL)

6.1.1. In the event of any ambiguity or contradiction in Information Security Policy/Standard material, the more restrictive control statement should take precedence, unless there is an approved business requirement at the local organisation.

6.1.2. To enable HSC organisations the ability to make local decisions balancing both risk and benefit, along with legislative baseline contractual terms and obligations, this Information Security Policy sets out minimum expectations.

6.1.3. The accompanying Information Security standards provide more detailed expectations but allow for a greater degree of local decision making by limiting mandates and allowing for local risk assessment, interpretation or judgement where possible.

6.1.4. Exceptions may be permitted through local approval processes. Refer to the policy or standard owner for further guidance or clarification.

7. REPORTING AN INFORMATION SECURITY INCIDENT

7.1.1. Information Security incidents must be identified and subsequently reported to the local IT service desk, or other local incident reporting process, as soon as is possible:

- When a security control has been breached;
- In case of a failure of a security measure that potentially or actually has a detrimental effect to the confidentiality, integrity and/or availability of HSC information assets or systems;
- When unusual behaviour is detected through protective monitoring.
- Where actual or suspected loss/theft of HSC hardware has occurred
- Non-compliance with policies and guidelines

7.1.2. See the Information Security 1.09 Incident Identification and Reporting Standard for more details.

8. NON-COMPLIANCE / POLICY BREACHES

8.1. SANCTIONS

Failure of HSC Organisations

8.1.1. Where an HSC organisation is found to be in breach of this policy it is expected that that HSC organisation will investigate in accordance with The Regional Incident Management Process and report their findings to the internal ICT management framework group.

8.1.2. If the breach is deemed significant enough to put other HSC organisations at risk, it may be necessary to limit or remove access to regional IT health systems and/or other HSC organisations. Any eventual end action required at HSCB level will be taken by the Regional Director of eHealth and External Collaboration.

8.1.3. Where serious breaches have occurred, it may also be necessary to report to the Information Commissioners Office for a Personal Data Breach (DPA 2018, GDPR 2018), the Competent Authority where required for a NIS Regulation (NIS 2018) incident, or other appropriate regulatory bodies.

Failure of HSC Employees

8.1.4. Where an HSC employee is found to be in breach of this policy it is expected that the employing HSC organisation will investigate in accordance with Adverse/Serious Adverse Incident procedures, which may result in the initiation of disciplinary action and/or initiation of criminal/civil proceedings. Where serious breaches have occurred, it may also be necessary to report to the Information Commissioners Office or other appropriate regulatory bodies.

Failure of third parties, temporary/agency staff, volunteers, students or any other party making use of HSC Information Assets and Systems

8.1.5. Where an individual is found to be in breach of this policy it is expected that the employing HSC organisation will investigate in accordance with Adverse/Serious Adverse Incident procedures, which may result in the termination of the contract and/or initiation of criminal/civil proceedings. Where serious breaches have occurred, it may also be necessary to report to the Information Commissioners Office or other appropriate regulatory bodies.

9. MONITORING

9.1.1. Staff must be aware that any data on the organisation's systems remains the property of HSC. HSC reserves the right to monitor and record any use of organisation information and systems to ensure they are used for legitimate purposes, and that policies and standards are being complied with.

9.1.2. All monitoring must be undertaken in accordance with the appropriate legislation such as Regulation of Investigatory Powers Act (2000), Human Rights Act (1998), and good practice guidance such as "Employment Practices Code Part 3: Monitoring at Work" issued by Information Commissioners Office.

10. RELATED POLICIES, PROCEDURES AND LEGISLATION

10.1. MINIMUM LOCAL POLICIES / PROCEDURES

10.1.1. All HSC organisations should ensure that, as a minimum, they have local policies, standards, procedures, and guidelines, to meet the requirements of the HSC Information Security Policy and associated All User and Technical Information Security Standards as listed in Section 1 of this policy.

10.1.2. Legislation imposes a need for all HSC organisations to take steps to ensure compliance with all statutory requirements. The following Information Security frameworks, legislation, regulation and guidance have been used to underpin the development of this policy - note this list is not exhaustive:

Source	Comment
Computer Misuse Act (1990)	Covering unauthorised access to computer material, unauthorised access with intent to commit or facilitate commission of further offences, unauthorised acts, causing or creating risk of serious damage to computer systems.
General Data Protection Regulation (GDPR)	Specifically chapter 2, chapter 4, chapter 5 and the fundamental principles as listed below: • Lawful, fair and transparent • Purpose limitation • Data minimisation • Accuracy • Storage Limitation • Integrity and Confidentiality • Accountability
Data Protection Act 2018	Specifically chapter 4 and covers a number of offences in relation to the control and access of data specifically section 55, section 170 and the fundamental information principles as listed below: • Must be used in a way that is adequate, relevant and limited to only what is necessary

	• Must be handled in a way that ensures appropriate security, including protection against unlawful or unauthorised processing, access, loss, destruction or damage
Network and Information Systems 2018	The goal of the Network and Information Systems Regulations of 2018 (NIS Regulations) is to drive improvement in the protection of the network and information systems which are critical for the delivery of digital services and essential services in the UK.
HMG Civil Contingencies Act 2004	How the government prepares and plans for emergencies, working nationally, locally and co-operatively to ensure civil protection in the UK.
The Copyright, Designs and Patents Act 1988	The Copyright Designs and Patents Act (1988) gives creators of digital media the rights to control how their work is used and distributed.
The Access to Health Records Act 1990 and Northern Ireland Order (1993)	The Access to Health Records Act 1990 allows patient's personal representatives and any person who may have a claim arising out of the patient's death access to their record. The Northern Ireland Order (1993) has been repealed to the extent that it now only affects the access to health records of deceased patients.
The Health and Safety at Work (NI) Order (1978) Health and Safety (display Screen Equipment) Regs (NI) 1992	The Order imposes duties on employers to look after the health and safety of their employees and responsibilities on employees to comply with the measures put in place for their health and safety.
The Human Rights Act (1998)	Article 8, relating to privacy, is of most relevance to Information Security. It provides a right to respect for an individual's "private and family life, his home and his correspondence".
The Employment Practices Data Protection Code	The Employment Practices Data Protection code deals with the impact of data protection laws on the employment relationship. It covers such issues as the obtaining of information about workers, the retention of records, access to records and disclosure of them.
The Obscene Publication Act 1958	An Act to amend the law relating to the publication of obscene matter.
Freedom of Information Act 2000	The Freedom of Information Act gives individuals a right of access to information held by HSC organisations, subject to a number of exemptions.
The Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000	The Telecommunications (Lawful Business Practice) (Interception of Communications) Regulations 2000 (the Regulations) give businesses the right to monitor communications on their own networks.
Regulation of Investigatory Powers Act 2000	The Regulation of Investigatory Powers Act 2000 (RIP or RIPA) is an Act of the Parliament of the United Kingdom, regulating the powers of public bodies to carry out surveillance and investigation, and covering the interception of communications.
National Institute of Standards and Technology (NIST) Special Publication for Information Security	This Information Security Handbook provides a broad overview of Information Security program elements to assist managers in understanding how to establish and implement an Information Security program.
International Organisation for Standardisation (ISO)	ISO/IEC 27001 is the best-known standard in the ISO family providing requirements for an Information Security management system (ISMS). ISO/IEC 27001:2013 Information technology

National Cyber Security Centre guidance	Guidance on how organisations can protect themselves in cyberspace, including the 10 steps to cyber security: https://www.ncsc.gov.uk/collection/10-steps-to-cyber-security
Cabinet Office -	Security policy framework (April 2014), Government Security Classifications (April 2014).
DOHNI -	Code of Practice on Protecting the Confidentiality of Service User Information (April 2019), Information and Communication Technology Controls Assurance Standards (2008/9), DOH & HSC Protocol For Sharing Service User Information for Secondary Purposes (August 2011)
NHS Digital	HSCN Connection Agreement
Information Commissioners Office (ICO)	Employment Practices Code Part 3: Monitoring at Work
Protection of Children (Northern Ireland) Order 1978	Protection of Children (Northern Ireland) Order 1978

11. PROCEDURES TO IMPLEMENT THE INFORMATION SECURITY POLICY

Standard Reference Number	**All User Standards**
1.01	Email Communications
1.02	Removeable Media
1.03	Use of Internet Services
1.04	Asset Management
1.05	Clear Desk and Screen
1.06	Cloud Security
1.07	Data Transfer
1.08	Encryption
1.09	Incident Identification and Reporting
1.10	Remote and Mobile Working
1.11	Accounts and Passwords

Standard Reference Number	**Technical User Standards**
2.01	Asset Management
2.02	Cloud Services and Security
2.03	Encryption
2.04	Incident Management
2.05	Remote and Mobile Working
2.06	Privileged Account Management
2.07	Patch Management
2.08	Vulnerability Management
2.09	Incident Response
2.10	Network Discovery
2.11	Anti-Virus and Endpoint Protection
2.12	Public Key Infrastructure
2.13	Wireless
2.14	Joiners, Movers, Leavers

12. REVIEW CYCLE

12.1.1. This policy will be subject to annual review or following any significant incidents, changes to UK or EU legislation or changes to the HSC structure or functional responsibilities.

12.1.2. All HSC organisations are responsible for ensuring their own local policies, standards and procedures are subject to regular review and take into account any

changes to this Information Security Policy.

<<Add Name>>.

<<Add Role>> Date: 19/02/2020

<<Add Name>>.

<<Add Role>> Date: 19/02/2020

Southern Health and Social Care Trust

Quality Care - for you, with you

Southern HSCT General Data Protection Regulation and Data Protection Act 2018 Policy

Lead Policy Author & Job Title:	Catherine Weaver
Directorate responsible for document:	**Performance & Reform**
Issue Date:	**26 November 2018**
Review Date:	**1 November 2020**

Policy Checklist

Name of Policy:	**Southern HSCT General Data Protection Regulation and Data Protection Act 2018 Policy**
Purpose of Policy:	• To ensure that Trust staff understand the principles of the General Data Protection Regulation and the Data Protection Act and their responsibilities under both the Regulation and Act
Directorate responsible for Policy	Performance & Reform Directorate
Name & Title of Author:	Catherine Weaver
Does this meet criteria of a Policy?	Yes☒ No☐
Trade Union consultation?	Yes☒ No☐
Equality Screened by:	Nicola Bawn
Date Policy submitted to Policy Scrutiny Committee:	08th January 2019
Approved ☐ Rejected ☐ Amended☐	
Policy Implementation Plan included?	Yes ☐ No☐
Any other comments:	Click here to enter text.
Date presented to SMT	Click here to enter a date.
Director Responsible	Aldrina Magwood
SMT Approved/Rejected/Amended	Approved ☐ Rejected ☐ Amended☐
SMT Comments	Click here to enter text.

Version Control Sheet

Title	Title:	**Southern HSCT General Data Protection Regulation and Data Protection Act 2018 Policy**
	Version:	3.0
Supersedes	SHSCT Data Protection Act 2018 Policy V2_3	
Originator	Name of Author:	Catherine Weaver, Head of Information Governance

	Directorate:	Performance & Reform
Policy Scrutiny	Referred for approval by:	Catherine Weaver
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	Responsibility of:	Head of Information Governance

Date returned to Directorate Lead for implementation (Board Secretary)	Click here to enter a date.
Date received by Board Secretary for Database/Intranet/Internet	Click here to enter a date.
Review Period	2 Years

Contents

SOUTHERN HEALTH & SOCIAL CARE TRUST

General Data Protection Regulation and Data Protection Act 2018 Policy

1. Introduction

1.1 The General Data Protection Regulation (GDPR), which came into effect on 25 May 2018, has introduced a new framework of rights and duties for the protection of personal data. The Regulation harmonises data privacy laws across Europe and strengthens and extends individual's rights and protections in relation to their personal data.

1.2 The Data Protection Act 2018 (DPA) ensures the standards set out in the GDPR have effect in the UK. As well as strengthening some of the requirements of the GDPR the DPA also provides some exemptions from the GDPR.

1.3 The Southern Health & Social Care Trust is committed to ensuring that all of our employees, including volunteers, temporary staff, agency, bank staff, locums, and contractors comply with data protection legislation in order to safeguard the integrity and confidentiality of personal data processed by the Trust.

1.4 The priority of the Southern Health & Social Care Trust will be to ensure the rights and freedoms of individuals are protected before any processing of personal data. Employees are reminded that failure to comply with data protection legislation not only infringes on individuals rights, but may also result in the loss of reputation, loss of public trust, substantial fines and criminal proceedings against the Trust and / or individuals.

2. Purpose

2.1 The purpose of this policy is to set out our obligations under data protection laws, demonstrate our commitment to compliance with these, and explain the measures we have put in place in order to achieve this.

2.2 This Policy aims to fulfil the requirement for the fair, lawful and transparent processing of all personal data created or received by the Southern Health & Social Care Trust.

3. Scope

3.1 The Policy relates to all Trust staff including volunteers, temporary staff, agency, bank staff, and locums and also those staff contracted to carry outwork on behalf of the Trust.

3.2 The Policy relates to all records regardless of format or medium, including paper, electronic, audio, visual and photographic.

4. Data Protection Principles

4.1 Article 5 of the GDPR sets out six principles relating to the processing of personal data which the Trust must be able to demonstrate compliance with. Personal data shall be:

a) processed lawfully, fairly and in a transparent manner in relation to individuals ('lawfulness, fairness and transparency');

b) collected for specified, explicit and legitimate purposes and not further processed in a manner that is incompatible with those purposes; further processing for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes shall not be considered to be incompatible with the initial purposes ('purpose limitation');

c) adequate, relevant and limited to what is necessary in relation to the purposes for which they are processed ('data minimisation');

d) accurate and, where necessary, kept up to date; every reasonable step must be taken to ensure that personal data that are inaccurate, having regard to the purposes for which they are processed, are erased or rectified without delay ('accuracy');

e) kept in a form which permits identification of data subjects for no longer than is necessary for the purposes for which the personal data are processed; personal data may be stored for longer periods insofar as the personal data will be processed solely for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes subject to implementation of the appropriate technical and organisational measures required by the GDPR in order to safeguard the rights and freedoms of individuals ('storage limitation');

f) processed in a manner that ensures appropriate security of the personal data, including protection against unauthorised or unlawful processing and against accidental loss, destruction or damage, using appropriate technical or organisational measures ('integrity and confidentiality')."

5. Definitions

5.1 Personal data is information that relates to an identified or identifiable living individual

5.2 The GDPR definition of what constitutes personal data is more detailed and has been expanded to include a wide range of identifiers, reflecting changes in technology, and the way organisations collect information about people. For example, online identifiers like IP addresses can be personal data.

"Personal data means any information relating to an identified or identifiable natural person ('data subject'); an identifiable natural person is one who can be identified, directly or indirectly, in particular by reference to an identifier such as a name, an identification number, location data, an online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person.'[1]

5.3 Special categories (previously referred to as sensitive) personal data requires additional protection and is further defined in the Regulation to mean;

[1] GDPR Article 4 (1)

'Processing of personal data revealing racial or ethnic origin, political opinions, religious or philosophical beliefs, or trade union membership, and the processing of genetic data, or biometrics for the purpose of uniquely identifying a natural person, data concerning health or data concerning a natural person's sex life or sexual orientation…'[2]

5.4 Processing refers to any use of personal data including collection, storage, retrieval and destruction.

6. Personal Data Processed by the Trust

6.1 The Trust processes personal data in order to, but not limited to:

- Provide health and social care to patients and service users
- Help review the care given and ensure it is of the highest standard, this is done through internal audits and external inspections
- Training and educating staff
- Looking after the health and social welfare of the general public
- Investigating complaints or legal claims
- Preparing statistics on the Trust's activity and performance
- Payment of Salaries, Travel, Subsistence, Sick Pay, Maternity Pay, Pension Administration etc.
- Her Majesty's Revenue and Customs (HMRC)
- Staff Engagement
- Management of Sickness Absences, Maternity Leave etc.
- Compliance with legal obligations, for example police investigations

6.2 The Trust processes different categories of personal data including, but not limited to:

- Name
- Address
- Date of Birth
- Contact Details

[2] GDPR Article 9 (1)

- Bank Details
- Employment Details
- Education and Training Details
- Personal identifiers e.g. identification numbers, online identifiers

6.3 The Trust processes the following special categories of personal data:

- Physical and / or Mental Health
- Criminal proceedings
- Racial or Ethnic Origin
- Political Opinions
- Religious Beliefs
- Sexual Life
- Trade Union Membership

7. Policy Statement

7.1 In order to fulfil our obligations under data protection law the Trust is committed to:

- Making data subjects aware of when we collect personal data about them, and explaining the ways in which the information will be used;
- Making data subjects aware of their rights and how they can exercise them;
- Ensuring there is lawful basis for any processing;
- Ensuring that processing is fair
- Processing personal data which is adequate, relevant and limited to what is necessary for the intended purposes
- Ensuring the personal data is accurate and kept up to date
- Retaining personal data only for as long is needed in line with DHSSPS Good Management, Good Records Retention and Disposal Schedule
- Taking appropriate technical and organisational measures to safeguard the integrity and confidentiality of personal data
- Ensuring that personal data is not transferred outside the EEA without appropriate safeguards

- Maintaining records of processing activities and organisational compliance

7.2 This is achieved through:

- Use of privacy notices and privacy information to inform data subjects wherever the collection and processing of personal data takes place, outlining the purposes for which the data will be used, who it will be shared with, how it will be securely retained, and how individuals may access it
- Efficient handling of subject access requests and other information rights requests
- Identification of a Data Protection Officer with specific operational responsibility for data protection in the Trust
- Training all Trust staff in data protection and information management in order to ensure they understand their obligations
- Operation and regular review of comprehensive procedures for the management and security of Trust information, regardless of media or format
- Maintenance of an information asset register and records of processing activities
- Regular monitoring, review and audit of the way in which personal data is collected, stored and used by the Trust
- Active use the DHSSPS Good Management, Good Records retention and disposal schedule to ensure information is only retained for as long as is necessary
- Ensuring individuals are aware of their obligations when being given access to personal data for research purposes
- Sharing information lawfully and in accordance with the Information Commissioner's Office Data Sharing Code of Practice
- Entering into a data access agreement whenever the Trust processes personal data for secondary purposes
- Entering into a contract when processing personal data on behalf of another data controller or where the Trust contracts data processing services
- Carrying out data protection impact assessments before we begin any processing of personal data which is likely to result in a high risk to individuals

- Carrying out information governance compliance checks to assess compliance with data protection laws
- Engaging and consulting with the Information Commissioner's Office
- Notifying the Information Commissioner's Office of any reportable personal data breaches within 72 hours of becoming aware and notifying individuals where there is a high risk to their rights and freedoms.

8. Roles and Responsibilities

8.1 The Trust's Chief Executive as "Accountable Officer" has overall responsibility for ensuring the aims of this policy are met.

8.2 The Personal Data Guardian is responsible for ensuring that the Trust is compliant with the confidentiality requirements of the GDPR and DPA 2018. The Trust Personal Data Guardian is the Medical Director.

8.2 The Director of Performance of Reform, as the Senior Information Risk Owner (SIRO), will take ownership of the organisation's information risk, act as an advocate for information risk on the Board and provide written advice to the Accounting Officer on the content of their annual governance statement in regard to information risk.

8.3 The Assistant Director of Informatics is accountable to, and reports to the Director of Performance and Reform, and in conjunction with other operational Assistant Directors is responsible for the delivery of the strategic and operational management of the Information Governance Management agenda. He/she is also the Trust Data Protection Officer (DPO) and is responsible for ensuring that the Trust processes the personal data of staff, patients and service users in compliance with the applicable data protection legislation, regulatory requirements and best practice.

8.4 The Head of Information Governance is responsible for:

- ensuring compliance within data protection legislation and good practice within the organisation;
- progressing the Information Governance Strategy and Framework;

- providing guidance and advice to staff in relation to compliance with the relevant legislation; and
- reporting via the adverse incident reporting process on any breaches of Data Protection legislation.

8.4 Directors, Assistant Directors and Heads of Service are responsible for information held manually and electronically within their department. As Information Asset Owners their responsibilities include:

- informing the Head of Information Governance of any changes in the processing of personal data;
- identifying and justifying how sets of data are used;
- identifying all personal data for which they are responsible; and
- agreeing who can have access to the data.

8.5 All Trust staff including volunteers, temporary staff, agency, bank staff, and locums and also those staff contracted to carry outwork on behalf of the Trust have a responsibility to abide by the principles contained within this document and to adhere to the associated procedural guidelines. Further responsibilities include:

- observing all guidance and codes of conduct in relation to obtaining, using and disclosing personal information;
- observing all information sharing protocols in relation to the disclosure of information;
- obtaining and processing personal information only for specified purposes;
- only accessing personal information that is specifically required to carry out their work;
- recording information accurately in both manual and electronic records;
- ensuring any personal information held is kept secure; and
- ensuring that personal data is not disclosed in any form to any unauthorised third party.

9. Legislative Compliance, Relevant Policies, Procedures and Guidance

Staff must comply with relevant legislation, professional standards and guidance and other DHSSPS publications as follows:

- Data Protection Act 2018
- The General Data Protection Regulation
- Public Records Act (Northern Ireland) 1923
- Disposal of Documents Order (Northern Ireland) 1925
- Freedom of Information Act 2000
- Environmental Information Regulations 2004
- Access to Health records (NI) Order 1993
- Human Rights Act 1998
- Computer Misuse Act 1990
- The Common Law Duty of Confidentiality
- The Code of Practice on the Confidentiality of Service User Information
- DHSSPS Good Management, Good Records
- Northern Ireland Records Management Standard (PRONI)
- Controls Assurance Standard
- ISO 15489 International Standard on Information and Documentation – Records Management

Relevant Trust Policies and Procedures

- Information Governance Policy
- IT Security Policy
- Data Quality Policy
- Records Management Policy
- Clear Desk Procedure
- Policy for the Safeguarding Movement & Transportation of Patient/Client/Staff/Trust Records Files and Other Media Between Facilities
- Policy for the Transfer of Electronic Data
- Bring Your Own Device Policy
- Email Encryption Guidance
- Social Media Policy
- Disciplinary Procedure

10. Equality and Human Rights Consideration

This policy has been screened for equality implications as required by Section 75 and Schedule 9, of the Northern Ireland Act, 1998. Equality Commission for Northern Ireland Guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to those.

Using the Equality Commission's screening criteria; no significant equality implications have been identified. The policy will therefore not be subject to an equality impact assessment.

Similarly, this policy has been considered under the terms of the Human Rights Act, 1998, and was deemed compatible with the European Convention Rights contained in the Act.

Alternative Formats

This document can be made available on request in alternative formats, e.g. plain English, Braille, disc, audiocassette and in other languages to meet the needs of those who are not fluent in English.

11. Review of Policy

The Trust is committed to ensuring that all policies are kept under review to ensure that they remain complaint with relevant legislation.

This policy will be reviewed in April 2020 by the Head of Information Governance.

12. Sources of Advice and Further Information

Information Commissioner Office https://ico.org.uk/

The European Data Protection Board https://edpb.europa.eu/

The Information Governance Alliance
https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/information-governance-alliance-iga

Southern Health and Social Care Trust

Quality care – for you, with you

COMMITTEE REPORT SUMMARY SHEET

Meeting: Date:	Governance Committee 5th December 2019
Title:	Information Governance Framework: Personal Identifiable Data (PID) and Personal Sensitive Data (PSD) Audit Report
Lead Director:	Mrs Aldrina Magwood Director of Performance and Reform
Corporate Objective:	Promote a culture of good Information Governance and identify risks to personal/personal sensitive information so that risks can be mitigated to an acceptable level.
Purpose:	For Assurance
Overview: Annual report submitted to the Trust's Senior Information Risk Owner to accept the current risks associated with personal/personal sensitive information.	
Outcomes from SMT Discussions: SMT noted improvement on Corporate Mandatory Training (CMT) in Information Governance (IG) Mandatory Training from 80% to 82%. SMT noted changes in Directorate Performance in IG Framework Audits. SMT requested Directors to consider actions to address high rick items within their areas.	
Key areas for Committee consideration: Findings of the current level of risk associated with personal/personal sensitive information as highlighted by the Trusts Information Asset Owners. High level risks identified and the Information Governance Team providing support and advice to manage to IAOs to manage these risks.	
Human Rights/Equality: There are no Human Rights or Equality concerns	

Information Governance Framework: Personal Identifiable Data (PID) and Personal Sensitive Data (PSD) Audit Report

Version 1.0
Informatics
Performance and Reform
November 2019

CONTENTS

1.0 Background

The Permanent Secretary in his letter of 22 September 2010 to all Chief Executives of HSC Trusts requested that the Trust undertake a series of actions:

- Appointment of staff to the roles of Senior Information Risk Owner (SIRO) and Information Asset Owners (IAOs);
- Assessment of information risks ensuring that these are migrated to an acceptable level;
- Annual assurance to the SIRO from Head of Information Governance; and
- Provision of assurance by the SIRO to the Department on an annual basis and when requested.

2.0 Introduction

The Trust relies on good quality information being available at the point of need in order to provide a high quality service.

As part of the Information Governance Framework agenda the Trust is required to maintain a register of all its major information assets and assign responsibility for their ownership. Information assets must be documented in an asset register, this is to implement the required security controls across the Trust.

Staff rely on the quality of data they use to make decisions about patient care and treatment, and the way in which we use resources to carry out Trust business. It is important for staff to understand their own responsibility for recording information to a consistently high standard and for keeping it secure and confidential. Public confidence in our ability to handle their data responsibly and efficiently is based on a good reputation for keeping their data safe.

On an annual basis the Trust's IAOs will provide assurances to the Trust's SIRO on the security and use of assets they 'own'. This will be achieved by completing the IG Framework Audit questionnaire and risk assessments, these findings will be presented to the SIRO in the annual Information Governance Framework: Personal Identifiable Data (PID) and Personal Sensitive Data (PSD) Audit Report (this report) via Head of Information Governance.

3.0 Key Roles and Accountability

Staff have been appointed to the three roles which are required to ensure structured management arrangements for information risk. These include:

Role	Responsibility	Lead
SIRO	The Senior Information Risk Owner is an executive who is familiar with and takes ownership of the	Director of Performance

	Trusts information risk policy and acts as an advocate for good information governance Trust-wide.	and Reform
IAO	The Information Asset Owners understand and assess risks to the information assets they 'own' and provides assurance to the SIRO on the security and use of those assets. They will carry out an annual review and audit of specific assets.	Heads of Service
Assurance Reporting	The Head of Information Governance is responsible for co-ordination of the Information Asset Register and provision of a report to the SIRO on risks and mitigation actions (this report).	HOS Information Governance Informatics

4.0 IAO Training & Awareness

A SIRO training day was held for Senior staff in January 2017 where the Trust IG Framework Questionnaire, the Risk Assessment and the Trust Risk Matrix were discussed. The SIRO training day stressed that it is mandatory for IAOs to complete the questionnaire and to identify any risks associated with their areas. A copy of the Powerpoint presentation used for SIRO training day has been placed on Sharepoint.

A SIRO and an IAO e-learning module has recently been developed and is available from the HSC Leadership Centre eLearning site. On-going advice and guidance is available on request from the Information Governance Team. Staff are encouraged to use the elearning module to refresh their understanding of the IAO responsibilities.

It is a mandatory requirement for all staff to undertake Information Governance training which is appropriate to their role. Until 2016 this training was provided by a separate Records Management and Data Protection e-learning modules.

These separate modules were replaced by a combined on line Information Governance module and by awareness and adherence to the Trust's Information Governance Policies (see table 1 below for training rates as at 30th June 2019).

Table 1: Mandatory Information Governance Training rates (%) 2019

	Information Governance			
Directorate	**Not Trained**	**Trained**	**Head Count**	**% Trained**
Acute Services Total	**1052**	**3299**	**4351**	**76%**
Chief Executive's Office Total	**5**	**8**	**13**	**62%**
Children & Young People's Services Total	**295**	**1274**	**1569**	**81%**
Finance & Procurement Total	**39**	**208**	**247**	**84%**
HR & Organisational Development Total	**25**	**126**	**151**	**83%**
Medical Total	**7**	**38**	**45**	**84%**
Mental Health & Disability Services Total	**264**	**1355**	**1619**	**84%**
Older People & Primary Care Total	**298**	**2502**	**2800**	**89%**
Performance & Reform Total	**6**	**154**	**160**	**96%**
Total	**1991**	**8964**	**10955**	**Avg. 82%**

5.0 Methodology for Information Governance Framework Audit 2019

5.1 One hundred and twelve (112) Information Asset Owners (IAOs) were identified based on their roles as Heads of Service/Service Leads.

5.2 Training and advice was offered to all Information Asset Owners following dissemination of the IG Framework Audit questionnaire (see Appendix 1).

5.3 Responses have been received from 109 IAOs (97% response rate) – see Table 2 below.

5.4 The Information Governance Dept. considered the responses from the IG Framework Audit questionnaires which were completed by each IAO – as outlined below (Table 2).

Table 2 - Response rates for Completion of the IG Framework Audit Questionnaires

Directorate	No. of IAOs	Number of responses received	% Complete 2017	% Complete 2018	% Complete 2019	% increase / decrease
Acute	24	24	71.5%	100%	100%	-
CEO	2	2	50%	50%	100%	**+50%**
C&YP	19	18	83%	100%	94%	**-6%**
Finance (Inc.Estates)	12	12	100%	80%	100%	**+20%**
HROD	9	9	85%	100%	100%	**-**
Medical	5	5	71%	100%	100%	**-**
MH&D	14	12	61.5%	77%	85.5%	**+8.5%**
OPPC	16	16	86%	100%	100%	**-**
P&R	11	11	100%	100%	100%	**-**
Total / Average	**112**	**109**	**78.5%**	**90%**	**98%**	**+8%**

6.0 Outcomes of Information Governance Framework Audit

6.1 Risk Assessments

IG Risk Assessments **(Appendix 2)** have been completed by the IAOs following the identification and rating of risks from the questionnaire responses. When a relevant risk is identified, a Risk Assessment is completed and the risk assessed using the Trust Risk Assessment Matrix. A total of 241 risks were identified by the IAOs (this is believed to be a result of better reporting and is an increase from 172 identified risks in 2018) and these were rated as low, medium or high. The Information Governance Team will continue to work with the IAOs to confirm their risk ratings and offer advice on any mitigation of these risks.

6.2 Data Flow Questions

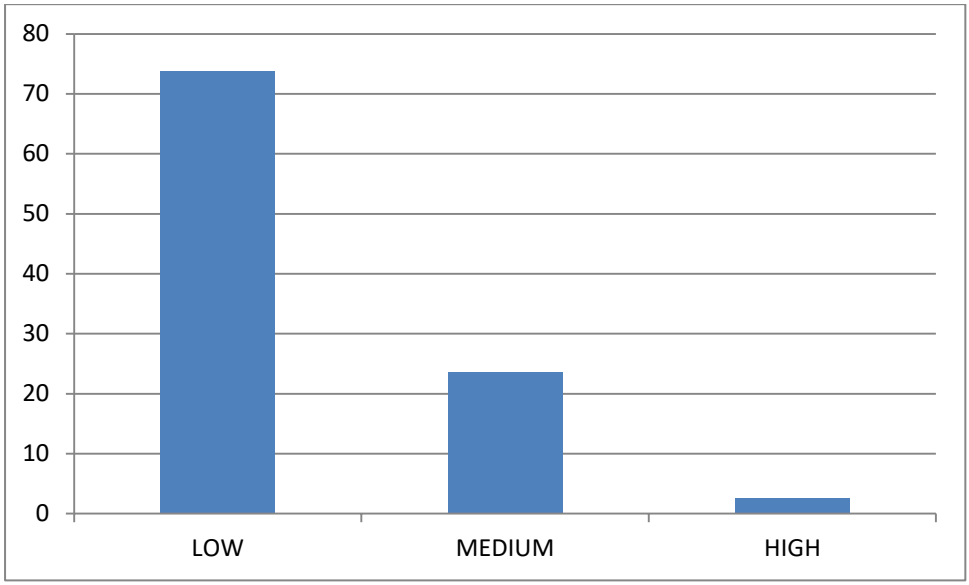
In preparation for any work to enable data flows outside the UK to continue in the event of a no-deal Brexit, additional questions were included in this years' questionnaire. This question was specifically in relation to data flows from the UK to the EEA or outside of the EEA. The response to this question has helped ensure the appropriate contractual clauses have been included in any contracts. These ensure the lawful transfer of personal data following the UK leaving the European Union.

7.0 Information Governance Framework Audit Risk Rating

While all information assets should be protected, the importance of ensuring that the personal sensitive category of records is held securely is vital. The register of assets will be verified and maintained through annual risk assessments of the Trust's information assets and placed on the Departmental, Directorate or Corporate register as appropriate.

Following the completion of the IG Framework Audit questionnaire and Risk Assessments, each IAO identified their risks (if applicable) and how these risks were to be managed.

Graph 1 2019 Risk Rating Trust wide %



Graph 1 shows that:

- 2.5% of all Trust Risks reported are rated as High.
- 23.6% of all Trust Risks reported are rated as Medium.
- 73.8% of all Trust Risks reported are rated as Low.

For a list of High risks identified see Table 3 - Appendix 3. (PAGE 16)

7.1 Information Governance Framework Audit Key Findings – High Risks Trust wide (see Table 3 Appendix 3 – Page 16)

There have been 6 High Risks identified by IAOs, these are detailed below.

Physical security/Inappropriate access (66%)
3 IAOs have expressed concern regarding physical security and possible inappropriate access to records. These concerns relate to a variety of issues e.g. inappropriate access, lack of physical security etc. Evidence that this risk has been included on the Directorate Risk Register has been requested from the relevant IAOs. The Information Governance Team provide advice to the IAOs and they are reminded that access to records must be in the course of their work and that all records must be kept secure and with appropriate security, such as in locked filing cabinets, locked drawers, locked filing rooms, within fob accessed areas etc. Staff should carry out good record management housekeeping and ensure that records are destroyed or transferred to the Trust Closed Record Stores as appropriate.

Inappropriate access to systems /Permission rights not reviewed (33%)
One IAO has expressed concerns regarding System Access and access rights not being appropriately reviewed. These concerns relate to access rights not being kept up to date which could lead to staff inappropriately accessing client/staff information etc. Whilst the Information Systems Team regularly receive lists of staff who no longer work in the Trust and deactivate user accounts on Information Systems, Managers should also alert IT if staff move role and no longer require access. Evidence that this risk has been included on the Directorate Risk Register has been requested from the relevant IAO. The Information Governance Team advise IAOs that access rights must be regularly checked to ensure system access is on a need to know basis, staff must log off any system when not in use and remind all users that the Trust can audit users' access history.

7.3 Information Governance Framework Audit High Risk Rating by Directorate – See Table 4 Appendix 4.

8.0 Information Asset Register

It is important to know and fully understand what information we hold as a Trust in order to support and evidence our decisions, performance, legal rights and obligations to ensure that our information assets are adequately protected.

With the introduction of the General Data Protection Regulations (GDPR) effective (2018), which replaces the Data Protection Act 1998, there is a requirement on the Trust to identify not only what information we hold in general but, in particular, all our personal and sensitive information assets to ensure full compliance with the new Regulations.

GDPR introduces a new Accountability & Governance Principle, which requires the Trust to maintain internal records of their processing of personal data. Formally documenting our assets and any associated risks to our information in an Information Asset Register will help us demonstrate compliance with this Principle.

8.1 Information Asset Register (IAR)

An Information Asset Register (IAR) is a simple way to help the Trust to identify, understand and manage both the information assets for which it is responsible and the potential risks to them e.g. loss of personal data. Providing a comprehensive list of the assets which are important to the Trust, along with additional information about each asset to support understanding as to how it should be managed and protected, will provide assurance that processes are in place which help protect and manage our information assets, as well as supporting compliance with our legal obligations.

All IAOs in the Trust were tasked to complete an Information Asset Register template (See appendix 5).

One hundred and twelve (112) Information Asset Owners (IAOs) were identified based on their roles as Heads of Service/Service Leads.

8.2 Asset Register

Information Assets identified include:

- Databases (including excel and access files)
- Electronic Record Systems
- Shared Drives
- Audit information
- Client Records
- Staff Records
- Clinical Research Records
- Incident records
- Finance records
- Complaints records

Responses have been received from 90 IAOs (80.5% response rate) – see Table 5 below.

Table 5 - Response rates for Information Asset Register 2019

Directorate	No. of IAOs	Number of responses received	% Complete 2019
Acute	24	17	71%
CEO	2	1	50%
C&YP	19	15	79%
Finance	12	11	92%
HROD	9	9	100%
Medical	5	5	100%
MH&D	14	8	57%
OPPC	16	16	100%
P&R	11	9	82%
Total / Average	**112**	**91**	**81%**

9.0 Conclusion

IAOs have completed risk assessments which detail how to manage their identified risks and accept their responsibility to manage or escalate all risks and to notify any changes to the Information Governance Team. An Information Asset Register has been established for the Trust. It is the responsibility of the Information Governance Team to ensure that the register is updated as notified.

The Trust is currently working in partnership with the other Trusts, BSO and DoH to implement a common Information Asset Register and to develop regional guidance. This will ensure a consistent approach to the management of an Information Asset Register across the HSC. Once this Register is established IAOs will no longer have to complete and return a register, they will be asked to verify their assets on this register on an annual basis.

It was noted in compiling this report that there appears to be a lack of consistency in interpreting risks e.g. risks that have been identified by individual IAOs such as concerns with transporting records have been rated as both 'Medium' and 'Low'. However, the instances of higher risks may reflect the volume, sensitivity and/or frequency of the records being transported.

The Information Governance Team will continue to liaise with all IAOs to address their identified risks. The Information Governance Team will commission IAO training in 2020 in advance of the request to complete the Risk Assessments to enable consistency. The Information Governance Team would recommend that this training is Mandatory.

10.0 Way Forward

The Information Asset Owner – reviews their Information Asset Register at least annually and submits details of changes to the Information Governance Team.

The Head of Information Governance provides assurance to the SIRO that an assessment of information risk has been carried out via this report which will be tabled to SMT on 26th November 2019 and the Governance Committee on 5th December.

The individual Head of Service (IAO) has responsibility for mitigating their risks to an acceptable standard in line with the Trust's Risk Management Strategy. These risks should be reviewed at their Team meetings.

The Information Governance Dept. will follow up with IAOs who have not responded to date and advise the IAO of training. However, if no response is received the escalation process will be implemented.

11.0 Endorsement

This report will be issued to the SIRO for submission to the Governance Committee on 5th December. This report will also be shared with all IAOs. It is recommended that IAOs table this report at Team Meetings.

20191114_InformationGovernanceFramework_Report_V1.0_SHaughey

Appendix 1 - IG Framework Audit questionnaire 2019

Information Asset Owner Questionnaire 2019			
Name:			
Directorate:			
Job Title:			
Date:			
What is Personal Data?	**Personal identifiable data means data which directly identifies a living person (eg. demographic information).**		
What is Sensitive Data?	**Sensitive Personal Data (SPD) means data which reveal particularly sensitive information about a person, such as their mental or physical health**		
Risk Assessments must be completed using the Trust Risk Assessment Matrix and the Information Governance Risk Assessment spreadsheet *IAOs are responsible for identifying and managing risks in their area*			
Staff awareness	**Response**		
Do all new staff receive induction training?	**Yes**	**No**	**Comment (if necessary)**
Are all staff in your Department (including recruitment agency staff) advised to read and understand Information Governance (IG) policies & procedures pertinent to their roles?	**Yes**	**No**	**Comment (if necessary)**
Is IG training and awareness included in Departmental induction for all staff?	**Yes**	**No**	**Comment (if necessary)**
Have all staff in your Department completed their mandatory Data Protection Training? This should be carried out every 3 years.	**Yes**	**No**	**Comment (if necessary)**
Is mandatory IG training followed up annually during staff Personal Development Review (PDR)?	**Yes**	**No**	**Comment (if necessary)**
Systems/Record Access			
Are you confident that physical access to information including all hardware, systems and records within your Department is secure?	**Yes**	**No**	**Comment (if necessary)**

Is access to your physical records restricted? If yes, comment how e.g. keypads, fob system, lock and key etc?	**Yes**	**No**	**List security precautions:**
Do you review staff access and permission rights to information systems on a regular basis e.g. quarterly?	**Yes**	**No**	**Comment (if necessary)**
Record Management			
Can you identify where alll records are stored for your Department?	**Yes**	**No**	**Comment (if necessary)**
Are any records for your Department stored in unsecure areas or unmanned/vacated buildings?	**Yes**	**No**	**Comment (if necessary)**
If yes, please list type of records and storage location.	**List:**		
Does your Department actively implement the Trust's Retention & Disposal Schedule	**Yes**	**No**	**Comment (if necessary)**
Retention & Disposal Schedule			
Information Assets			
Are you aware of the Trust's Information Asset Register?	**Yes**	**No**	**Comment (if necessary)**
Do you ensure that the Information Governance Dept. is advised of any new or decommissioned asset for your Department?	**Yes**	**No**	**Comment (if necessary)**
Transfer/Transportation of Information			
Are your staff aware of what they can/cannot send by email?	**Yes**	**No**	**Comment (if necessary)**
When sending personal/sensitive information outside of the Trust by email, do staff in your Department adhere to the email encryption procedure?	**Yes**	**No**	**Comment (if necessary)**
How to encrypt an email			

Are all staff in your Department aware of the Data Access Agreement arrangements within the Trust?	**Yes**	**No**	**Comment (if necessary)**
Does your Department share personal/sensitive information with 3rd party HSC organisations? e.g. Health Boards, DoH, other HSC Trusts etc.	**Yes**	**No**	**Comment (if necessary)**
Does you department share personal information with any organisation outside the UK	**Yes**	**No**	**Comment (if necessary)**
Does you department share personal information with any organisation outside the EAA	**Yes**	**No**	**Comment (if necessary)**
If yes, do you ensure that the information shared is not excessive and only the minimum required information is shared?	**Yes**	**No**	**Comment (if necessary)**
Does your Department share personal/sensitive information with 3rd party organisations? e.g. private contractors, charities etc.	**Yes**	**No**	**Comment (if necessary)**
If yes, do you ensure that the information shared is not excessive and only the minimum required information is shared?	**Yes**	**No**	**Comment (if necessary)**
When sending personal/sensitive information by post (both internal and external) do staff clearly state the recipent's name, job title (if applicable) and full address?	**Yes**		**Comment (if necessary)**
Do staff also state the sender's details on the reverse of the envelope so undeliverable post may be returned to the sender?	**Yes**	**No**	**Comment (if necessary)**
Do staff in your Department transport personal/sensitive data during the course of their work e.g. between Trust sites, to client's homes, courts etc?	**Yes**	**No**	**Comment (if necessary)**
If yes, do staff adhere to the 'Safeguarding, Movement and Transportation of Records	**Yes**	**No**	**Comment (if necessary)**

Policy?			
Transportation of Records			
Staff amendments and terminations			
Upon termination or transfer of staff - is there a process in place to ensure that assets are returned and access rights are revoked?e.g. email accounts closed, system access revoked, keys/fobs, laptops returned etc.	**Yes**	**No**	**Comment (if necessary)**
Risk Management			
Is there a proactive approach to incident reporting within your Department?	**Yes**	**No**	**Comment (if necessary)**
Are issues in respect of personal/sensitive information included in your Department or Directorate Risk Register?	**Yes**	**No**	**Comment (if necessary)**
Are you aware of any risks to personal/sensitive information that should be included in your Departmental or Directorate Risk Register?	**Yes**	**No**	**Comment (if necessary)**
If yes, please assess these risks using the Risk Assessment Matrix which has been issued with this questionnaire.	**Complete Risk Assessment**		
Please return completed Questionnaires to: Janet.McKay Personal information redacted by USI **no later than Friday 21st June 2019**			

Appendix 2 – Information Governance Risk Assessment

Information Governance Risk Assessment Table					
Risks identified from IG Framework Audit					
Please complete the IG Risk Assessment Table and provide details of any additional risks for your Team. Please refer to the Trust Risk Assessment Matrix when completing this Risk Assessment Table					
Name	**Job Title**	**Directorate**	**Date**		
(1) Asset or Operation at Risk	**(2) Description of Risk**	**(3) Opportunities for Prevention or Mitigation of Risk**	**(4) Impact (Consequence) Levels**	**(5) Likelihood**	**(6) Risk Rating**
***This is an Example* SOSCARE System**	***This is an Example* Staff's access rights to SOSCARE is not reviewed on a regular basis**	***This is an Example* Review staff access permissions in line with staff's current duties on a monthly basis**	***This is an Example* Minor (2)**	***This is an Example* Possible (3)**	***This is an Example* Low (6)**
INSTRUCTIONS					
Column (1): Compile a list of assets Information Systems, Patient/Client records, Corporate records, staff, facilities etc.	Column (2): For each asset, describe the risks that could cause an impact.	Column (3): As you assess potential risks, identify any actions/measures that could prevent/mitigate the risk.	Column (4): Please refer to the Trust's Risk Assessment Matrix to analyse the Impact (consequence).	Column (5): Please refer to the Trust's Risk Matrix to estimate the likelihood of the risk occuring.	Column (6): The "Risk Rating" is a combination of the Impact (Column 4) and the Likelihood (Column 5).

Appendix 3 - High Risks Reported by IAOs for the Southern HSC Trust

Table 3 High Risks Reported by IAOs for the Southern HSC Trust

Asset/Operation at Risk	Number of High Risks reported
Physical security/Inappropriate access (66%)	4
Inappropriate access to systems /Permission rights not reviewed (33%)	2
Total	**6**

IAOs are to consider including these risks on Directorate Risk Register for review in line with Regional Risk Management Programme and managing locally (if not already included). These are key to the audit findings.

It was noted in compiling this report that there can be a lack of consistency in interpreting risks e.g. risks that have been identified by individual IAOs such as concerns with access to records have been rated as both 'Low', 'Medium' and 'High'.

The Information Governance Team continues to support the IAOs in carrying out the Risk Assessment to ensure consistency in the overall risk rating. Follow up calls with the IAOs occurs once the Risk Assessments have been received.

In order to support the IAOs Face to Face Training is planned for 2020 prior to the completion of the Risk Assessment with the aim to improve the understanding of the Risk Assessment process. The IG Team would recommend that this Training is Mandatory for the IAOs.

Appendix 4 – Table 4 Information Governance Framework Audit High Risk Rating by Directorate

	Acute	CEO	CYP	FIN	HROD	MED	MH&D	OPPC	P&R	Total
High Risks Reported 2018	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**1**	**0**	**2**
High Risks Reported 2019	**1**	**0**	**0**	**0**	**0**	**0**	**4**	**1**	**0**	**6**

Appendix 5 – Information Asset Register template

Information Asset Owner details e.g. name, job title, Directorate	Asset Name	Location of Asset	Does the Asset contain Personal Information?	Description (Information Held)	Status e.g. is the information/data actively updated	Users (Staff/Departments including external organisations that use or access the asset)	Business Value e.g. essential to patient care; essential to corporate business	Risks to the asset	Retention period. (Refer to GMGR)	Date of last Risk Assessment / Review	Who is the information shared with? E.g. Trust staff; Other Trusts staff; DoH; 3rd party Contractors etc	Information Asset Type e.g. paper, electronic etc	Security measures in place	Additional Comments (if applicable)
EXAMPLE: DEBBIE TUMILTY, HOS INTEGRATED CARE TEAM, OPPC.	**EXAMPLE:** PARIS (COMMUNITY INFORMATION SYSTEM)	TRUST SERVER	YES	CLIENT/PATIENT HEALTH INFORMATION.	PARIS IS LIVE SYSYTEM- ACTIVELY UPDATED.	NOMINATED ICT STAFF.	ESSENTIAL TO ICT STAFF FOR ACCESS TO UP TO DATE INFORRMATION FOR DIRECT PATIENT CARE	SYSTEM CRASH. INAPPROPRIATE SYSTEM ACCESS.	8 YEARS IN LINE WITH ICT RECORDS	Aug-19	Care Plan information and referrals are made to outside agencies involved in Care Delivery such as Marie Curie services	DATABASE	USER NAME AND PASSWORD PROTECTED. SYSTEM AUDIT FUNCTION.	ONLY ICT STAFF HAVE ACCESS. ACCESS RIGHTS MONITORED.
EXAMPLE:CATHERINE WEAVER, HOS INFORMATION GOVERNANCE, PERFORMANCE & REFORM, INFORMATICS.	**EXAMPLE:** SUBJECT ACCESS REQUEST CASE RECORDS	IG OFFICES IN GILFORD AND SOUTH TYRONE HOSPITAL.	YES	SAR REQUESTS, CORRESPONDENCE, PATIENT HEALTH/SOCIAL CARE RECORDS AND COPY OF PATIENT IDENTIFICATION.	INDIVIDUAL SAR INFORMATION ONLY HELD FOR AN INTERIM PERIOD DURING THE SAR PROCESS.	IG DEPT STAFF.	ESSENTIAL TO FULFILLING SUBJECT ACCESS RIGHTS OF PATIENTS IN LINE WITH DPA LEGISLATION.	BREAK INFORCED ENTRY. INAPPROPRIATE DISCLOSURE TO 3RD PARTIES.	3 YEARS FROM CASE CLOSED	Aug-19	SHARED WITH THE DATA SUBJECT OR WITH A 3RD PARTY WITH THE EXPLICIT CONSENT OF THE DATA SUBJECT	MANUAL RECORDS	RECORDS HELD IN LOCKED FILING CABINETS. ONLY IG STAFF HAVE ACCESS.	ONLY IG STAFF HAVE ACCESS. STORED IN SECURE AREAS NOT ACCESSIBLE TO THE PUBLIC.

Southern Health and Social Care Trust

Policy Checklist

Name of Policy:	Data Quality Policy
Purpose of Policy:	Outline and communicate responsibilities for data quality with a view to improving the quality of the Trust information.
Directorate responsible for Policy	Directorate of Performance and Reform
Name & Title of Author:	Karen McCoy, Head of Information and Data Quality/Data Quality Steering Group
Does this meet criteria of a Policy?	
Trade Union consultation?	
Equality Screened by:	Karen McCoy, Head of Information and Data Quality/Data Quality Steering Group
Date Policy submitted to Policy Scrutiny Committee:	05/05/2021
Members of Policy Scrutiny Committee in Attendance:	

Policy Approved/Rejected/ Amended	
Policy Implementation Plan included?	
Any other comments:	
Date presented to SMT	
Director Responsible	
SMT Approved/Rejected/Amended	
SMT Comments	
Date received by Employee Engagement & Relations for database/Intranet/Internet	
Date for further review	

POLICY DOCUMENT – VERSION CONTROL SHEET	
Title	Data Quality Policy 'Right First Time - Every Time' V3
Supersedes	V2
Originator	Name of Author: Karen McCoy Title: Head of Information & Data Quality
Scrutiny Committee &SMT approval	Referred for approval by: Date of Referral: Scrutiny Policy Committee (Date) SMT approval (Date)
Circulation	Issue Date: Circulated By: Issued To: As per circulation List (details below)
Review	Review Date: 16/04/2021 Responsibility of (Name): Adrian McElvanna Title: Acting Head Of Information & Data Quality

Southern Health and Social Care Trust

DATA QUALITY POLICY
'Right First Time – Every Time'

Karen McCoy
Head of Information and Data Quality
Reviewed April 2021
Version 3

Contents

1.0 Introduction to Policy

1.1 The Southern Health & Social Care Trust (hereafter referred to as the "Trust") is committed to providing high standards in its management of data, working in accordance with best practice to provide appropriate assurances regarding data quality.

1.2 The Trust recognizes its statutory responsibilities in relation to the quality and management of data under General Data Protection Regulation (GDPR) (EU) 2016/679, Data Protection Act 1998, the Freedom of Information Act 2000, Human rights Act 1998 and Access to Health Records Act 1990 together with the requirements to meet the Controls Assurance Standards for Information Management.

1.3 This policy therefore develops a context for ensuring that data quality is given a high priority within the Trust and that information recorded on the Trust's Information Systems is accurate, complete and fit for purpose.

2.0 Purpose and Aims

2.1 This Policy aims to:-

- Ensure that data produced, held and used within the Trust is of a high standard and that service delivery and patient/client safety is supported by good quality data.
- Ensure that all staff are aware that data quality is everyone's responsibility and understand that inaccuracies in such data might adversely impact on both work within their service area and that of the wider Trust.
- Ensure that data quality is embedded across all services and is a key consideration for all staff dealing with data.
- Ensure that roles and responsibilities in relation to data quality are clearly identified.
- Ensure that clinical data held on Trust systems complies with Regulatory and Professional Guidelines in relation to record keeping.

3.0 Scope of the Policy

3.1 This policy applies to all staff within the Trust and is intended to cover all types of data collected and recorded within the Trust – including but not limited to; patient/client/service user data, staff related data as well as other Trust data.

4.0 Policy Statement

4.1 Data Quality Management is an integral part of the Trust's operational, performance and governance arrangements so that it drives service improvement and policy. All decisions, whether clinical, management or financial, need to be based on information which is of the highest quality.

4.2 A key principle of recording Health & Social Care information is **'right first time – every time'**. Information retrieved from Information Systems is only effective and of use if it is of a high quality, accurate and complete. The Trust is committed to the prevention of poor quality data by getting it **right first time – every time**.

4.3 The Trust has adopted the Audit Commission's 'Standards for Better Data Quality' and will seek to ensure that its processes for collecting, managing and reporting on data are efficient, effective and provide data which exhibit the following characteristics:-

- **Accuracy** – Data should be sufficiently accurate and detailed for their intended purposes and should be captured once only – as close to the point of activity as possible.

- **Validity** – Data should be recorded and used in compliance with relevant requirements – including adherence to definitions/Technical Guidance and rules to ensure consistency and thereby measuring what is intended to be measured.

- **Reliability** – Data should be collected and processed consistently over time and across collection points to provide confidence that any performance monitoring reliably reflect service provision rather than being due to any variations in data collection approaches or methods.

- **Timeliness** – Data should be captured as quickly as possible at the time of the event or activity and be available for the intended use quickly and of a sufficient frequency to support information needs and to influence service or management decisions.

- **Relevance** – Data captured should be relevant to the purpose for which they are used. This requires regular review of requirements to reflect changing needs.

- **Completeness** – Data requirements should be clearly specified based on the information needs and data collection processes should match these requirements.

5.0 Responsibilities

5.1 Trust Board

The role of the Trust Board is to take corporate responsibility for ensuring the organisation is able to deliver on the implementation of this policy.

5.2 Chief Executive

The Trust Chief Executive has overall responsibility for ensuring the aims of this policy are met.

The Chief Executive has appointed the Director of Performance & Reform as lead Director with responsibility for monitoring the implementation of this policy.

5.3 Director of Performance & Reform

The Director of Performance & Reform will provide strategic leadership, direction and oversight of this policy and its implementation. The Director of Performance and Reform is also the Trust's SIRO (Senior Information Responsible Owner).

5.4 Role of Line Managers

Line Managers should ensure compliance with Trust Data Quality Policy, Data Quality User Guidance and good practice.

Line managers are responsible for ensuring that the data for their service area is accurate, timely and complete.

Line Managers should ensure they and their teams take a proactive role in using the various reports either available within the systems or provided by the Data Quality team to validate the information as recorded for their services.

Line Managers are responsible for ensuring that corrective action is taken arising from data quality monitoring reports to address data quality errors such as incorrect or missing data.

Line Managers should ensure that data quality and information are considered and discussed at team meetings as well as one:one supervision meetings.

5.5 All Staff

Responsibility for good data quality lies with all staff who record information, whether clinical, technical or clerical.

All staff are responsible for ensuring that they are aware of the data quality requirements incumbent upon them and for ensuring that they comply with these on a day-to-day basis.

Staff should ensure they attend training and awareness sessions to maintain their knowledge and skills in relation to the Trusts Information Systems and their role in data quality to ensure they get it '**right first time – every time'**.

Staff should ensure that they adhere to Trust Data Quality Policy, Data Quality User Guidance and good practice in relation to ensuring a high standard of data quality.

All staff who record information have a responsibility to ensure that the data they record is accurate and as complete as possible.

Where it is identified that data is inaccurate, all staff have a duty to take corrective action in a timely manner.

5.6 Data Quality Team

The Data Quality Team will support the wider Trust in achieving a high standard of Data Quality on patient and client systems by providing support and guidance to staff to assist them to meet their Data Quality obligations.

The Data Quality team will provide Technical or User Guidance/Standard Operating Procedures to set out how information on specific patient and client systems should be recorded.

The Data Quality Team will raise awareness of the importance of high standards of data quality and encourage ownership and responsibility to get it '**right first time – every time'**.

The Data Quality Team will work with operational services and with the Information Management Team to 'identify' data quality issues.

The Data Quality Team will provide regular monitoring and feedback to services outlining key Data Quality errors on patient and client systems.

The Data Quality Team will produce an annual Data Quality Workplan setting out key data quality objectives, actions and timeframes for the year ahead.

The Data Quality Team will produce a Data Quality Annual Report setting out performance on key performance indicators for the previous year.

6.0 Monitoring and Reviewing the Policy

It will be the responsibility of the Head of Information & Data Quality to ensure the policy is implemented. Formal monitoring of this Policy will be undertaken by the Data Quality Steering Group.

7.0 Equality and Human Rights

This policy has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Using the Equality commissions screening criteria, no significant equality implications have been identified. The policy is therefore not subject to equality impact assessment.

8.0 Alternative Formats

This document can be made available on request in alternative formats, e.g. plain English, Braille, disc, audiocassette and in other languages to meet the needs of those who are not fluent in English.

9.0 Sources of Advice and Further Information

Further advice regarding this Policy and associated Procedure can be sought from the Data Quality Team or visit the Data Quality SharePoint site.

Delayed Transfers of Care from General Acute Sites

Definitions and Reason for Delay Codes to Assist Monitoring Reductions in Delayed Transfers of Care

Health and Social Care Board/Public Health Agency
February 2021

Date for Review: February 2022

1. Introduction

This document sets out the definitions and monitoring arrangements that apply to the following standards to facilitate the effective transfer of care of patients from a **general acute hospital setting and should be fully implemented within Trusts from the 1.3.21.** For details as to the hospitals which are to be included please refer to table 2.1

This monitoring will exclude patients discharged from the specialities of obstetrics, mental health and learning disability and will apply only to adults. For the purposes of this monitoring an adult is defined as anyone **not** discharged from a Paediatric ward. For full list of exclusions please refer to section 2.2.

Please note complex codes and definitions have been updated. Non-complex codes will be reviewed at a later stage.

Current Performance Standards

(i) ***Ensure that 90% of all Complex Discharges from an acute hospital setting take place within 48 hours of a patient being*** **declared a delayed transfer of care**

(ii) ***No Complex Discharge from an acute hospital setting takes longer than 7 days from when a patient is declared a delayed transfer of care***

(iii) ***All Non-Complex Discharges from an acute hospital setting take place within 6 hours of a patient being declared medically fit for discharge.***

The underlying aim of these standards is to ensure that patient care needs are identified and assessed as swiftly as possible and that they have prompt access to appropriate care to meet those needs, in the most appropriate setting.

Appendix 3 outlines the methodology for how these targets will be monitored. For some patients, there will be a period during their illness when their needs can only be met in an acute setting because of the severity and unstable nature of their condition. Ensuring efficient and effective use of acute beds should mean that when an acutely unwell patient needs access to an acute bed, a bed to meet their needs is available.

For others, appropriate care could be provided in a setting other than an acute bed because their needs have changed and whilst they may still require a level of medical supervision and nursing care, the focus may be more on assessment of ongoing needs and rehabilitation to allow the patient to return to independence as much as is possible. The goal is identification of patient needs as soon as is possible in the course of their care, that the appropriate services are put in place to meet those needs and that all the different services work together effectively to allow the patient to achieve their full potential as soon as possible.

There is a need to gather regional data which demonstrates how well the different needs of patients along the spectrum of care, are being met. The coding structure that is in place to code transfers of care and any delays is designed to highlight process or infrastructure pressures in organisations to allow those organisations to address them. Reliable and

consistent regional data provides regional planners and commissioners with robust information to highlight any areas where action may be needed.

Information on performance against these standards will be monitored on a regular basis. **Delayed transfers of care will be monitored against the discharging hospital and the patient's Trust of Residence.**

Appendix 1&2 gives a list of the principal reasons for delay for use in the discharge delay monitoring system including relevant PAS codes. In order to facilitate effective, accurate consistent monitoring of transfers of care and delays, all Trusts must ensure that:

a. **Complex codes should be recorded on PAS/Patient Centre when key discharge decisions are taken. In particular, the date and time that a patient is declared a delayed transfer of care must be recorded on PAS/Patient Centre within 24hrs of the decision being made. Trusts are expected to update PAS/Patient Centre in the out of hours and weekend period.**

b. **Changes to the transfer of care codes must be captured on the PAS/Patient Centre system.**

c. **All discharges monitored under these standards must have the appropriate discharge code recorded on PAS/Patient Centre.**

2. Definitions associated with the standards for reducing Delayed Transfers of Care

2.1 Facilities to be included.

Performance as outlined above, apply to only those hospitals with acute beds and to Musgrave Park Hospital as follows:

Belfast Trust	Belfast City Hospital Cancer Centre Mater Hospital Musgrave Park Hospital Royal Victoria Hospital
Northern Trust	Antrim Area Hospital Causeway Hospital
South Eastern Trust	Downe Hospital Lagan Valley Hospital Ulster Hospital
Southern Trust	Daisy Hill Hospital Craigavon Area Hospital
Western Trust	Altnagelvin Hospital South West Acute Hospital

2.2 Exclusions from the standards monitoring.

The following specialties on discharge will be excluded from delayed discharge monitoring:

- Obstetric/Maternity (Korner specialty codes 501, 510, 520, 540, 550, 560)
- Mental Health/Learning Disability (Korner specialty codes 700, 710, 711, 712, 713, 715)

In addition, the following exclusions will also be applied:

- Patients where the intended management is day case or regular day/night ward attenders whose length of stay is zero (adults and paediatrics)
- Patients whose method of discharge does not map to the category of 'Patient discharged on medical advice' on PAS.
- Patients discharged from a Paediatric Ward
- Patients who are transferred to ICU / HDU beds in another hospital

In addition to these generic exclusions a list of specific ward exclusions has been agreed between the HSC Board and Trusts. As this list is subject to change, rather than include it in this document, it is available at the HSCB Information Sharepoint site at :

https://hscb.sharepoint.hscni.net/sites/pmsi/information/SitePages/Beds.aspx

This site will be updated as necessary and Information staff within the Trusts have access to it.

These exclusions are intended to help ensure that only appropriate hospital discharges are included in the monitoring system.

2.3 When does a delayed transfer of care start?

A 'delayed transfer of care' occurs when a patient is ready to leave hospital but is still occupying a bed. Delays can occur when patients are being discharged home or to a supported care facility, such as a residential or nursing home, or are awaiting transfer to a community hospital. In keeping with NHS England 2018[1] the following definition of a delayed transfer of care is to be applied; a delayed transfer of care occurs when all of the following conditions are met; A clinical decision has been made that the patient is ready for transfer, alongside the multidisciplinary team (MDT) decision that the patient is ready for transfer and the patient is considered to be safe to transfer.

The clinical decision re readiness to transfer or being medically optimised, is the point at which care and assessment could be continued outside of the acute setting.

[1] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2018/11/Monthly-Delayed-Transfers-of-Care-Situation-Report-Phttps://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2018/11/Monthly-Delayed-Transfers-of-Care-Situation-Report-Principles-Definitions-and-Guidance.pdfrinciples-Definitions-and-Guidance.pdf

Medically optimised means professionals asking themselves the following questions (where relevant):

- Does the patient's care need to be continued in the current clinical setting?
- Are the needs of the patient better met in a different care setting?
- If the support and services required, to meet the assessed need at home, were available at this moment, would the MDT in the hospital confirm that the patient could now go?
- If I saw the patient today in outpatients, or in the Emergency Department, would I admit them or would I try to get them straight home again with any additional support they needed?

Medically optimised for discharge decision making process:

- Is **not** dependent upon whether or not the patient is back to a baseline level of function.
- It **is** date and time specific and as such should be acted upon in a timely manner otherwise the clinical decision may need to be reassessed.

The multi-disciplinary decision that the patient is ready to transfer must align as closely as possible with the clinically ready to transfer status so that there are no delays. It is expected that the two processes should work in tandem to be expedient and that planning for discharge should commence as soon as possible after admission. An Estimated Date of Discharge (EDD) and the date of medical optimisation, which is regularly updated at ward level will be a useful reference point to help align the clinical and multi-disciplinary fit decision.

As highlighted in the List of Principal Reasons for Delay Codes in Appendix 1& 2, Trusts will update their codes as the reason for the delayed transfer of care changes. Updating the reason for delay code throughout the patient journey provides a more accurate and informed understanding of the reason for the delay which aids communication within and across Trusts. Implementation of this measure also provides more consistent and reliable data that DOH, HSCB/PHA, Trusts can use to scrutinise the issues, assist planning for future services and affect change.

The primary focus is to ensure that the patient leaves the acute setting as soon as their clinical needs are such that these could be met in another setting. Where a patient has been an acute inpatient and they are moved to a sub-acute or non-acute bed, even within the same Trust, this must be recorded as a transition and coded accordingly.

The following paragraphs define the different levels of care:

- **Acute Bed/Care.**

An acute bed is a bed within an acute facility which has 24 hours a day consultant cover and rapid access to a range of services including cardiac arrest teams, laboratories, radiology. There should be access to AHP and social work services. Services provided should reflect the unstable and unpredictable nature of acutely unwell patients, who have a real risk of their condition worsening quickly, and thus would require urgent intervention.

- **Sub-Acute Care and Non-Acute Care.**

The bed does not have 24 hours a day, 7 days per week rapid access to diagnostics, cardiac arrest teams, etc. Patients admitted to such facilities although unwell are deemed

safe to be cared for within a facility with rapid access to the services detailed above. There may be specialist medical cover, or the facility may be nurse–led. Patients may have specialist nursing or AHP input in such facilities, generally with a strong assessment, rehabilitation focus. In common with an acute bed, a stay in this type of bed is not a permanent arrangement but is a necessary step in the patient's journey to allow the patient to regain as much medical or functional fitness as they have the potential to achieve before their next phase of care.

- **Intermediate Care**

The 4 categories of care within Intermediate Care are described below. The transfer of care codes and definitions, seek to use the same terminology as used in the categories of care (NICE Guidance).

Crisis Response - Community-based services provided to people in their own home or a care home. These services aim to avoid hospital admissions. Crisis response usually involves an assessment, and may provide short-term interventions. Crisis response is delivered by a multidisciplinary team but most commonly by healthcare professionals.

Bed Based IC - Assessment and interventions provided in a bed-based setting, such as an acute hospital, community hospital, residential care home, nursing home, stand-alone intermediate care facility, independent sector facility, local authority facility or other bed-based setting. Bed-based intermediate care aims to prevent unnecessary admissions to acute hospitals and premature admissions to long-term care, and to support timely discharge from hospital. For most people, interventions last up to 6 weeks. Services are usually delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).
For the purposes of complex coding, bed based IC has been broken down into non-acute/sub-acute hospital care and IC care home placement.

Home Based IC - Community-based services that provide assessment and interventions to people in their own home or a care home. These services aim to prevent hospital admissions, support faster recovery from illness, support timely discharge from hospital, and maximise independent living. For most people interventions last up to 6 weeks. Services are delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes).

Reablement - Assessment and interventions provided to people in their home (or care home) aiming to help them recover skills and confidence and maximise their independence. For most people interventions last up to 6 weeks. Reablement is delivered by a multidisciplinary team but most commonly by social care practitioners.

2.4 When does a delayed transfer of care cease?

A delayed transfer of care ceases when a patient is discharged. A patient is regarded as being discharged when the person has left the hospital site. **The clock starts when the patient is ready to leave the hospital with the three conditions outlined in section 2.3 having been met, and should not stop or be restarted until discharge. The exception to this is if the patient becomes medically unwell and not fit to leave the hospital site. Thus the clock is continuous, running from the time a delayed transfer of care is declared, through to community screening and discharge without stopping.**

For patients with either simple or complex discharge needs, any time spent in a hospital discharge lounge should be included in their overall discharge waiting time.

2.5 Complex Discharges

A discharge is regarded as complex when it can only take place following the implementation of significant home based or other community based services (including residential or nursing home services). Significant is defined as seven or more hours of care per week regardless of the period that the package is intended to be in place. A discharge may be regarded as complex if it includes the installation of adaptations such as hoists or chair lifts or the provision of equipment such as specialist beds, pressure relieving mattresses, specialist seating, etc.

Once a patient has been coded as complex (list of codes attached at Appendix 1), the coding should never revert to a simple code.

2.6 Non-Complex (Simple) Discharges

All Non-Complex discharges should take place within six hours of a patient being declared medically fit (as defined under 2.3 above) and formal monitoring will be on this basis. A non-complex discharge is defined as a discharge where the patient has non-complex needs. Please see Appendix 2.

Examples of when a discharge should be classified as non-complex include:

(a) A discharge involving the re-activation of a package already in place prior to the hospital admission in question.
(b) A discharge which is only dependent on the need to arrange a domiciliary visit by district nursing or other community health workers.
(c) A discharge involving the need to introduce non-complex domiciliary care packages including meals on wheels or domiciliary support requiring less than daily support visits by domiciliary care workers. As an indicator, packages of less than seven hours per week would be regarded as simple.
(d) A discharge where the only requirement is the need to have available simple items of equipment (e.g. commodes.)

The codes for non-complex discharge are also attached at Appendix 2. All non-complex discharges which are affected within four hours should be recorded under the Simple 10 code – No significant delay (SNODEL). All simple discharges which take longer than four hours to affect should be recorded under the relevant code from the other ten simple codes. This will allow Trusts to undertake further analysis of the areas where discharges are taking between 4 and 6 hours to affect.

Please note that although four hours is used for coding purposes, the monitoring of the performance standard around Non-Complex Discharges will be on the basis of delays greater than six hours as per the CPD Target.

2.7 Internal Monitoring

The HSCB and DoH will monitor performance of delayed transfers of care under the definition specified in section 2.3. However internally, Trusts are recommended to monitor their own performance in relation to any discrepancy between the clinical decision being made that the patient is ready for transfer and multi-disciplinary decision making. Trusts have the option to apply an internal assessment/processes code with a date and time to capture this information as outlined below. **The 'internal assessment' code, date and**

time must however change and be updated when a delayed transfer of care (as per the definition in section 2.3) occurs.

Performance will be analysed against the definition of a delayed transfer of care specified in section 2.3 and captured by the codes outlined in Appendix 1.
The date and time on PAS / Patient Centre must be updated when the delayed transfer of care occurs. (See appendix 5 for examples).

Internal Hospital Assessment Processes A clinical decision has been made that the patient is ready for transfer. The multi-disciplinary decision/assessment is however required. The MD team is inclusive of mental health and psychiatry assessment/processes not related to the MCA. **NB. Once the patient meets the criteria of being a delayed transfer of care the code must change to one of the codes outlined in Appendix 1. The date and time also requires to be updated.**	**IHAP**

2.8 Principal Reason for Delay

At the point of discharge the Trust must code the Principle Reason for Delay on their PAS/Patient Centre system. **The Principal Reason for delay is from the point a person meets the criteria for being a delayed transfer of care therefore Trusts select the appropriate code from Appendix 1.** The Principal Reason for Delay is the delay which has caused the longest wait in terms of days. If two reasons cause the same length of wait, the Trust can decide which code to use as their Principal Reason for Delay.

The HSCB Information Department will run a quarterly report for all Trusts to capture all coded delays within the patient journey. This information can be shared with Trusts and will be kept under review.

APPENDIX 1

List of Principal Reasons for Delay Codes, for use in Delayed Transfers of Care Monitoring System. *(Note that all codes should be mapped to PAS internal value 5)*

Reason for Delay	PAS Code
MCA ASSESSMENT	
Complex 101 – Mental Capacity Patient transfer of care is delayed whilst an assessment takes place in the acute setting of the patient's mental capacity. This can include Best Interest Decisions, Deprivation of Liberty Safeguards (DoLS) - assessments under the Mental Capacity Act and legal proceedings. **Once the assessments/forms are completed the patient can no longer remain on this code**.	**CAMENC**
INTERMEDIATE CARE	
Complex 102 - Crisis Response (for example Acute Care at Home) - Community-based services provided to people in their own home or a care home. These services aim to avoid hospital admissions but can be used to facilitate discharge. Crisis response is delivered by a multidisciplinary team but most commonly by healthcare professionals. **Patient waiting for acceptance onto Crisis Response service.**	**CICRIS**
Complex 103 - Bed Based IC - Care Homes Assessment and interventions provided in a bed-based setting, such as residential care home, nursing home or stand-alone intermediate care facility. Bed-based intermediate care aims to support timely discharge from hospital. Services are usually delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes). **Patient waiting for assessment and acceptance onto bed based Intermediate Care.**	**CIBBCH**
Complex 104 – Bed Based IC – Sub Acute / Non-Acute Hosp Assessment and interventions provided in a sub-acute or non-acute hospital setting, even where the setting is within the same Trusts. **Patient waiting for assessment and acceptance onto bed based, sub- acute or non-acute hospital care.**	**CIBBNA**
Complex 105 - Home Based IC Community-based services that provide assessment and interventions to people in their own home or a care home. These services support timely discharge from hospital, and maximise independent living. Services are delivered by a multidisciplinary team but most commonly by healthcare professionals or care staff (in care homes). **Patient waiting for assessment and acceptance onto home based Intermediate Care.**	**CIHBIC**
Complex 106 - Reablement Assessment and interventions provided to people in their home (or care home) aiming to help them recover skills and	**CIREAB**

confidence and maximise their independence. Reablement is delivered by a multidisciplinary team but most commonly by social care practitioners. **Patient waiting for assessment and acceptance onto home based Intermediate Care.**	
COMMUNITY SPECIALIST TEAMS	
Complex 107 - Community Stroke Patient's transfer of care is delayed because of capacity of community stroke rehab services to provide assessment/care.	**CSSTRO**
PATIENT/RELATIVE CHOICE	
Complex 109 – Patient/Relative Choice Patient's transfer of care is delayed because their (or their relatives) specified choice of bed based care is not immediately available. The patient or their relative may not agree with the proposed home based care package or discharge plan. The patient's transfer of care is delayed because of these factors.	**CRPCHO**
DOMICILIARY CARE	
Complex 110 – No Domiciliary Package Available Patient's transfer of care from hospital is delayed because there is no capacity in any of the appropriate home care agencies to provide a support package. **NB following screening and acceptance onto home based Intermediate Care or Reablement, the patient may then move to this code waiting the care package.**	**CDNPA**
EMERGENCY DIRECT PAYMENTS	
Complex 133 - Emergency Direct Payments Patient's transfer of care is delayed in the acute setting whilst seeking to facilitate discharge utilising Emergency Direct Payments **Please note that once the patient is referred to the Finance Department the patient is to be captured as a delayed transfer of care.**	**CEMDP**
CARE HOMES **(to include residential and nursing home care)**	
Complex 111 – Await Assessment/Acceptance to Care Home Awaiting transfer of care assessment and/or confirmation of acceptance to care home. Fully completed Regional Transition Documentation and referral made to care home. **Patient waiting for assessment and/or acceptance into the care home**	**CCHATC**
Complex 112 - Enhanced Care Requirements Patient may require an enhanced level of care for example 1:1 care. This may be related to brain injury, distressed reactions, complex clinical care e.g. tracheostomy care or other assessed care needs. Bariatric patients may also need enhanced care requirements.	**CCHECR**
Complex 113 - Physical Disability Patients who need placement in a care home (nursing or residential) which is able to accommodate patients with a physical disability.	**CCHPHD**
Complex 114 - Mental Health Patients who need placement in a care home (nursing or residential) which is able to accommodate patients whose primary need is mental health. This includes a functional mental health placement.	**CCMEH**

Complex 115 - Learning Disability Patients who need placement in a care home (nursing or residential) which is able to accommodate patients with a learning disability	**CCHLED**
Complex 116 - Dementia Patients who need placement in a care home (nursing or residential) which is able to accommodate patients with dementia.	**CCHDEM**
Complex 134 - Delirium Patient's transfer of care is delayed in the acute setting due to a presentation of delirium or resolving delirium, which prevents discharge.	**CCHDEL**
Complex 117 – No Care Home Bed Available Patient's transfer of care from hospital is delayed because there is no capacity in any of the appropriate care home providers. The Trust will make the decision as to what they regard as an appropriate available provider – proximity to family etc. **This code should NOT be used where a patient or their relative/carers have declined an available placement in an appropriate facility.** **Patient/relative choice (Complex 109) should be used in this scenario**	**CCHNCH**
EQUIPMENT	
Complex 118 – Essential Equipment/Adapt Not Available Patient's transfer of care from hospital is delayed because significant items of equipment/adaptations essential to the discharge are not immediately available. This reason should not be used for patients requiring simple items of equipment (e.g. commodes).	**CEEANA**
TRAINING	
Complex 119 – Training Related Delay A patient's transfer of care is delayed because specialist technique or patient specific training of family or community staff (including care home staff) cannot be delivered. This code should also be used when a number of staff need trained and training is not yet completed	**CTRAIN**
HOUSING	
Complex 120 – No Fixed Abode Patient is presenting as homeless or has no fixed abode.	**CHNOFA**
Complex 121 - Housing Patient is unable to return to their own home as the home is uninhabitable. Please note this code is not to be used for care home residents.	**CHHOUS**
PALLIATIVE PATIENTS	
Complex 122 – Palliative Care IP Arrangements Not Made Transfer of care of a terminally ill patient is delayed because appropriate inpatient based palliative care arrangements cannot be made.	**CPALIB**
Complex 123 – Palliative Care Comm Arrangements Not Made Transfer of care of a terminally ill patient is delayed because appropriate community/home based palliative care arrangements cannot be made.	**CPALCB**
NO DELAY	

Complex 124 – No Significant Delay Should be used where a complex discharge is affected within 48 hours (<48hrs). The 48 hour timeframe is from the time the patient is a delayed transfer of care. The clock should not stop from the time the patient has been pronounced a delayed transfer of care until discharge. The 48 hour target for discharge is inclusive of the community screening/assessment. The CNODEL code should only be used on the day of discharge if there is reasonable belief that the patient will be discharged within 24 hours. Following discharge it should only be recorded as a Principal Reason for Delay if the patient was discharged within the 48 hours target. If not discharged within 48 hours another code should be selected.	**CNODEL**
CoVID 19 RELATED DELAYS **Please note that a patient can only have one code attributed at any point in time. These codes are strictly for CoVID related delays only. If the patient is not delayed due to CoVID related issues, the December 2019 codes should be utilised.**	
Complex 125 – SAMPLING WITHIN THE ACUTE SETTING Patient's transfer of care is delayed whilst CoVID sampling takes place in the acute setting.	**CVSAS**
Complex 126 - Waiting the Test Result Patient's transfer of care is delayed whilst awaiting the test result. This can include the care setting refusing to assess and accept the patient until the outcome of the testing is known. This code could also apply to home care services. **Please note it is not a regional requirement for testing results to be available at the point of discharge from the acute setting.**	**CVWTR**
Complex 127 - Additional Criteria Applied by Care Home/Home Care Patient's transfer of care is delayed as the care home or the home care service has applied additional criteria to the discharge. One example being that for those patients who have tested positive for the virus, the isolation period is completed in the hospital setting. Other stipulations may arise during the course of the pandemic which are not reflective of regional guidance. **Please note this code would also apply to those who permanently reside in a care home and the care home advises that they will not accept back until the isolation period is completed in hospital.**	**CVACC**
Complex 132 – CoVID Rehab Assessment and interventions provided in a facility which provides rehab following a CoVID diagnosis, even where the setting is within the same Trust. **Please note that CoVID rehab is provided in different settings across the region to include the regional Whiteabbey Unit and designated care home beds.**	**CVRHB**
Complex 130 – STAFFING Patient's transfer of care is delayed due to the care home or domiciliary care agency not being able to meet the care needs of service users due to their own staffing issues caused by CoVID-19.	**CVSTA**
Complex 131 - CoVID OUTBREAK Patient's transfer of care is delayed as there are no available placements in an appropriate facility due to CoVID outbreaks and the care settings being closed to new admissions.	**CVOUT**

Complex 128 - PATIENT/FAMILY REFUSAL COVID SPECIFIC Patient's transfer of care is delayed as the patient and/or family refuse discharge due to CoVID specific reasons. These can include but are not limited to: not agreeing with the discharge plan; refusing the bed based care option due to a history of CoVID within the care setting; concern re contracting CoVID from the individuals who are planned to provide care on discharge, from the patient themselves on returning home or because they are not accepting of the isolation period required after discharge. **Please note this is for CoVID specific delays only**. If the patient or family refuse a package of care or a bed based care option but not for a reason related to CoVID this should be recorded under the existing code; **Complex 109 – Patient/Relative Choice**	**CVPFR**

Appendix 2

List of Principal Reasons for Delay codes for use in discharge delay monitoring system – Non-Complex Discharges

Reason for Delay	PAS Code
Simple 1 – Pharmacy Awaited There is a Pharmacy delay in the patient receiving drugs needed to allow him/her to leave. This type of delay is due to Pharmacy rather than delays in supply of prescriptions or discharge summaries to Pharmacy from Wards.	**SPHARM**
Simple 2 – Discharge Summary Awaited A discharge summary which must be completed and given to the patient for onward transmission to primary care is not available	**SUMMAR**
Simple 3 – Awaiting Ambulance If the patient's discharge is delayed because an ambulance, having been ordered, has not arrived	**SAMBUL**
Simple 4 – Awaiting transport from family or friends Where the delay is caused by the patient choosing to await transport home from friends or family.	**STRANS**
Simple 5 – Awaiting Tertiary Care Where a patient, occupying a bed in one hospital, is awaiting transfer to a specialist bed in another hospital and the transfer is delayed because a bed is not available in the receiving hospital.	**STCBED**
Simple 6 - Awaiting Secondary Care Bed Where a patient, occupying a bed in a specialist hospital is awaiting transfer to a non-specialist acute bed in another hospital and the transfer is delayed because a bed is not available in the receiving hospital.	**SSCBED**
Simple 7 – Simple Community Package A discharge is delayed because a simple community package is not in place. (A package would normally be regarded as simple if it involved the re-activation of a package already in place prior to the hospital admission in question. A package would normally be regarded as simple if it involved arranging a domiciliary visit by district nursing, health visiting or other community health workers A Package would be regarded as simple if it involved the need to introduce simple domiciliary care packages including meals on wheels or domiciliary support requiring less than daily support visits by domiciliary care workers. As a rule of thumb packages of < seven hours per week would be regarded as simple)	**SPACK**
Simple 8 – Simple items of equipment not available Patient's discharge from hospital is delayed because simple items of equipment	**SEQUIP**

essential to affecting safe discharge are not immediately available.	
Simple 9 – Other simple delay reason Where a patient discharge is delayed because the care arrangements are not yet complete for a reason other than specified above.	**SOTHER**
Simple 10A – No significant Delay Where a patient is discharged within four hours (<=4hrs) of being pronounced medically fit	**SNODEL**
Simple 10B – No significant Delay – Other Hospital Where a patient is transferred for treatment / tests in another hospital and the intention is that the patient will return to the same hospital for ongoing care.	**SNODOH**
Simple 11 – Ward- originated delay. This code should be used when there was a delay in the ward requesting an assessment, diagnostic or other intervention suggested in the patient's treatment plan or there is a delay in requesting a home-based or other community based service which is necessary for discharge, such as an assessment, and it accounted for most of the delay period.	**SWARD**

Appendix 3

Regional Performance Information Methodology

The Board monitor those patients discharged and also monitor daily those patients who are *currently* an inpatient each midnight. The Department only monitor those patients discharged.

Both sets of monitoring will be in line with this definitions document.

All BOXI queries used to extract the data from PAS will be written by HSCB and shared with the Department and Trusts via the use of the Common documents facility. A timescale as to when these reports will be run will be provided to Trust Information Departments.

Note that as Trusts can currently only see activity within their own hospital sites HSCB will provide an annoymised patient level report for activity of the Trusts residents in other hospitals.

PAS Technical guidance as to how to record delays along with a list of the delay codes and descriptions will be available at :

https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx

Appendix 4

Complex Coding – Guiding Principles

1. The definition of a delayed transfer of care[2] must be applied to patients who meet the criteria of being complex. There must be no delay between clinically ready to transfer and the completion of MD assessments.

2. Any discrepancy between the clinical decision that the patient is ready for transfer and MD decision that the patient is ready to transfer will be monitored internally by use of the 'IHAP' code on PAS/Patient Centre. The HSCB and DoH will not monitor performance against this code.

3. The HSC Trust can start the clock with date and time the patient is clinically ready if there is a reasonable belief that the MD assessment will not be completed at the same time. The MD team is inclusive of mental health and psychiatry assessments/processes not related to the MCA. This code is for internal monitoring only.

4. **There must be a date and time recorded on PAS/Patient Centre from when the patient meets the definition of being a delayed transfer of care. This is for HSCB and DoH monitoring.**

5. The delayed transfer of care code must be reviewed at least daily and updated as required.

6. The patient's code must reflect the reason for delay at that time. Thus if the discharge solution changes from domiciliary care to a care home for example this must be recorded.

7. The 'CNODEL' code should only be used on the day of discharge if there is reasonable belief that the patient will be discharged within 24 hours.

8. If the patient remains clinically ready to transfer the clock must not stop throughout the patient's journey. Thus the clock is continuous, running from the time a delayed transfer of care is declared, through to community screening and discharge without stopping.

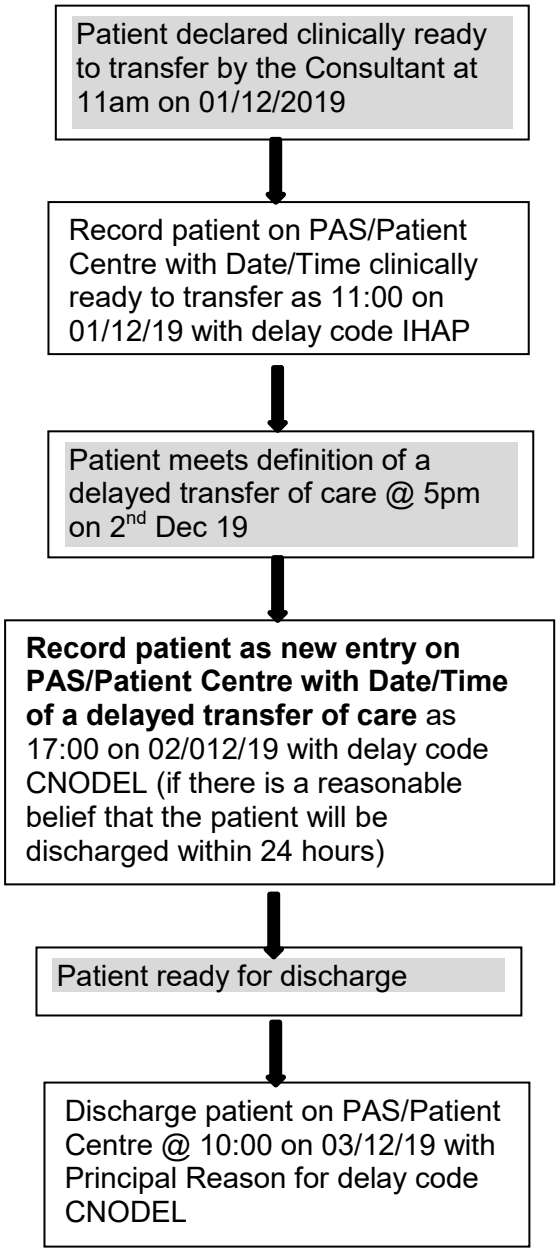
9. At the point of discharge the Trust must code the Principal Reason for Delay on their PAS system. The Principal Reason for Delay is the delay which has caused the longest wait after the person has met the criteria for being a delayed transfer of care. Trusts to choose the most appropriate code from Appendi

[2] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2018/11/Monthly-Delayed-Transfers-of-Care-Situation-Report-Phttps://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2018/11/Monthly-Delayed-Transfers-of-Care-Situation-Report-Principles-Definitions-and-Guidance.pdfrinciples-Definitions-and-Guidance.pdf

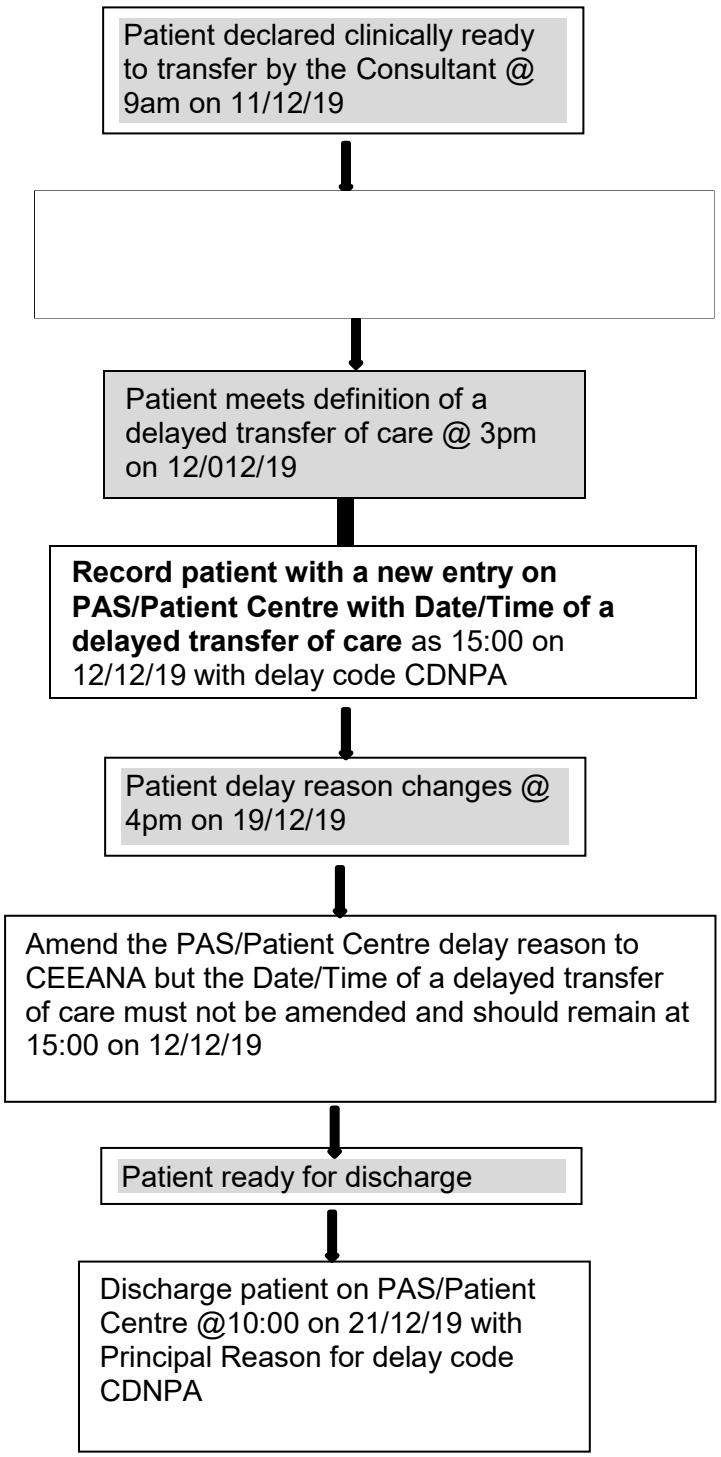
Appendix 5

EXAMPLES OF DELAYED PATIENT TRANSFERS RECORDING ON PAS / PATIENT CENTRE

1. Patient is declared clinically ready to transfer, on 1st December 2019 @ 11am, by the Consultant but does not meet the multi-disciplinary criteria outlined in section 2.3 and hence performance of the delayed transfer of care has not commenced. Trust wish to highlight this patient on their operational reports. On 2nd December 2019 @ 5pm the patient is declared a delayed transfer of care, there is no delay and they are discharged on 3rd December 2019 @ 10am.



2. Patient is declared clinically ready to transfer, on 11th December 2019 @ 9am, by the Consultant but does not meet the MD criteria outlined in section 2.3 and hence performance of the delayed transfer of care has not commenced. Trust wish to highlight this patient on their operational reports. On 12th December 2019 @ 3pm the patient meets the criteria of a delayed transfer of care, outlined in section 2.3, but is delayed due to commencement of a domiciliary care package. On 19th December 2019 @ 4pm the patients delay reason changes to waiting for essential equipment which is in place on 21st December @ 10am and the patient is discharged.



Validation Reports

Report	Frequency	Comment
DNA report Public folders/SHSCT/Non Information/Acute/Outpatients/Outpatient Activity/ Report 02C	3 times weekly	Send to Mary O'Neill and copy to Andrea Cunningham
Outpatient Attendances Not Recorded Public folders/SHSCT/Trust wide PAS Data Quality/Standard reports/General/Outpatients/Outpatient Activity Report 01E	Weekly	Send to all Service Administrators and Katherine Robinson, also include Jayne Agnew, Lyndall Barrett, Caroline Barron, OSL, Daniel Hughes, Elsie McCready, Pauline Matier, Ann O'Hagan
GENS consultant recorded for Reviews Public folders/SHSCT/Non Information/Trust wide PAS Data Quality/Standard reports/Active General /Outpatients Report 01G	Weekly	Filter on Review appointment given and Review later for both worksheets and forward to Health Records Managers
Delayed Discharges not coded Public folders/SHSCT/Non Information/Trust wide PAS Data Quality/Standard reports/Delayed Transfers of Care Report O1E	Weekly	Delete Paeds and Delivery Suite and Nursery's before sending on
Nursing homes not recorded in ED Public folder/SHSCT/Non Information/Medicine and Unscheduled Care/Emergency Care/Standard reports/Data Quality reports/Report 18	Weekly	Forward to ED managers
Medically fit and Discharge Time the same Public folders/SHSCT/Non Information/Trust wide PAS Data Quality/Standard reports/Delayed Transfers of Care Report O1D	Weekly	Forward to Hos and Ads. Ceara and Megan also forward this every Wednesday to ward clerks to chase up uncoded discharges
PAS Validation reports	End of month	Wait to about 5th of month and run through the reports to monitor all is up to date
eEMS Validation reports	End of month	

PAS monthly Reports – validated by Ceara and Megan		eEMS monthly Reports – validated by Sinead and Helen McC
01D		02 – ED – Unplanned with negative waits
01E		05 - ED – Missing postcode
01M		09- ED- Triage time is equal to examined time
01N		10 – ED – Attendance is new and initiator is unplanned
01T		11 – ED – Dental incident and initiator does not match
01U		12 – ED – unplanned reatttender with triage before arrive time
01V		14 – ED – UDDA uncoded
01W		18 – ED – nursing home not recorded on eEMS

Forde, Helen

From: Forde, Helen < Personal Information redacted by the USI >
Sent: 05 October 2020 10:32
To: OHare, Megan
Subject: RE: Validation Reports

Excellent.

Helen Forde
Head of Health Records
Admin Floor, CAH

Personal Information redacted by the USI
Personal Information redacted by the USI

From: OHare, Megan
Sent: 04 October 2020 09:26
To: Forde, Helen
Subject: RE: Validation Reports

Good Morning Helen

Highlighted are the reports I complete weekly. I will add Delayed Discharge – 0 mins from med fit to discharge and 01W – Transfers discharge lounge outside of hours

PAS monthly Reports – validated by Ceara and Megan
01D - Delayed Discharge – 0 mins from med fit to discharge
01E - Delayed Discharge – uncoded or coded with IHAP
01M – Inpt activity – Tnf to another hosp incorrect dest
01N – inpt activity – Tnf from another hos; incorrect adm
01U – Admission – Nursing home not recorded
01V – Discharge- Nursing home not recorded
01W – Transfers discharge lounge outside of hours
01E - IP ADMS LOS > 0 NIGHTS OR DAYCASE WITH LOS > 0 ADM TO AND DISC FROM A DAY ONLY WARD
01C - ELECTIVE ADMISSIONS AND DAYCASES WITH WL DATE/PRE ADM DATE = DATE OF ADM
01D - ELECTIVE ADMISSIONS AND DAYCASES WITH NO WL DATE/PRE ADM DATE

Megan

From: Forde, Helen
Sent: 02 October 2020 16:28
To: Corr, Sinead; McCaul, Helen; OHare, Megan; McCann, Ceara S
Subject: Validation Reports

Have a look and would you make sure that these are the reports that you are validating every week/month.

If any of you have any more would you add them on please.

Forde, Helen

From: Forde, Helen <[redacted]>
Sent: 09 October 2019 09:32
To: Corr, Sinead; McCaul, Helen
Cc: Ellis, Gregory; Poland, Orla
Subject: eEMS Validation

I ran through the eEMS validation reports this morning and have sent Greg and Orla some queries to look at.

Once again the standard of recording is very good – there is only a small percentage of data to check out – so well done to everyone and keep up the good standards of recording information.

Greg and Orla – thank you for checking all of these things out.

Helen Forde
Head of Health Records
Admin Floor, CAH

[redacted]
[redacted]

Southern Health and Social Care Trust

Quality Care - for you, with you

ADMINISTRATIVE & CLERICAL Standard Operating Procedure No

Title	Checklist for Ward Clerks: Final checks required on E-discharges when a patient is discharged from a ward. (Medical & Surgical Wards only)	
S.O.P. Number		
Version Number	v1.0	**Supersedes:** v0.1
Author	Sinead Corr, Lucia Cunningham & Pamela Lawson	
Page Count		
Date of Implementation		
Date of Review		**To be Reviewed by:**
Approved by		

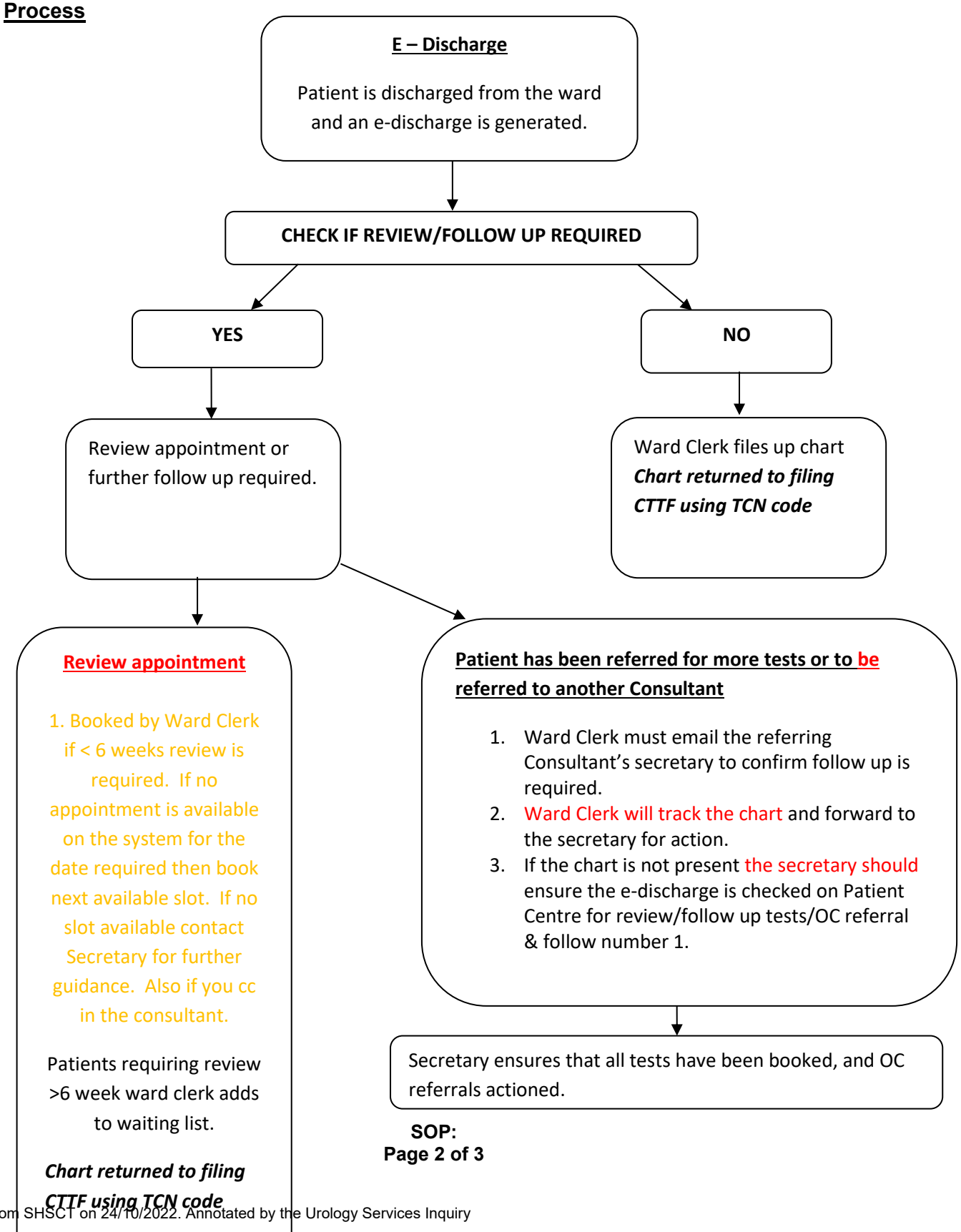
Standard Operating Procedure (S.O.P.)

Checklist for ensuring follow up is actioned for E-discharges

Introduction

This SOP details the flow chart for ward clerks (Medical & Surgical wards only) checking e-discharge's when a patient is discharged from a ward.

Process



Appendix 1: E-Discharge Referrals

Ward Clerk receives the e-discharge

Example 1- Outpatient appointments under 6 weeks

Patient has review appointment to be booked under the same speciality and same Consultant. The ward Clerk makes the appointment and sends out to the patient.

Example 2 – Outpatient appointment over 6 weeks

Patient has a review appointment to be booked under the same speciality and same Consultant. The Ward Clerk adds the patient onto the relevant OP Waiting list .

Example 3 – Patient has been referred to another consultant same speciality: The Ward Clerk ORE's the patient to the new Consultant and sends a copy of the e-discharge letter to the Referral and Booking Centre who will treat this as an OC referral.

Example 4 – Patient has been referred to another consultant another speciality. The Ward Clerk ORE's the patient to the new Consultant and sends a copy of the e-discharge letter to the Referral and Booking Centre who will treat this as an OC referral.

Example 5 – Patient has been referred to another speciality but the Consultant is un-named. The Ward Clerk ORE's the patient to the General Specialty code eg GSUR (General Surgery) and sends a copy of the e-discharge letter to the Referral and Booking Centre who will treat this as an OC referral.

Investigations

If on the E-discharge the patient is to be added for an investigation i.e XRAY/ECHO etc the Ward Clerk will email the e-discharge letter to the Consultant's Secretary just to make her aware that this is the next step in the patient's pathway. The Consultant's Secretary is then required to ORE the patient as a Ward review and put into DARO for follow up.

Southern Health and Social Care Trust

Quality Care - for you, with you

Standard Operating Procedure	
Title	Information / Guidance for Casenote Tracking
Author	Andrea Cunningham, Pamela Lawson
Date	28/03/2022
Review	27/03/2023
Scope of the Procedure	All those dealing with patient charts

1.0 OVERVIEW

Every member of staff involved in the handling of patient charts is responsible for case note tracking their movement. It is a mandatory requirement that this is done without exception.

The comment field must be completed in each instance to pinpoint the exact location of the chart.

Charts must be easily and quickly accessible at all times to ensure the best possible patient care.

Health Records staff are the custodians of all health records and charts should only be held outside of Health Records when actively in use, otherwise they must be returned to Health Records to ensure they are available when required by all services.

When a chart is issued from Health Records it should be tracked via the Casenote Tracking function “LCN”.

The responsibility for charts will remain with the person or department to which they are tracked. It is the responsibility of this person to ensure that there is as much information regarding the chart location in the office/department on PAS/PC to ensure a speedy retrieval if necessary.

It is the responsibility of all staff to ensure that pigeon holes/filing areas are well organised and labelled e.g., results, discharges, etc. to ease with retrieval of charts.
In the event that a chart is required by a different person or department, it is the responsibility of the person in possession of the chart to update the Casenote Tracking location. It is best practice that the receiver also checks this has been updated correctly.

In the event of a chart being required from an office or department when the occupant is not available, it is the responsibility of all staff to ensure that there is a mechanism in place for this information to be recorded and updated on PAS/PC immediately on return to the office.

Each department/person using charts should have a designated tracking code. This can be obtained from the Health Records Manager/Supervisor. Each tracking code will hold the role of the requestor, name, location and telephone number.

2.0 PAS/PC Guidance - CASENOTE TRACKING SYSTEM

Anyone who requires a set of notes can access the function CLE (Casenote Loan Enquiry). This will show the user who the chart is marked out to.

CLE Casenote Loan Enquiry
LCN Loan Casenote
TCN Transfer Casenote
RTC Return Casenote
CMG Clinic Management

Anyone who requests a chart is called a Borrower. Each borrower has a Borrower code on PAS/PC.

To request a borrower code (also known as a "Tracking Code"):

- Log on Ivanti and select the "Get IT Support " > IT Systems > IT System Access tile

When casenotes are moved between wards/offices/departments they are transferred via the function TCN.

When charts are being loaned or transferred sufficient information must be recorded in the Reason for Loan and Comment fields to enable anyone looking for the notes to locate them easily.

2.1 LOAN CASENOTES

This function is only used by Health Records/Filing Room staff when loaning charts.

Function Set	CNT
Function	LCN – PC – loan casenote
Borrower	Superhelp
Loan Date/Time	Defaults to today's date
Expected Return Date	Defaults to a preset date
Reason For Loan	Clinic/Admission/Dictation
Comments	(free text) e.g. 2 volumes sent

Casenote	The user can enter up to 25 casenotes before the system prompts for an update

If more than 25 charts are requested the system prompts the user “More casenotes for this Borrower?” Enter Y and continue to enter more or N to finish.

The pulling list CN FULL and the update list CN UPDATE both contain current borrower codes for casenotes that are not filed in the filing room.

2.2 TRANSFER CASENOTE

This function is used to transfer casenotes currently on loan between borrowers e.g. from ward to secretary or outpatients to filing.

FUNCTION SET	CNT
FUNCTION	TCN
Borrower	Superhelp
Loan Date/Time	Defaults to today's date
Expected Return Date	Defaults to a preset date
Reason For Loan	Clinic/Admission/Dictation
Comments	(free text) eg 2 volumes sent
Casenote	The user can enter up to 25 casenotes before the system prompts for an update.

If more than 25 charts are requested the system prompts the user "More casenotes for this Borrower?" Enter Y and continue to enter more or N to finish.

2.3 RETURN CASENOTES

This function is used solely by Health Records staff when returning charts to the library.

FUNCTION SET	CNT
FUNCTION	RTC
Return date/time	Defaults to today's date
Casenote	location Enter the location e.g. CMAT You can enter up to 25 charts at a time

2.4 OUTPATIENT DEPARTMENT

It is not necessary for Outpatients staff to transfer individual casenotes to the secretaries when a clinic is finished except in cases where pages & labels have been provided or casenotes are being sent elsewhere.

FUNCTION SET	CMG
FUNCTION	CMG/CMH
Enter the Clinic code	
Enter Doctor code	
Enter session start/end	
Enter the Option	TRANSFER CASENOTES

This automatically takes you into the transfer screen.

Enter Borrower code	Superhelp
Loan Date	
Expected Return date	
Reason For Loan	
Comments	
Include/Exclude	

Casenote: 1.
2.

If you enter INCLUDE and enter ALL at Casenote prompt you can transfer the whole clinic to the secretary.

If you enter EXCLUDE you can list the casenotes that you do not want to transfer to the secretary. All others will then automatically transfer.

The excluded casenotes (those not going to the secretary) are transferred via the Function TCN.

Exclude will be the option which is used most of the time in Outpatients.

Remember to exclude charts that are kept over for other clinics.

Remember to exclude charts that are sent to wards or other departments

Remember to exclude charts that are taken to other hospitals by Consultants (where possible)

PLEASE NOTE:-

THE CMG FUNCTION WILL ONLY DISPLAY THOSE PATIENTS WHO ARE CURRENTLY BOOKED TO THE CLINIC. IT DOES NOT DISPLAY PATIENTS WHO HAVE CANCELLED OR WALKINS THAT HAVE NOT YET BEEN RECORDED ON PAS.

ALL WALKINS MUST BE RECORDED BEFORE CASENOTES ARE TRANSFERRED THROUGH THE CLINIC MANAGEMENT FUNCTION.

ALL CRBS MUST BE TRANSFERRED VIA TCN WHEN THEY ARE GOING BACK TO FILE OR TO THE SECRETARIES.

CMG only allows you to look at current clinics i.e. Clinics that are taking place TODAY.

The function CMH is the historic function that allows you to look at clinics for dates in the past.

2.5 CASENOTE TRACKING – BORROWERS

CLE Casenote Loan Enquiry will tell you if a casenote is currently on loan

TCN The current borrower sends the chart to you and transfers the casenote to you on PAS. You are now the current BORROWER.

TCN A user rings you for a chart. You send the chart to the user and you transfer the casenote. You are no longer the borrower.

TCN You want to return charts to file.

CLE You see a chart is tracked out - the chart will be with the last borrower

2.6 CASENOTE TRACKING – LENDERS (LCN)

This function is only used by Health Records staff when removing charts from the library.

CLE can be used to ascertain if the chart is tracked out already.

Pull the chart and Loan the casenote (LCN) to the requestor.

2.7 CASENOTE LOAN ENQUIRY - CLE

This is the starting point for casenote tracking. It allows the user to identify if a casenote is in filing or already out on loan from the filing room.

FUNCTION SET CNT
Function CLE
Enter the casenote number that you wish to look at.

3.0 RESPONSIBILITY

It is the responsibility of every staff member to record accurate and timely information on the Casenote Tracking system when a chart is moved.

Responsibility for charts rests with the last borrower recorded on the Casenote Tracking system

Doctor's Induction – Admin Processes

Please see below some information which will help you in the processing of the patient through their journey in hospital from an admin point of view.

INPATIENTS

1. **DISCHARGE LETTER -** Discharge letters are typed on ECM and must be completed at the time of the patient discharge. When you are completing your discharge letter remember you must AUTHORISE them on ECM. If they aren't authorised they can't be printed and follow up actioned, e.g. making patient review.

2. **FOLLOW UP** – you must record the specific timeframe of the review, e.g. 2 months, or if you are referring the patient on to another consultant you must record the consultant's name, specialty and what hospital they are working in. This information **MUST BE recorded** in the **Follow up section**. Admin staff do not read the body of the letter so if the review is recorded in the body of the letter but not under the Follow Up section then it will be missed.

3. **TESTS/INVESTIGATIONS -** If you are arranging further tests/investigations for the patient you must use the appropriate referral form – the ward clerk will help you with this.

4. **CHANGING THE DISCHARGE LETTER –** On occasion you may need to change the discharge letter e.g change of medication, update results – if you do then you **must always advise** the ward clerk so they can print out the most up to date letter for the chart, and they will also check in case the follow up has changed.

5. **PATIENT DOCUMENTATION** – It is everyone's responsibility to ensure the safekeeping of patient charts therefore if you take a chart out of the trolley you must put it back where it come from. Please do not leave patient documents lying around work stations or wards – this poses a risk of information going missing, being misfiled and can cause serious breaches in patient data confidentiality.

6. **PATIENT CHARTS** - We have five sites in the SHSCT and each site at one time had their own chart, so you will be working with charts from CAH, DHH, STH, BPC and ACH charts. The majority of the charts are now filed in specialty order, but some of the older CAH and BPC charts are filed in chronological order. A filing protocol has been provided on each ward for your reference, and the ward clerk will also help you if you need guidance on where to look in the chart.

7. **PAGES AND LABELS -** When you are putting patient information/labels into a chart make sure that you put the right patient's information into the right chart. Another patient's information going into a chart will lead to Datix being completed, but more seriously may impact on the patient's care, so always check – right patient, right information.

8. **MOVING CHARTS -** Charts are tracked on PAS/Patient Centre to a specific ward, clinic or location. If you move a chart then it must be re-tracked so we know where it is. If you don't have access to track the chart ask one of the clerical team to do this for you – let them know where the chart is going to, and to whom. **This is of utmost importance as all charts must be accurately tracked to the right location so that they can be retrieved for outpatient clinics attendances or for admissions and can impact on patient care if misplaced or lost**

9. **RESULTS -** All results must be signed off to prove that they have been seen. If there is any follow up required, eg sending on a copy of the GP or making a review for the patient this must be recorded on the result and given to the Ward Clerk for actioning. In the future they will be signed off electronically, but in the meantime they can also be signed off manually. Please make sure you sign your results both on the ward and in the secretary's office as soon as possible.

10. **Outpatients -** When dictating clinic letters always highlight if the patient is a Red Flag/High risk. This means that this letter will be given priority when it comes to having it typed. Make sure you select the correct consultant when dictating.

11. **CLINIC OUTCOME SHEET -** To ensure the patient is appropriately followed up you must record on clinic outcome/clinic list if the patient **Must Be Seen (MBS**), is an urgent review or being referred to another consultant (OC). We have long waiting lists so if a patient is recorded as MBS or urgent review then these patients are put onto the Urgent OP Waiting List and they are sent for first.
    If a patient is to be added to an inpatient/day case waiting list you will fill out a WL proforma at the clinic. At the end of the clinic you need to put these proformas into an envelope and not in the chart. When the secretary gets the envelope she will put the patient on the waiting list immediately, so ensuring that the patient is not lost to follow up. If they go into the chart this will delay them being added to the Inpatient/Day Case waiting list.

12. **Mental Capacity Act (MCA) –** all MCA forms must be completed within the specified timescale and given to the Ward Clerk to forward to the MCA Admin team.

Thank you

The admin staff provide a valuable service with regards to the care of the patient and by working together we can ensure the patient is recorded properly, is followed up in time, and remains safe. We are here to help you so please ask if you are in doubt about any of the above, and we will help you to help us.

Helen Forde

Head of Health Records

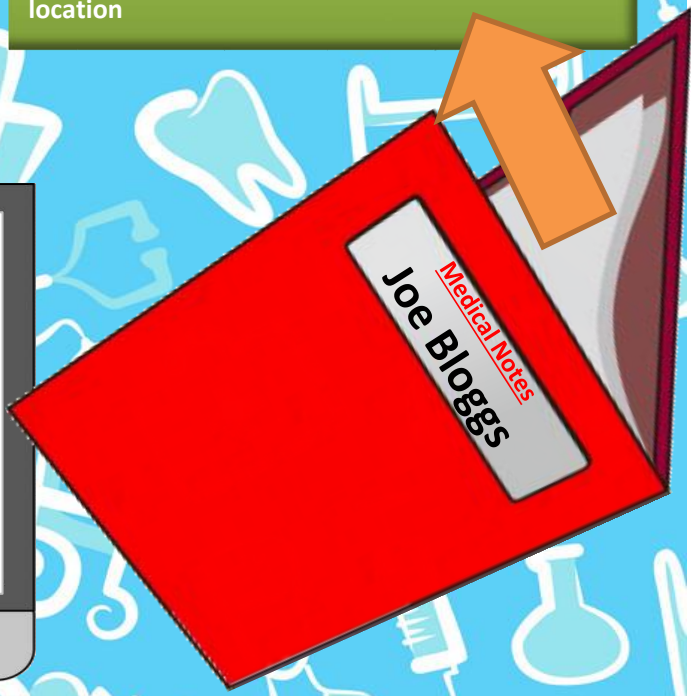
IMPORTANT INFORMATION

Outpatient Clinic Checklist

- When dictating always highlight if patient is RF/High Risk and select correct consultant
- Record on clinic outcome sheet if patient **Must be Seen, Urgent Review** or **referred to another consultant**
- Put all WL proformas into an envelope at the end of clinic

Make sure when putting documentation and labels into a chart that they belong to the ***correct patient***

If you are taking a chart off the ward you **must** tell the ward clerk so that it can be tracked to its new location



E-Discharge Summary Checklist

- **Give specific details in the follow up section e.g. Review 3/12**
- **If referring to another consultant, give full name, speciality and hospital**
- **Authorise your letter**
- **If you make any changes to a letter let the ward clerk know**

All results must be signed on the ward

Results in the secretaries office need actioned *ASAP*

Received from SHSCT on 24/10/2022. Annotated by the Urology Services Inquiry

Ref	Title	Potential for Risk/Harm	Controls Already in Place	Impact	Likelihood	Risk Rating	Further Controls Planned	Owner	Target Date	Updates
1	Chart Not Available	If a chart is not available for a clinic or ward admission vital medical information will not be available.	Clinicians can use NIECR. Pages and Labels provided. LABS and NIPACS available electronically. Will drive to other site if chart needed urgently. Specific information can be scanned to the appropriate site if required.	3	1	3	None at present			**OCT 20:** Chart retrieved from Oasis as express delivery
2	Wrong Chart provided for clinic or admission	Patient could receive inappropriate treatment	SOPs in place to pull charts ensuring names and unit numbers match. Given to staff at induction. Reiterated at team meetings.	5	1	5	None at present			
3	Security of Charts	Charts at reception or other public areas (eg portering, awaiting transport etc) where there is an increased risk of them being removed or viewed by non authorised staff	The introduction of Savience has removed a lot of charts from reception areas. Staff are trained in security and confidentiality of charts and trained in Data protection. Signs on all reception area doors to say 'Staff Only'. Cages sitting outside Records areas should be taken into department overnight and at weekends.	5	1	5	None at present			
4	Multiple records for a patient	A patient can have more than one health records chart. This could result in a patient being admitted without all of the information being available for the patient admission/appointment. A patient could be admitted with a chart from one hospital, but relevant medical history in a different chart on another site. **OCT 20:** Temporary blue charts introduced during COVID pandemic - risk of not being filed into original chart in a timely manner and information not available for any subsequest admission/appointment. (07/10/2020)	NIECR and information systems available to give additional information on the patient's history. Weeding and reduced registration (no BBH, STH or ACH charts being registered) meanthere are less charts in the system. Ongoing piece of work. This is also on the Corporate Risk Register.	3	2	6	Continuation of weeding of charts		Ongoing	
5	Duplicate Charts	Patient's treatment could be affected due to information not being available	Guidance available	3	2	6	SOP to be updated	PL?	Apr-21	

Ref	Title	Potential for Risk/Harm	Controls Already in Place	Impact	Likelihood	Risk Rating	Further Controls Planned	Owner	Target Date	Updates
6	Broken and Damaged Bays	If filing bays are broken there is the potential for staff to suffer an injury when trying to move the filing bay	SOP in place for broken bays - notices put up on broken and reported immediately to Estates. If need be that bay is taken out of use. All staff must complete their mandatory training in Manual Handling. Health and Safety a standing item on team meeting agendas.	5	2	10				Charts were sent to Villa to address this risk - complete
7	Charts in the Chapel and kitchen, SLH	Lone working - member of staff could be injured and no-one would know	Trust SOP on Lone Working available Staff are told to email someone to let them know they are finished shift etc	5	1	5	Specific guidance for Health Records staff to be created		Apr-21	Is this a duplication?
8	Lone working e.g. Villa	Working on own wouldn't know until next working day if serious injury or took unwell suddenly	Emailing Manager 10pm - ceased wef 22/01/21	5	1	5	Specific guidance for Health Records staff to be created	AC	Apr-21	
9	Overcrowding in libraries	charts are being filed on top of the bays as there is no space left in the bay. Risk of charts falling on top of staff when bays are being moved. Also, increased risk of overstretching which can lead to falls and injuries.	Steps available and staff instructed on how to use. weeds are done as and when overtime payments are available. Health and safety is a standing item at team meetings. All staff must complete their Manual Handling training. Signs up in the libraries regarding bending, stretching and use of mobile bays.	5	1	5	**MAR 20:** Funding being requestd for increased usage of off-site storage and	JMCE	May-21	
10	Health Records Equipment 07/10/2020	Potential for staff to suffer an injury if existing equipment fails/breaks eg ladders, trolleys etc.	Any equipment not fit for purpose identified labelled and/or taken out of circulation. Routine spot checks carried out monthly (min).	5	2	10	None at present			
11	Difficulties complying with social distancing 07/10/2020	increased risk of COVID infection	Introduction of shift work during the week and weekend work. Use of reception areas when available	4	2	8				
12	Clanrye House	construction works on-going	Risk Assessment completed Dec 2020			0				What is the risk here?
13	Risk of heat stress when wearing PPE	Risk of heat stress when wearing PPE	Staff reminded to take regular breaks and hydrate. Staff reminded of the signs and symptoms of heat stress/heat exhaustion and dehydration and encouraged to look out for the signs of heat stress in each other. HSE guidance shared with staff							
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Functional Support Services Division
Divisional, Head of Service and Team Risk Register - November 2019

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3799	23/05/2016	Provide safe, high quality care		Falls from height DHH	Condition of Buildings, possible effects from drugs and alcohol, inadequate door access, poor lighting, machinery, equipment, spills, violence. Potential for injury, harm or death.	See action plan attached to Risk	27.02.18 Minor works request submitted for outstanding controls. 12/12/2016 A separate risk assessment is being completed by Acute Governance in relation to falls from heights. Erection or raising of anti-climb fencing in several areas. Secure 3 external doors at exterior of ED Dept,. Enclose plant and equipment.	MOD	DIV
3978	25/09/2018	Provide safe, high quality care		Ineffective monitoring and reduced IT security of CCTV System on network DHH	The CCTV system at DHH is digital and has been put on the Trust Network and this is causing issues from an IT security perspective. The CCTV surveillance coverage does not extend to all of the areas required. Cyber attack and the hacking of data Loss of patient information Breach of Data Protection Act 2018 Compromised safety of all personnel on site Compromised security of both Trust and personal property Inability to detect crime and footage unable to be used in prosecutions Inability to investigate incidents	Precautionary measures by Estates / IT	Business Case to be prepared to secure funding to have all CCTV transferred onto a Single Trust Digital Platform. Identify areas that require cameras on a risk basis and complete Minor Works Form for additional cameras	MOD	DIV
3985	19/11/2018	Provide safe, high quality care	Trustwide	Typing backlogs for secretarial areas	Typing backlogs due to not enough staff plus maternity leaves covered at only 50% and 0.5 WTE allocated for new consultants/services. This is never enough. This can result in late follow up of patients to other clinics, patients being added to inpatient waiting lists etc Areas with continuous backlogs are Gastro, Rheum, Respiratory, T & 0, ENT, Diabetic/Endo, RACP, Derm	If Consultants use the Clinic Outcome sheet then follow up will be documented on this and then this should not be an issue, however, this is not used everywhere. Overtime is granted occasionally to try and keep backlogs down. Service Administrators monitor this information fortnightly and continually move resources around and across all sites to try and equalise backlog typing.		MOD	DIV
4035	11/06/2019	Provide safe, high quality care	Trustwide	Incomplete ED flimsy records	The ED flimsy is a record of the assessment and treatment of a patient in ED, and also any follow up required. All relevant information relating to the accurate disposal of the patient and any further follow up for the patient is to be recorded on the back page in the appropriate text boxes. The admin staff read the back page of the ED flimsy which should provide them with the information they need to discharge the patient accurately from ED and also the information they need to arrange any further referral for the patient to another clinic/service, or if the patient has had an x-ray and needs to be placed in the x-ray audit. The information is not always recorded on the back page and this means that patients are not referred on to another clinic/service and so places the patient at risk as their further treatment/follow up will not be arranged for them. There is a risk to the patient in that if the back page is not correctly filled in with any instructions as to referring the patient to another clinic/service that the patient will be lost to follow up. This has happened and has only come to light when the patient has phoned asking about their follow up.	Agreed with medical staff that all appropriate information relating to the accurate disposal and follow up of the patient must be recorded on the back page.		MOD	DIV
4036	11/06/2019	Provide safe, high quality care	Trustwide	Discharge letters not being completed	When a patient is discharged they should be given a discharge letter which will give them details of their treatment in hospital and also detail out any follow up in terms of review, investigations that are required. If the letter is not done then the appropriate review/investigations may not take place. Risk to the patient of being lost to follow up.	Raised with Heads of Service asking them to remind the doctors to complete their discharge letters. Ward clerks let the doctors know that there are outstanding discharge letters. Ward clerks will let the Sister/Nurse in Charge know. However the situation has not improved.		MOD	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3911	15/08/2017	Provide safe, high quality cMak e the best use of resources		Backlog of filing in Obs and Gynae	Filing in Obs/Gynae area constantly backlogged, results are not in patients charts at time of appointments. These are held on NIECR but directorate has to make a decision. Also non signing of results by doctors is a problem, Hand held charts not being returned timely from community so filing cannot take place. Results filing then sitting on wards, in box for midwifes etc but not in chart.		17.10.17 Risk remains unchanged	MOD	DIV
3941	27/02/2018	Provide safe, high quality care		Use of 2 Work neutral detergent which is classified as 'Corrosive' without eye protection	This product is extensively used throughout the Trust in the main production kitchens, ward kitchens, staff tea rooms, for dishwashing, general cleaning and cleaning of floors etc. The use of eye protection when using this product is unrealistic and something that would be extremely difficult to enforce given its extensive use in the Trust.	Induction training, on the job training and BIC's training for Support Services staff. • COSHH awareness training (all staff) • Observation of user completing task/using chemical • Spot checks • Safe Systems of Work (Support Services staff only) • Protective aprons and gloves • Eye Protection for dilution of chemicals (Support Services staff only) • Staff reminded to continue to report incidents to their supervisor/manager • Pre-Employment Medical Advice – skin care etc • Ill Health Referrals to Occupational Health • COSHH Risk Assessment and Data Safety Sheet • SHSCT Policies and Procedures • Trained COSHH Assessor in each locality	17/12/18 - The cleaning chemicals contract is being retendered and this product will not be included in the new contract which should be introduced in April 2019. Feb 2018 A Customer Complaints Form was submitted to BSO and a request made to have this product replaced with a non-classified, 1 litre detergent, which is safe to use. BSO unable to take action as this is a regional contract and the Southern Trust was the only Trust in the region to raise concerns. This matter cannot be resolved until action is taken by BSO.	MOD	DIV
3973	28/08/2018	Provide safe, high quality care		Risk of injury when cleaning fixed beds in Bluestone	There are 68 beds of these beds in the Bluestone Unit. Hazard - manual handling (risk of musculosketal injury) and Infection Prevention and Control - areas of the bed not accessible for cleaning and no programme for cleaning underneath the bed which is fixed to the floor. Mattress type is an issue - no grips on the side of the mattress to aid moving and handling, mattress cannot be folded in half to clean. Low fixed height of the bed is an issue for manual handling.Musculosketal injury, infection control	Induction training, on the job training and BIC's training for Support Services staff. o Infection Control training o Waste management training o Manual Handling training core/refresher o Observation of user completing task/using chemical o Spot checks o Safe Systems of Work - task specific (Support Services staff only) o Protective aprons and gloves o Staff advised to wear enclosed and low footwear o Faults reporting o Staff reminded to continue to report incidents to their supervisor/manager o Staff advised to check if the load is within their capabilities before lifting it. o Staff advised to seek assistance if a load is beyond their capabilities i.e. a colleague. o Pre-Employment Medical Advice o Ill Health Referrals to Occupational Health o SHSCT Policies and Procedures	17/12/18 - Health and Safety have recommended 2 people to clean the bed. However, Domestic staff work on their own most of the day. Assistance from nursing staff required to turn the mattress during cleaning. Ergonomic assessment completed by Physio department. This risk will only be eliminated if the beds change but funding is required.	MOD	DIV

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3812	20/07/2016	Safe, High Quality and Effective Care	Switchboard	Lack of Emergency Major Incident Planning Software	Switchboard follows a Major Incident protocol, individually calling a list of key contacts, with a Major Incident Alert, Major Incident Declared and Major Incident Stood Down. In the event of a Major Incident declared up to 50 people may be contacted. This is time consuming, resulting in delays in key staff being notified. On site staff are individually bleeped. Switchboard staffing levels are reduced in the Out of Hours period, which will create further delays as additional staff will be required to come in. Switchboard manually record on paper as each person is contacted. Reports are available showing time of alert and numeric message. Voices over messages are not recorded.	Continue to monitor the situation. Paper completed to identify the risks shared with Acute SMT.	15.5.19 Full implementation of roll out of smart phones has been completed. All Emergency calls to ext [irrelevant redacted by the USI] are now being recorded. New iMessage bleeping system is now fully operational. IT are currently PEN (Security) testing the App. When complete test group will be identified & App tested prior to roll out to all Major Incident responders. 19.12.18 IT/Telecoms have rolled out new smart phones to all blackberry holders as the Appear App will not work on the blackberry phone. Implementation of the Imessage Appear App by Estates Telecoms Team has been rescheduled to April/May 2019. 5.4.18 Imessage Appear App (Emergency Planning Software) has been purchased. Trial is ongoing with the Northern Trust. SHSCT awaiting feedback from Northern trial before implementing. IT/Telecoms currently rolling out new smart phones to all blackberry holders as the Appear App will not work on the current blackberry phone. Full implementation scheduled for April/May 2018. All Emergency calls to ext [irrelevant redacted by the USI] are now being recorded. 16.8.17 New iMessage system delivered March 2017. Problem with the servers discovered during implementation. Estates has advised that "go live" will be September 2017.	MOD	DIV
3861	13/12/2016	Provide safe, high quality care	Grounds	Car Parking and Traffic Management Problems DHH	Risk of injury to patients having to park distance from hospital entrance. Patients missing appointments as unable to find parking space - disabled and able bodied. Staff, patients and others unable to use foot paths due to cars parked on them - risk of injury from collision with vehicles. Inappropriate parking compromising access for emergency vehicles and pedestrian access to hospital. Risk of collision due to disregard by drivers of one way system. Risk of injury to pedestrians entering Car Park F as no safe footway.	Security porters, cones and sticker patrols to prevent inappropriate parking. As part of Major Incident Review the Director of HR / Estates clarified Estates are responsible for traffic flow on site and FSS are responsible for car parking.	17/12/18 Relocation of Pay and Display in Car Park C starting in Jan 2019 due to relocation of OOH and OPD. 27.02.18 Parking enforcement has been introduced at protect drop off zones, red hatched areas, emergency routes, ambulance bays and disabled spaces.	MOD	DIV
3753	04/01/2016	Provide safe, high quality care		Falls from height CAH	Condition of Buildings, possible effects from drugs and alcohol, inadequate door access, poor lighting, machinery, equipment, spills, violence. Potential for injury, harm or death. 21.11.16 The new retaining wall beside the footpath up the main drive has created additional potential for harm.	None - Action Plan Attached.	13/6/19 Estates and Support Services to review outstanding actions. 23.02.18 Minor Works request submitted for outstanding controls.	MOD	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3754	04/01/2016		Office(s)	Dermatology Office Risks due to file storage issues	Electric shock from electrical equipment in the office. Faulty equipment could lead to a fire which would spread rapidly due to the amount of combustible material in the office which is stored on walkways. Fire would subsequently result in damage to property. Staff may suffer smoke inhalation and/or burns. Musculoskeletal injury while moving/retrieving charts. Personal injury to members of staff due to the storage of patients charts on the floor and underneath desks. Walkways cannot be kept clear due to the volume of files processed in this office and the limited availability of shelving which also has an impact on the safe evacuation of staff from this area in the event of a fire. See Hazard no. 9 & 10. Risk of musculoskeletal injury from incorrect workstation set up.	Fire Safety training for staff. Fire Safety Policy. Fire evacuation plan. Electrical equipment is subject to Portable Appliance Testing (PAT). Manual Handling Policy is available on the intranet. Manual handling training (3 yearly for low risk staff). Limited shelving is available. DSE Procedure is available on the intranet.	1/7/19 Pilot started re charts not to go to clinics but pages and labels only, consultant to use NIECR. This will help with volume of charts in office. 12.12.16 No further update 22.02.16 Ongoing. Urgent fire risk assessment required. Please contact Vincent Burke to request this.Remind staff to complete fire safety training on an annual basis. Remind staff to report any faults with electrical equipment, mark it faulty and remove from use. Manual handling risk assessment to be completed for inanimate loads e.g. patients charts, stationery items etc and shared with staff. Request should be made for additional accommodation to facilitate the storage the storage of charts by as the current accommodation is unsafe and a high fire risk.Request to be made to Estates to measure the office to determine if it meets the requirements of Regulation 10 of the Workplace, Health, Safety & Welfare Regulations. DSE self-assessment and 12 point plan to be issued to staff. Staff to be made aware of their entitlement to eye and eyesight testing in accordance with the Trust's DSE Procedure. Staff should complete the DSE awareness via e-learning. Access should be requested via earning.suppor[irrelevant redacted by the USI]	MOD	DIV
3792	13/04/2016	Provide safe, high quality cafBe a great place to work		Waste Storage and Handling CAH	Lack of space for waste dispersal rooms on 1, 3 and 4 North leading inappropriate storage / segration of waste and risk of leaks from contaminated clinical waste if not stored safely. Waste storage area on 1 East / 1 West and 2 East / 2 West are too small for ward requirements.	3 North waste is stored in the Sluice Room; 4 North waste is stored in a store room and 1 North waste is stored in the Domestic Store. Housekeeping arrangements are in place to ensure waste is stored as safely as possible. Staff are aware to report incidents, which are subsequently recorded on Datix. Spills are cleaned immediately. PPE is provided for staff handling waste and staff are trained in the use of PPE. Staff receive waste management training.	23/2/2018 - 4N have black and yellow bins in their dispersal now. 1N, 3N, 1W/1E, 2W/2E no progress.	MOD	DIV
4038	11/06/2019	Provide safe, high quality care	Trustwide	Results not signed off on the wards	Hard copy patient result forms are not being signed off by the doctors on the wards. This means that the ward clerk cannot file the results and they are left on the wards where they could be misplaced or something could be missed regarding the patient's condition. If the results are not signed off there is the possibility the something could be missed regarding the patient's condition. The ward clerk cannot file the results until they are signed so the results are left on the ward and there is the potential for them to be misplaced.	Ward clerks remind the staff that they need to sign the results. Electronic sign off is being implemented. DHHS ward clerks have been told to forward unsigned results to the consultant for them to sign.		MOD	DIV
4067	24/09/2019	Provide safe, high quality care		Non Destruction of Patient Records due to Infected Blood Inquiry	Risk to staff hurting themselves as they are managing records in libraries that are full. Filing and retrieval of charts is difficult as they are very closely packed in the pigeon holes. The filing bays are heavy when moving them. Trust will not have enough space to store all the patient records so some will have to be sent to commercial off site storage which incurs a cost. Staff could hurt themselves trying to assess charts. Charts will be more difficult to retrieve which could lead to a delay in their being available.	All staff must complete their Mandatory Training. Inspection of libraries has taken place by Health Records Managers and areas of concern highlighted. A plan has been set out to transfer some of the less active charts to the commercial off site storage which will leave space for the more recent charts.		MOD	DIV
3291	28/11/2012	Safe, High Quality and Effective Care	Grounds	Car Parking and Traffic Management problems CAH	Contractors taking up space. Limited entrance and exit access causing grid lock of site in the event of an emergency / major incident. Limited parking spaces around the site. Risk of injury to patients having to park distance from hospital entrance. Patients missing appointments as unable to find parking space - disabled and able bodied. Staff, patinets and others unable to use foot paths due to cars parked on them - risk of injury from collision with vehicles. Inappropriate parking compromising access for emergency vehicles and pedestrian access to hospital. Risk of injury to pedestrians as no safe footway in parts of the site.	Security porters, cones and sticker patrols to prevent inappropriate parking. As part of Major Incident Review the Director of HR / Estates clarified Estates are responsible for traffic flow on site and FSS are responsible for car parking.	7/5/19 - Planning application for 2nd entrance applied for Lisnisky Lane gate is opened in emergencies. Increased level of complaints following the extension of enforcement in November 2018. Difficultt parking is resulting in patients being late / non-attendance at clinic appointments. 23/2/2018 - Parking enforcement has been introduced at protect drop off zones, red hatched areas, emergency routes, ambulance bays and disabled spaces. Additional spaces at Craigavon Area Hospital. Traffic calming measures including ramps at pedestrian crossings and speed control signage at Craigavon Area Hospital. Renewed markings on disabled spaces to ensure they are visible.	MOD	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
4074	20/11/2019	Provide safe, high quality cMak e the best use of resources		Incomplete Consultant of the Week Rota or Consultants not recorded on PAS	The consultant of the week rota is not always up to date or has not been recorded on PAS. This means that the ward clerks do not know which consultant to admit the patient under. This could lead to the patient not being assessed by any medical staff. If the consultant is not recorded on PAS it means that the patient cannot be admitted under the correct consultant, which could lead to the patient not being seen in the appropriate timeframe or issues relating to follow up of treatment.	Reminders have been sent to the Heads of Service asking for clarification as to which consultant is on call. Assistant Director wrote to the Assistant Directors requesting this information is given asap and also that any new consultants are recorded on PAS asap.	Nov19 risk added to Divisional Register	MOD	DIV
3977	25/09/2018	Provide safe, high quality care		Ineffective monitoring by current CCTV System CAH	The current CCTV system uses outdated technology (analogue) and surveillance coverage does not extend to all of the areas required. This can result in no CCTV footage available or poor quality images. 1. Compromised safety of all personnel on site 2. Compromised security of both Trust and personal property 3. Inability to detect crime and footage unable to be used in prosecutions 4. Inability to investigate incidents 5. The Trust is not fully compliance with the Data Protection Act 2018 - GDPR Compliance Assessment attached	Health and Safety Risk completed and is attached. Regular checks are carried out on the CCTV system and faults are reported to Estates. Maintenance Contract with Radio Contact. Some faults in the system are unable to be repaired as the technology is outdated and require a longer-term solution - a list of outstanding faults is attached. A list of areas requiring CCTV cameras have been identified on a risk assessed basis and is attached.	£50k has been allocated to address local issues with CCTV Develop Business Case to upgrade and extend the system on a risk basis	LOW	DIV
3355	16/05/2012	Safe, High Quality and Effective Care		Actichlor plus	Risks highlighted: Ingestion of product, Skin damage due to contact, Eye damage due to contact, Unauthorised access to product, Unsafe systems of work by staff, Inhalation	All staff are trained in the safe use of this chemical i.e. induction, BICS, COSHH, food safety and on the job training and in compliance with regional guidance on colour coding. Staff are advised to wear correct PPE when using this product and during the disposal of large quantities and in the event of a large spillage. PPE includes eye protection, apron, & gloves. Safe storage of the product - product stored upright in a closed labeled container - in a cool, dry, well ventilated area. Store away from incompatible materials and sources of direct heat. Store in locked cupboard in Domestic Services store - locked if available. Staff are trained not to mix chemicals. COSHH risk assessments and safety data sheets are located in the managers/supervisors office and in sister's office in A&E. Colour coding for area. Ongoing monitoring & reviewing of COSHH risk assessments. Trust policies & procedures e.g. Health & safety at work, COSHH, Manual handling etc. Cleaning work schedules. Kitchen hygiene audits - monthly audits and spot checks. Uniform audits e.g. low and closed in shoes. Staff referral to occupational health where necessary	12.12.16 As good control measures are in place the risk rating is being reduced from Moderate to Low.	LOW	DIV
3453	26/06/2013	Safe, High Quality and Effective Care	Switchboard	Internal Bleep System Failure	Risk to patients, staff, service users in the form of: Potentially unable to activate Emergency Teams e.g. Cardiac, Stroke, Paeds, Obstetrics, ILS, etc. Unable to reach individuals in an emergency e.g. Cardiac Nurse, Stroke, Security, etc.	Daily tests carried out on all teams. Maintenance contracts in place with Multitone (bleep providers) and Estates responsible, protocols in place for activating bleeps.	15.5.19 No further update 19.12.18 No update to report 5.4.18 New Multitone iMessage paging system in operation. System is now running of multiple transmitters to ensure that if there are any outages that another server provides resilience. 16.8.17 New iMessage system delivered March 2017. Problem with the servers discovered during implementation. Estates has advised that "go live" will be September 2017.	LOW	DIV

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3777	08/03/2016			Waste Management South Tyrone Hospital	Risk of Infection from waste contaminated with blood/bodily fluids. Injury due to sharps being disposed of incorrectly into waste bags, laundry etc and coming into contact with member of staff. Risk of musculoskeletal injury from handling waste which involves carrying on the same level and also between stairwell levels, bags being overfilled. There is excessive handling of waste bags due to lack of storage facilities in wards and departments to allow waste to be placed in the bins by the users. Waste is a as result handled 3 to 4 time by staff thus increasing the risk of injury/ exposure. Risk of injury from slips, trips, falls due to the lack of storage. Lack space to provide suitable waste management arrangements leading to excessive handling result in injury to staff, leaks from contaminated clinical waste if not stored correctly. Portering staff have to go out in all-weather to move waste, from the vehicle and as all the bin storage is open to the elements.	Sharps boxes are provided for disposal of sharps. Segregation of waste. Safe Management of Healthcare Waste- 2013 (information available on the intranet). Waste management training. PPE provided for staff handling waste. Staff trained in use of PPE. Corporate Risk Assessment on Blood Borne Viruses (available on intranet). Staff aware to report incidents, which are subsequently reported on Datix. Manual handling training. Waste management training (advised not to overfill bags). Manual Handling policy. Manual handling risk assessment. Safe systems of work. Staff aware to report incidents, which are subsequently reported on Datix. Cleaning of spillages immediately. Housekeeping arrangements are in place to ensure waste is stored correctly. Staff aware to report incidents, which are subsequently reported on Datix. Cages are provided to store waste. Spills are cleaned immediately. Staff aware to report incidents, which are subsequently reported on Datix. PPE raincoats s are provided.	13/6/19 traffic and people parking at the back of the kitchen / the pad store and beside the waste area are blocking the bin lorry from getting access. There is now a chain on the area around Loane House and this has helped. The old portacabins are being dismantled mid June 2019 so this should then provide a new bin collection area for the rest of the site and may ease the problem. 12.12.16 As all the recommendations made following the HSENI Clinical Waste Inspection visit on the 1 December 2015 have now been actioned the risk rating is being reduced from Moderate to Low. 8/3/16 Domestic Services staff to be advised not to overfill bags and waste receptacles. Communication to be forwarded to ward/department managers advising their staff not to overfill bags. Manual handling risk assessment shared with staff.	LOW	DIV
4062	20/08/2019	Provide safe, high quality care Mak e the best use of resources		No electronic interface between SSD instrument tracking systems and TMS	There would be a delay in identifying patients and instrument sets used in the event of a look back exercise due to the lack of an electronic interface. Patient identification is currently only achievable by manually going through the patients notes to look for barcode stickers relating to the instrument sets. Possible infection risk to patients due to the length of time required to identify patients manually where there is a possibility of cross contamination. Impact on staff time and resources.	Checks are carried out manually if required		LOW	DIV
4063	20/08/2019	Provide safe, high quality care Mak e the best use of resources		Lack of Long Term Contingency for Laundry Dept	SE Trust and a private laundry in Belfast can provide contingency in the event of a short term breakdown but cannot sustain this for longer than a couple of days in the event of a major laundry equipment breakdown or loss of production e.g. loss of essential utilities or fire. Possible risk of infection to patients due to lack of clean linen	SE Trust and a private laundry in Belfast can provide short term cover in the event of breakdown but cannot sustain this for longer period.		LOW	DIV
4064	20/08/2019	Provide safe, high quality care Mak e the best use of resources		Aging Decontamination Equipment	Possible risk of breakdown of aging decontamination equipment. Three sterilises and three endoscope washer disinfectors are past the end of their anticipated life cycle and whilst they are still in working order there is an increasing risk of faults or breakdowns. Possible unavailability of sterile instruments / clean endoscopes leading to possible delays or cancellations of procedures	Estates maintain and service the equipment as per manufacturer's recommendations. Replacement parts are currently available.	12.11.19 The Lancer Endoscope Washer Disinfector manufacturer has confirmed that they will support the FC2 /4 model until 2022 for the electronics and until 2025 for mechanical parts	LOW	DIV
4037	11/06/2019	Provide safe, high quality care	Trustwide	Breakdown of mobile bays in Health Records	The mobile bays in Health Records in CAH and DHH are old and are breaking. This means that the staff cannot use the mechanism to move the bays but have to manually push the actual bay. Risk of member of staff hurting themselves while trying to move the mobile bays.	All staff must be trained in Manual Handling. Notices put on bays letting staff know which ones are broken. Estates notified and ask to repair as a matter of urgency.	Ongoing risk placed on register June 2019	LOW	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3281	26/11/2012	Provide safe, high quality care Maximise independence and choice for patients and clients Support people and communities to live healthy lives and improve their health and wellbeing Make the best use of resources	Kitchen/Dining Room	Risk of vulnerable patients contracting E coli 0157 from very low levels of contamination of ready to eat foods	E. coli O157 is a particularly dangerous type of bacteria because it can cause serious, untreatable, illness and even death from very low-levels of contamination of ready-to-eat food. Because E. coli O157 survives at freezer, chill and ambient temperatures, measures to control cross-contamination apply to all of these environments. Although E. coli O157 is the key focus of this guidance, the measures outlined will also help in the control of other food poisoning bacteria, such as campylobacter and salmonella. The risk of E. coli O157 cross-contamination should be considered wherever raw foods such as raw meat and unwashed vegetables are handled and where ready-to-eat foods are also handled. Without strict controls, E. coli O157 can be spread throughout any food processing environment. It is therefore essential that ready-to-eat foods are at all times handled and stored in clean areas where controls ensure the environment is free from E. coli O157 contamination.	1. External inspection by Environmental Health Officers and CDCC. 2. All food handlers are trained in food safety and HACCP. 3. There is a HACCP in each facility. HACCP plans are reviewed by the Catering Manager and the Locality Support Services Manager as required. 4. Hand washing and Food Safety Audits are completed. 5. There is complete physical separation of raw and ready to eat food during delivery, handling and storage in fridges. 6. The Trust has a dress code policy which covers uniforms, the wearing of jewellery etc. and audits are conducted to measure this compliance. 7. All staff are trained on cleaning disinfection and hand washing.	12/6/19 This risk could be de-escalated to the Catering Service Risk Register due to the controls in place. 121.12.16 No further update 26.02.16 Controls have been improved in all food production . At CAH this has been completed by the building of a partition and in DHH a separate area is used , in other units measure are in place to keep these function to sepetate area/times and handling to a minimum. Additional training on all aspect of e-coli has been delivered F ood handling and staff practices continue to be monitored, and audit arrangements have been updated. Additional checks are in place at meal times. Supervision has been reviewed at CAH and there is now a lead cook on shifts. Contingency plans have been reviewed and the learning from Incident in June 2015 has been taken on board. a new contract is in place fo microbiological testing and locally ATP machines are purchased to allow more frequent sampling of surfaces and handwashing.	LOW	HOS
3454	26/06/2013	Safe, High Quality and Effective Care	Switchboard	Risk of Telecoms Failure Across CAH, SLH, STH, and LH	Potential for telephone lines to go down: a)Internally b)Cross-site c)Internally/cross-site/externally d)External lines only Risk 1: If lines go down internally - risk to patients and staff Risk 2: If lines go down externally - risk to members of the public	- Contracts are in place with Telecoms providers. - Protocols are in place with Estates services in relation to re-establishing telecoms links. - Mobile telephones are also available for use within A&D, and C&B localities.	May 2019: New Trust wide Equinox telephony system now in place which means the majority of phones run off the IP system. Fall back servers are in place to ensure resilience. Craigavon Hospital Switchboard can now provide full cover for Daisy Hill Switchboard or vice versa if required 19.12.18 New telephony system "Equinox" to be installed by Estates Telecoms at both CAH and DHH switchboards in January 2019. 5.4.18 New telephony system "Equinox" to be installed from April 2108. Significant increase in amount of VOIP handsets within the Trust. 16.8.17 Partial roll out of VOIP handsets - Estates awaiting approval of revenue funding to enable full roll out of VOIP handsets. 22.02.16 Capital funding approved to enable Estates to purchase additional hardware. Estates awaiting approval of revenue business case for roll out of VOIP handsets.	LOW	HOS

POSITION PAPER
EXTENSION OF WARD CLERK PROVISION
AT CRAIGAVON AREA & DAISY HILL HOSPITALS

V0.6 as of 5 April 2016

INTRODUCTION

The pressures placed upon Hospital wards within the Southern Health & Social Care Trust are ever increasing due to the growing healthcare demands of its resident population. These will continue to escalate as there will always be patients presenting at its Hospitals' Emergency Departments 24 hours a day, 7 days a week who require admission to a Hospital ward for further medical intervention. Furthermore, the need for elective surgery to be performed will at all times remain a central component within any healthcare setting. Such demands in conjunction with a decrease in the average length of stay inevitably results in the Southern Trust's wards constantly working at full capacity.

Ward Clerks are a fundamental part of any ward whether a medical or surgical ward, an Intensive Care Unit or an Emergency Department, as they provide essential administrative/clerical services. Primarily, Ward Clerk provision is delivered during the hours of 8.00 am – 4.00 pm, Monday to Friday and their role in supporting medical and nursing staff to undertake their duties efficiently and in compliance with respective Trust policies and procedures, is crucial in ensuring the delivery of safe patient care.

This paper outlines the current Ward Clerk provision, the inadequacies of the existing service model and identifies the proposed changes which will support the delivery of a highly efficient and effective Ward Clerk service across Craigavon Area and Daisy Hill Hospitals.

Available recurrent funding of £218,357 has arisen from reconfiguration of services provided within the Functional Support Services division of the Acute Services Directorate and approval to proceed with this proposal has been received from the Director of Acute Services.

BACKGROUND

The role of a Ward Clerk forms an integral part of any Hospital's clinical environment, as they are often the first point of contact for patients, relatives, carers and healthcare professionals. The primary responsibilities of a Ward Clerk comprise of:-

- Completion of Ward Return
- Ensuring PAS is up-to-date in order that 'real-time' data is available on the FLOW board
- Maintaining ward trollies (ensuring all patients' medical charts are filed correctly and trollies remain organised/uncluttered)
- Filing of clinical documentation within patients' medical charts

- Patient Follow-up (making appointments and creating referrals on PAS/Patient Centre)
- Ensuring Delayed Discharge Tracker Forms are updated on PAS and following up on incomplete forms
- Recording of Ward Attenders and Estimated Date of Discharge on PAS
- Printing out patients' details from the 'Information HUB'
- Booking of ambulances/interpreters as and when necessary
- Answering telephones and dealing with queries
- Ordering ward stationery as appropriate

CURRENT SERVICE PROVISION

Ward Clerks are based within a number of wards across both of the Southern Trust's two Acute Hospital sites (Craigavon Area and Daisy Hill Hospitals).

The current Ward Clerk establishment within the Southern Health and Social Care Trust is detailed in Table 1 below:-

Table 1 – Ward Clerk Establishment within CAH & DHH

Site	Ward	WTE	Hours Covered	No of Beds
CAH	1 North	1	8.00 am – 4.00 pm Monday – Friday Weekends - limited	32
	1 South	1	8.00 am – 4.00 pm Monday – Friday Weekends - limited	36
	2 North Haematology	1	8.00 am – 4.00 pm Monday – Friday Weekends - limited	18
	2 North Respiratory/Winter Ward	1	8.00 am – 4.00 pm Monday – Friday Weekends - limited	35
	2 South Stroke	0.25	8.00 am – 10.00 am Monday – Friday Weekends – limited	19
	2 South Acute	0.25	10.00 am – 12.00 noon Monday – Friday Weekends - limited	17
	3 South	1	8.00 am – 4.00 pm Monday – Friday Weekends - limited	36
	4 North	1	8.00 am – 4.00 pm Monday – Friday Saturday & Sunday - 8.00 am – 4.00 pm (winter pressure hours)	34
	4 South	1	8.00 am – 4.00 pm Monday – Friday Weekends - limited	36
	Acute Medical Unit	1.85	7.30 am – 8.00 pm Monday – Friday Weekends – 7.30 am – 12.30 pm	35
	Clinical Day Care Centre	1	8.00 am – 4.00 pm Monday – Friday No cover at weekends (can be opened due to winter pressures)	9 + Additional Beds
	Elective Admissions Ward	0.8	7.30 am – 3.00 pm Monday – Friday No cover (can be opened due to winter pressures)	23
	Orthopaedic Ward	0.8	8.00 am – 2.00 pm Monday – Friday No cover at weekends	23
	Trauma Ward	0.8	7.00 am – 3.00 pm Monday – Friday Weekends – 7.15 am – 10.45am	28

Site	Ward	WTE	Hours Covered	No of Beds
DHH	Elective Admission Ward	1	8.00 am – 4.00 pm Monday – Friday No cover at weekends (can be opened due to winter pressures)	24
	Day Clinical Centre	1	8.00 am – 4.00 pm Monday – Friday No cover at weekends - closed	7
	Female Medical	1.10	8.00 am – 4.00 pm Monday – Friday Weekends – 8.00 am – 12.20 pm	34
	Female Surgical & Gynae	0.8	8.00 am – 2.30 pm Monday – Friday Weekends - limited	27
	Male Medical + Coronary Care	1.20	8.00 am – 4.00 pm Monday – Friday Weekends – 8.00 am – 4.00 pm	34
	Male Surgical + High Dependency Unit	1	8.00 am – 4.00 pm Monday – Friday Weekends - limited	28
	Level 6 Stroke/Rehab	1.10	8.00 am – 4.00 pm Monday – Friday Weekends – 12.30 pm – 2.00 pm	30

The delivery of Ward Clerk services proves particularly challenging for the Acute Services Directorate taking into consideration the various deficiencies in terms of the existing service model which include:-

1. Staffing Resources

- **Working Pattern**
  The majority of Acute wards have a designated Ward Clerk on duty from Monday to Friday between the hours of 8.00 am to 4.00 pm. Within some ward areas, the Ward Clerk may start at 6.30 am or 7.30 am to suit the needs of the ward, however this can impact upon cover provided during the afternoons as a reduced level of service will be available.

  Ward Clerk provision during evenings, weekends and Bank Holiday periods is very limited with only a skeleton service being delivered. At weekends, this may merely consist of a single Ward Clerk working across two or three Acute wards between the hours of either 8.00 am to 1.00 pm or 8.00 am to 4.00 pm in order to undertake a number of key tasks.

- **Recruitment & Retention**
  The Acute Services Directorate continuously experience difficulties with regards to the recruitment and retention of Ward Clerks. This is primarily attributable to a high percentage of temporary staff being in post (eg agency, block booking, as and when), many of whom resign from their Ward Clerk position to take up a permanent post elsewhere within the Trust/outside of the organisation.

2. Training

Once a Ward Clerk has taken up post, a comprehensive training programme will commence. This will encompass training on relevant IT packages (eg Patient Centre), induction and a period of work shadowing another Ward Clerk.

As it is not good practice for newly appointed staff to be left unassisted during the course of their training, this can be problematic for wards as it emanates in reduced productivity until the full complement of staff are back in their substantive posts.

3. Ward Clerk 'Float' Facility

The establishment of a dedicated Ward Clerk 'Float' facility offering temporary support during a Ward Clerk's absence (whether on sick or annual leave) is unsustainable within the present resources.

While the Acute Services Directorate has been able to appoint 0.50 WTE of an agency worker (located at Daisy Hill Hospital) in a Ward Clerk 'Float' capacity, this level of staffing is both unrealistic and impracticable in terms of the number of Acute wards across both Hospital sites.

4. Admissions, Discharges & Transfers In

The level of discharges which take place during 8.00 am and 1.00 pm are relatively low in comparison to the number of discharges which happen after 1.00 pm. Generally, the highest volume of discharges occur on Friday afternoons. Appendix 1 details the number of discharges which have taken place before 1.00 pm and after 1.00 pm per day, during the last 3 month period (November 2015 – January 2016).

As a consequence of the aforementioned activity happening mostly outside of a Ward Clerk's contracted working pattern, this frequently causes a backlog of discharge information to accumulate (eg from Friday to Monday or on Bank Holidays from Friday to Tuesday).

Table 2 below, shows the volume of admissions, transfers in and day cases which have continued to steadily grow over the past 3 year period:-

Table 2 – SHSCT Admissions, Transfers In & Day cases				
	2013/14	**2014/15**	**2015/16 (April 2015 to January 2016)**	**Extrapolated to 2015/16 Year End**
ADMISSIONS				
• **Craigavon Area Hospital**	39,520	40,264	33,962	40,754
• **Daisy Hill Hospital**	28,602	28,661	24,161	28,993
TRANSFERS IN				
• **Craigavon Area Hospital**	20,351	21,532	17,319	20,782
• **Daisy Hill Hospital**	8,016	9,715	7,882	9,458
DAYCASES				
• **Craigavon Area Hospital**	16,091	17,727	15,907	19,088
• **Daisy Hill Hospital**	7,059	7,486	7,176	8,611

The lack of adequate Ward Clerk provision during evenings, weekends and Bank Holidays continuously results in the work associated with the discharge of a patient being delayed for a number of days which inevitably leads to a backlog of discharge information developing, particularly at weekend and Bank Holiday times.

In addition, delays associated with the coding of delayed discharges have a detrimental effect on the Trust's ability to comply with the Health & Social Care Board's (HSCB) monitoring programme. Due to the requirement for weekly reports to be submitted to the HSCB, should a Ward Clerk be unable to progress the coding of discharges within a timely manner, the information provided to the HSCB can be inaccurate.

5. Demand & Capacity

As stated earlier, the volumes of activity (as detailed in Table 2) are rising year on year however the existing Ward Clerk capacity has not increased and is insufficient to fully meet the needs of the service.

PROPOSAL

In order to address the current issues and effectively manage the demands placed upon its Acute wards, the Acute Services Directorate wishes to adapt the current Ward Clerk service model in order to provide a more robust Ward Clerk service during annual/sick leave, evenings, weekends and Bank Holiday periods.

The implementation of the planned changes will enable an enhanced Ward Clerk service to be delivered to Acute Wards across Craigavon Area and Daisy Hill Hospitals.

During 2015/16, the Acute Services Directorate received funding to facilitate a temporary expansion of Ward Clerk cover at weekends to be implemented. At that time, as a number of Ward Clerks had resigned from their posts, the additional staff initially recruited as part of the expansion pilot, were used to fill the core hours rather than enhance the service provision.

Understandably, the combination of staff leaving their posts, the commencement of newly appointed staff and the progression of training programmes significantly restricted the level of Ward Clerk cover that could be delivered during weekend periods. The outcome has resulted in the Acute Services Directorate being unable to evaluate the benefits associated with the expansion pilot.

In view of the service already functioning at full capacity, the prospective of taking forward any further improvements within the existing resources, without additional investment is not possible.

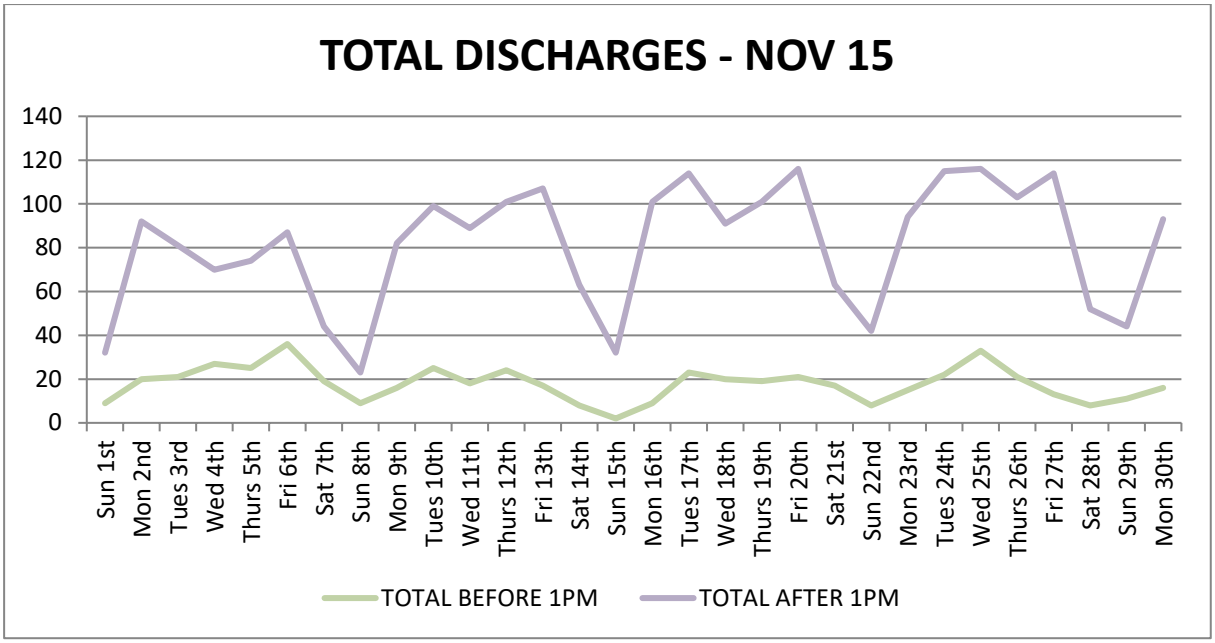
Therefore, the Acute Services Directorate is seeking to secure additional staffing resources in order to supplement the current levels of administrative/clerical services to the various Acute wards within Craigavon Area and Daisy Hill Hospitals.

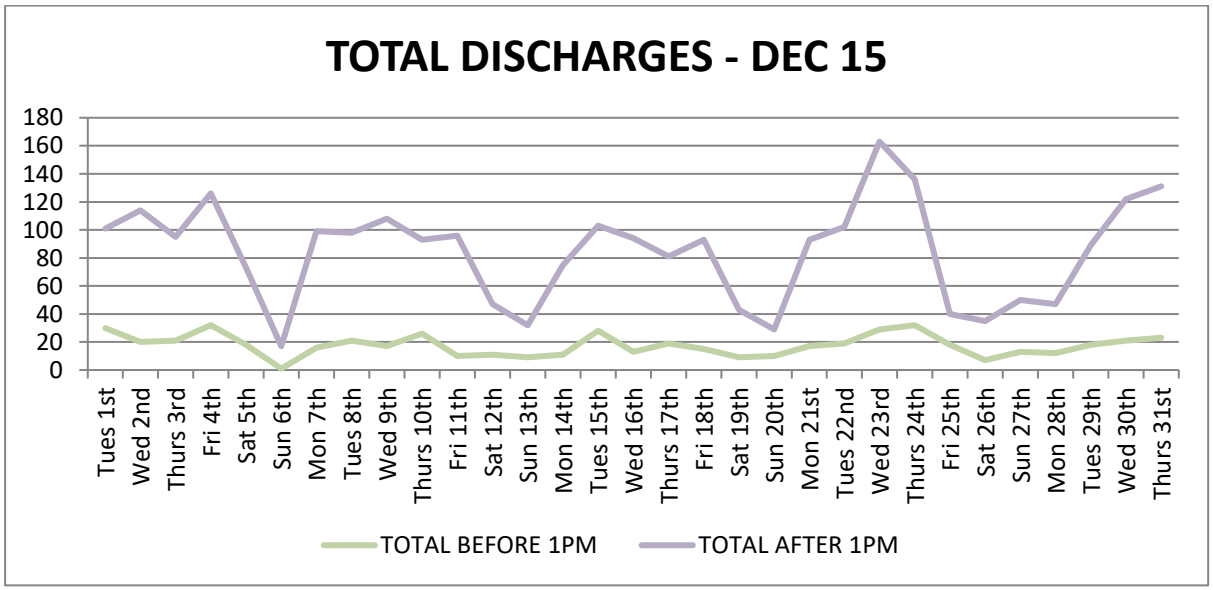
The recurrent revenue requirement associated with the proposal is shown in Table 3 below:-

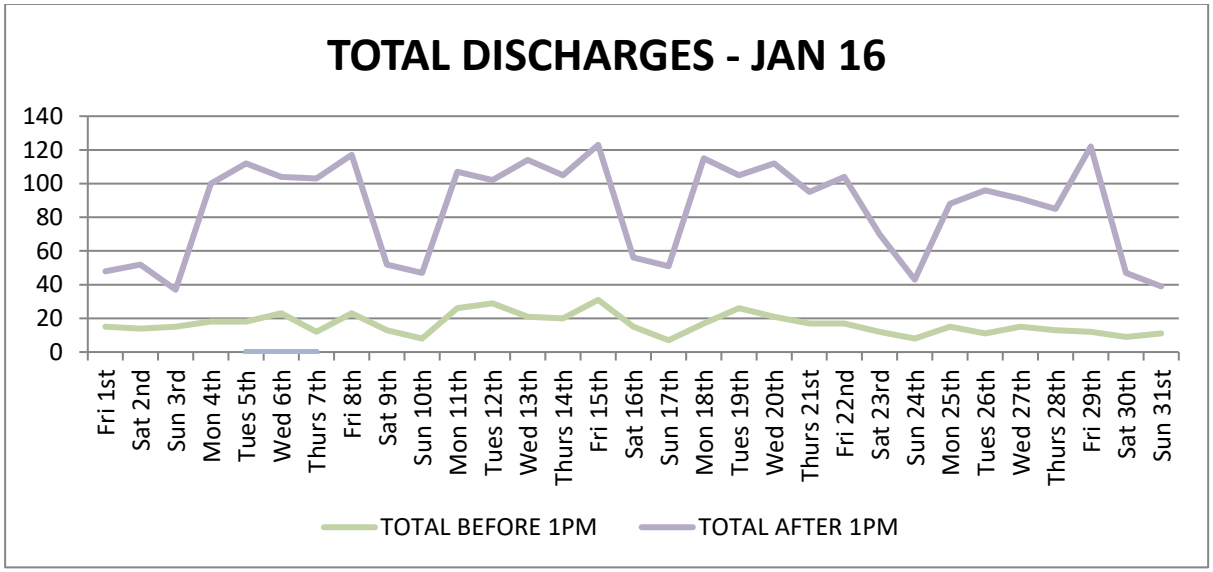
Table 3 – Additional Staffing Resources (Extension of Ward Clerk Provision)	
Basic Band 2 (9.65wte)	£205,748
Unsocial Saturday	£4,203
Unsocial Sunday	£8,406
TOTAL COSTS	**£218,357**

**Costs have been calculated using the HSCB Costing Schedule 15/16 at mid-point +1 including 10% for payroll related G&S.*

APPENDIX 1 - TOTAL NO OF DAILY DISCHARGES BEFORE 1.00 PM & AFTER 1.00 PM (NOVEMBER 2015 – JANUARY 2016)







Proposal for the additional storage for Health Records – Craigavon Area Hospital

Background

There are 8 health records libraries on the CAH site which store current charts. Current charts are those which must be retained in line with the Retention and Disposal schedule. (The Retention and Disposal Schedule states that all health records for adults should be retained for 8 years after conclusion of treatment , and in the case of children until their 25th birthday, or 26th birthday if the young person was 17 at the conclusion of treatment, or 8 years after last entry).

These libraries are situated as follows – 2 in the main Outpatient Department, 4 in the basement and 2 on the first floor of the Ramone building. All the libraries are overcrowded, with no room for some of the charts in the filing bays. This has resulted in charts being placed on top of the bays or in boxes on the floor which poses health and safety risks both in terms of charts falling on top of staff, or staff tripping over boxes. The filing bays are very full and heavy to manoeuvre. Pulling and filing of charts is difficult due to the cramped filing bays.

As the libraries are all full we now have to look for additional accommodation for charts. Approximately 1000 number of charts are created each month and we are running out of space for these charts.

In light of the fact that there is no storage for any more charts on the CAH site, and to alleviate the current issues regarding lack of space additional storage is required for health records.

Current Controls

There are measures in place to reduce the number of charts created, ie -

- All patients who are registered on NIPACS (Radiology system), NIMATS (maternity system) and NIRAES (A&E system) are registered first on PAS and are given a PAS number. This is to allow the patient demographic details and the Health and Care Number to be downloaded onto the other systems.

- These patients do not get a general hospital chart as they may be a GP referral to x-ray, they will have a maternity chart created and not a general chart, and when attending A&E they will use the A&E card and not a general chart. The patients are registered on PAS with a comment NCR – No Chart Required. This control ensures that it is only when they are actually seen in the hospital that a chart is created for that number.

- All charts which can be removed as per the Retention and Disposal Schedule have been removed, so the CAH libraries contain only current charts.

Reasons for requiring additional accommodation

No space for current charts on the CAH site

All the Health Records libraries are full and additional storage space is required for the new charts being created. Additional space is also required in each library to resolve the problem of over crowded filing bays and the Health and Safety issues.

Risks to charts

In March 2010 charts one of the basement libraries sustained water damage due to a leak from the ward above, and in September 2010 charts in a different basement library sustained water damage due to an overflow from a manhole. These two incidents resulted in 569 original patient charts being damaged.

The majority of charts damaged were those which were on the top of the filing bay, and therefore not protected by the metal filing bay from the water coming down, and those in boxes on the floor.

On discussion with Estates there is no guarantee that this will not happen again.

In order to reduce the risk of damage to charts and protect them should there be a further leak all charts should be filed in the filing bays, with no charts on the top of the bays or in boxes on the floor where the risk of damage is greater. However, due to the overcrowding there is on room for these charts to be filed in the bays.

Libraries in clinical areas

There are 2 libraries in the Ramone building, and at some stage in the future this accommodation may be required for clinical use, thus requiring relocation of these records.

Aims of acquiring additional accommodation for Health Records

- Acquire additional accommodation to allow for the growth of records
- Create space in the existing libraries to allow for all charts to be filed in filing bays.
- Remove Health Records from the Ramone building.
- Resolve the health and safety issues by eliminating the risk of staff tripping on charts on the floor, or having charts fall on them from the top of the filing bay.

Storage

At the present time the Health Record libraries hold 6 years of charts on site, with the remainder of charts being stored in McConnells commercial off site storage for which there is an average monthly cost of £4100. (The Trust no longer sends charts to McConnells – these are the charts that were sent during the legacy agreement).

The Retention and Disposal Schedule states that general charts should be held for 8 years following the conclusion of treatment, with the exception of paediatric charts which must be stored until the patient is 25,or 26 if the patient was 17 at the conclusion of their treatment.

Therefore storage space to allow for an additional 3 years of information is required, (this will provide storage for the full 8 years records, and current year, eg full 8 years 2003 – 2010 and current year 2011), and in addition space to alleviate the current overcrowding is required. If further accommodation was made available it would allow for the charts held in McConnells to be recalled and stored on site until such time as they can be legitimately destroyed as per the Disposal Schedule, and so reduce this monthly spend on storage.

Approximate requirement for storage space for 3 years	=	1440 linear m
Approximate requirement to alleviate overcrowding	=	820 linear m
Approximate requirement for off site storage recall	=	?m/2
Total requirement for storage	=	?m/2

Criterion for Accommodation for Health Records Library

Accommodation needs to be on the ground floor or basement level due to the weight of the filing bays. There must also be good access for transport to deliver and pick up charts. The area must be safe and secure.

Options

The preferred option would be that all current health records remain on the CAH site, however the availability of accommodation on the CAH site has been explored and there is no space large enough on the site to provide the accommodation and meet the criterion that is required.

Other sites have been considered and the most suitable option, which meets the accommodation requirement and the criterion, is Villa 3 on the St Luke's site.

Option 1 – look for accommodation on the CAH site.

There is no available accommodation on the CAH site which would meet the requirements.

Option 2 - Villa 3 for new charts

Refurbish Villa 3 and use this facility as a new library. All new charts created would be stored and retrieved from Villa 3 and transported to CAH as required. The rationale for sending the most current charts to Villa 3 would be that they have the shortest patient history filed, and the information stored is more likely to be available electronically on the CAH site, which would help alleviate problems where a chart was required urgently.

To meet the aims of project it would also be proposed that all charts currently stored in the Ramone building be transferred to Villa 3 for storage, thus removing Health Records from a clinical area.

The dexion shelving (fixed shelving as opposed to mobile shelving bays) in Ramone could be transferred to Villa 3 for storage of charts.

Benefits

Health Records would now have the accommodation it requires for growth.

The charts stored in Ramone could be removed and stored in Villa 3. The dexion shelving could be transferred to Villa 3 for use. The Ramone libraries are extremely cramped – to move them to Villa 3 will alleviate the crampy bays and ease the pulling and refiling of these charts.

Villa 3 could be used to store some of the large charts in the remaining libraries on the CAH site, thus reducing the overcrowding in those libraries.

Disadvantages

An initial outlay would be required to provide the shelving required to allow for the storage of the new records to Villa 3. As this library would be for the growth of the charts over a 3 year timeframe the purchase of any additional shelving could be phased over a period of time.

As some of the charts would be inaccessible to other staff in CAH these charts required for purposes of secretaries filing clinical correspondence, results would have to be requested from the library and transported over and returned, increasing the transport requirement, and also increasing the work of the Health Records staff who would have to pull and refile these charts

Option 3 – move all Health Records to Villa 3

All CAH charts to be relocated to Villa 3, to be pulled and transported to CAH for attendance or admission. Following completion of treatment the charts to be returned to Villa 3 for refiling.

Benefits

All charts would be on the one site for ease of pulling and refiling.

The overcrowding of the filing bays would be resolved, making it easier to pull and file charts.

Health and safety and risk issues would be resolved as space would be available to file all charts in the filing bays, and not on top of the bay or in a box on the floor.

Space on the Ramone site would be available for clinical use.

Disadvantages

A large initial outlay would be required to provide the additional shelving required to allow for the transfer of all the records to a new store.

It would be planned that existing filing bays would be moved to Villa 3 to store the charts; however some of these filing bays are old and may not be able to be refitted.

As all the charts would have to be transported from Villa 3 to CAH, and then all the charts returned there will be a huge impact on transport services, and the current service would not be able to cope with the volume.

As the charts would be inaccessible to other staff in CAH all charts required for purposes of secretaries filing clinical correspondence, results would have to be requested from the library and transported over and returned, further increasing the transport requirement, and also increasing the work of the Health Records staff who would have to pull and refile these charts.

All charts would have to be pulled, tracked, transported and refiled to Villa 3 – this would be a time consuming and costly exercise, and could not be carried out during normal working hours.

Preferred Option

The preferred option would be to have the charts on the CAH site, however, as this is not possible due to the lack of space the most viable option would be option 2 - to use Villa 3 for current charts.

Costs

Initial costs for converting Villa 3 into a Records Store have been estimated at £70,000 for the complete area, which would include:

Removing dividing walls to provide 2 large record storage areas and 1 smaller area
Moving electrics
Securing windows with grills

However, as in the first instance only one of the storage areas would be required this could be reduced to approximately £35,000.

There would be additional costs for the purchase of filing bays for the charts. To allow for the transfer of charts from Ramone and also to provide the storage for 2011 charts to be filed the cost would be approximately £50,000. (There is no space or shelving currently in place for 2011 charts)

PAS cabling

Fixtures and furnishings for staff

?? Additional transport costs

?? Additional boxes for charts

Summary of Costs and Requirements

Storage requirements for 2011 = 1080 linear metres

1000 charts created per month = 12,000 charts per year
One linear meter hold 25 – 30 charts
Using 25 charts per linear metre requirement for records storage = 480 l/m per year

To remove charts from Ramone = 600 linear metres

Cost requirements for 2011 = £90,000 (approximate cost)

Refurbishment of part of Villa 3 = £35,000
Cost of filing bays for 2011 = £50,000
Cabling/printers/fixtures = £ 5,000

Barriers/Constraints

Costs

There is a large cost required to convert the accommodation to an appropriate records storage unit. To offset some of the cost it is proposed that the records information

currently stored in McConnells and paid for by Health Records is retrieved and held in Villa 3 until such time as it can be destroyed under the Retention and Disposal Schedule. Average monthly costs associated with McConnells storage is £4,100. The budget for this storage is £2,000 per month, so this would provide a savings of £24,000 per annum, and a cost avoidance of £25,200 per year - total per year £49,200 which could be offset against the £90,000 expenditure.

Charts off site

Technological solutions need to be taken forward for dealing with urgent need for provision of information until such time as the chart is transported to the hospital site eg use of Patient Centre, Filemaker, scanning of information from the Records Library to the appropriate ward.

Transport of charts

Internal transport currently picks up charts from Armagh to CAH twice daily – 8.30 am and 12.30 pm.

Redeployment of staff

There are no health records staff on the St Luke's site therefore some staff will have to be redeployed which may lead to excess mileage costs. However some work will transfer off the CAH site and so it would be proposed that the temporary staff are notified that due to the transfer of work their post in CAH is no longer required, but a post on a different site would be available for their redeployment. If the temporary staff agreed to this move then no excess mileage would be incurred. This proposal will also take into consideration the redeployment of staff in the Armagh area.

Conclusion

There is an immediate need for additional accommodation for CAH health records. No suitable space is available for another library on the CAH site. Various sites have been considered and the most suitable long term solution is that Villa 3 in St Luke's Hospital is used as a storage area for health records charts. will resolve health and safety issues, and will allow for the retrieval of charts currently stored in off site storage.

Mrs Helen Forde
Head of Health Records
November 2010

Forde, Helen

From: Carroll, Anita <[redacted]>
Sent: 27 January 2015 11:55
To: Trouton, Heather; Corrigan, Martina
Cc: Forde, Helen
Subject: Aob and charts at home

Heather

Do you think you ? Should have something on risk register in relation to this

Anita

Stinson, Emma M

From: Forde, Helen
Sent: 14 January 2011 08:59
To: Corrigan, Martina
Cc: Robinson, Katherine; Carroll, Anita
Subject: RE: Triage of Urology outpatient letters

That's great Martina, and I know that the Booking Centre are chasing up referral letters and that Katherine keeps you updated, but our staffing levels in the Booking Centre have reduced and therefore I am keen to ensure that all their efforts go to booking the appointments, and that time taken for issues such as chasing up referral letters is reduced as far as possible.

Regards.

Helen Forde

From: Corrigan, Martina
Sent: 13 January 2011 18:18
To: Forde, Helen
Cc: Robinson, Katherine; Carroll, Anita
Subject: RE: Triage of Urology outpatient letters

Helen,

As you know this has been an ongoing problem for years with the urologists and they have been spoken to on a number of occasions by a number of people including recently by Dr Rankin and Mr Mackle. I actually talked specifically about this to Katherine a few weeks ago just to make sure that this was still under control and I was advised that whilst it was not 100% it was still not as bad as it was at the beginning of last year.

Katherine always escalates problems to me when letters have not been triaged and when the booking centre are not having any success in resolving the outstanding ones as these are really only a few in comparison to what it was.

The one that you refer to for July we have been chasing and we have now requested another copy from the GP and this will be triaged and seen at one of the additional new patient clinics.

I have already spoken to the consultants about the rest of the long ones and they (secretaries probably) are investigating and again if there are issues then we will request replica letters.

I hope this responds to your query and just to reassure you that it is on my radar thanks to Katherine and the booking centre.

Thanks

Martina

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

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

From: Forde, Helen
Sent: 13 January 2011 07:06
To: Corrigan, Martina
Cc: Robinson, Katherine; Carroll, Anita
Subject: Triage of Urology outpatient letters

Martina, I know that Katherine has discussed the lateness of triage of outpatient letters with you, but as we are aiming to meet 9 weeks by the end of March for outpatients it's vital that the letters are triaged.

IEAP states they should be triaged within 3 working days, but even if they were triaged within 5 working days that would help.

I've got the PTL's and the longest waiter was referred on 20.7.10 and has no WL code beside him, which shows he hasn't been triaged. There's one more patient in September and then several in October and November that haven't been triaged.

I know that you will be working on this, but from our end we need to be highlighting these concerns. If there's anything I can help you with in improving this let me know, and a quick chat on the delays would be helpful - could we catch up on Tuesday after our 9 am mtg?

Regards.

Helen Forde
Ground Floor, The Rowans, CAH
Direct Line Personal Information redacted by the USI

Stinson, Emma M

From: Forde, Helen
Sent: 07 October 2011 09:19
To: Carroll, Anita; Robinson, Katherine
Subject: Escalation Process for issues/concerns from the Booking Centre

Original Escalation Process

Formally
Katherine meets with the HoS every two weeks on a Friday morning. For this meeting the HoS are provided with information relating to their specialities. This information details out issues per speciality relating to capacity per site, capacity for urgent new and reviews, and issues re delay in triage. These issues are then discussed at the meeting and actions agreed.

Informally
If issues arise which need to be addressed prior to the next meeting, eg additional clinic meant to have been set up but not finalised, actions not completed when required, then Katherine contacts the HoS either by e-mail or by telephone to discuss/remind.

Revised Escalation Process

Continue as above with Katherine discussing with HoS initially and then escalating to HoS when actions have not been taken.

If issues have not been resolved then Katherine will escalate to Anita and Helen, and Anita will raise the issue with the appropriate AD and inform Katherine and Helen of the agreed actions and timescale.

Helen Forde
Head of Health Records and Booking Centre The Rowans, CAH

Tel : Personal Information redacted by the USI

Forde, Helen

From: Forde, Helen < Personal Information redacted by the USI >
Sent: 23 November 2016 10:38
To: Corrigan, Martina
Subject: Mr O'Brien and charts

Martina in October we completed 3 Datix relating to charts being in Mr O'Brien's home.

I've been speaking with Simon and I'm aware that some of Mr O'Brien's colleagues are working with him regarding his admin practices so I wanted to keep you in the loop re these Datix.

If you need any further details please let me know.

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

Forde, Helen

From: Forde, Helen [redacted]
Sent: 21 June 2012 12:26
To: Corrigan, Martina; Scott, Jane M
Subject: Charts for urology

There are 3 patients coming in to urology – one tomorrow for urodynamics and the other 2 are being admitted on Saturday. The ward is looking these charts now, however, they are with Mr O'Brien at home so we can't get them. Leanne has informed Mr O'Brien that these charts are needed.

Martina – I'm going to raise this issue with Anita as really the hospital chart should not be removed from the hospital.

The ward staff do know that the charts can't be provided.

Regards.

Helen Forde
Head of Health Records/Booking Centre
The Rowans
CAH
[redacted]
[redacted]

Forde, Helen

From: Forde, Helen < Personal Information redacted by the USI >
Sent: 04 March 2015 09:17
To: Corrigan, Martina
Cc: Lawson, Pamela
Subject: FW: MR AOB

Martina – there seems to have been an awful lot of charts to be requested from Mr O'Brien this week – could you talk to him and ask him to bring some of them back and only have a few at home. Thanks.

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

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From: Lawson, Pamela
Sent: 04 March 2015 08:00
To: O'Brien, Aidan
Cc: Corrigan, Martina; Forde, Helen
Subject: FW: MR AOB

Dear Mr O'Brien

Can you please bring in this chart for the South West Acute hospital clinic on Monday?

Many thanks
Pamela

From: Lenehan, Dolores
Sent: 03 March 2015 19:37
To: Lawson, Pamela
Cc: Mills, Barbara
Subject: MR AOB

Hi Pamela
I would be grateful if you would email Mr AOB and see if he has chart Personal Information redacted by the USI tracked to his clinic EURAOB 28.4.14. It is needed for EUROAOB clinic 09.3.15.
Many thanks
Dolores

Forde, Helen

From: Forde, Helen < Personal Information redacted by the USI >
Sent: 21 January 2015 09:34
To: Corrigan, Martina
Cc: Carroll, Anita
Subject: Fw: AOB CHART

We have a patient in majors in ED this morning and they are requesting the patients chart but we believe the chart is at Mr o'briens home. Just to keep you informed in case there would be any issue.

Sent from blackberry

From: Lawson, Pamela
Sent: Wednesday, January 21, 2015 09:18 AM
To: Forde, Helen
Subject: FW: AOB CHART

Helen

This gentleman is in Majors ED dept and they are requesting his notes.

Notes possibly with Mr O'Brien.

P

From: McCorry, Tierna
Sent: 21 January 2015 09:13
To: Lawson, Pamela
Subject: AOB CHART

Pamela,
Barbara said you wanted to be informed about Mr O'Brien's charts.
I was given a hit this morning for majors, chart was tracked to CAOBUO 19/12/2014 and cannot be found.
Apparently there is a possibility this chart could be at home with Mr O'Brien and he is on call this morning. I have let majors know the situation and given the details to Ciaran.

Thanks
Tiarna McCorry
Medical Records
Craigavon Area Hospital
Ext: Personal Informatio

Stinson, Emma M

From: Hynds, Siobhan
Sent: 15 May 2017 16:18
To: Forde, Helen
Cc: Chada, Neta
Subject: STRICTLY CONFIDENTIAL - TO BE OPENED BY ADDRESSEE ONLY

Importance: High

In Strict Confidence

15 May 2017

Dear Helen

Dr Neta Chada is currently assigned as the case investigator for a case under the Maintaining High Professional Standards Framework (MHPS) into concerns in respect of Mr Aiden O'Brien, Consultant Urologist. I am assisting Dr Chada with this investigation. This process is strictly confidential and therefore I would be grateful if you could ensure this matter is not discussed with anyone.

We believe you may have information relevant to our investigation and therefore we would like to meet with you, as previously arranged, on Monday 5 June 2017 at 2pm in Meeting Room 2, Admin Floor, Craigavon Area Hospital. At this meeting we intend to take a formal statement from you to be used as part of the overall information gathered as part of our investigation.

There are specific terms of reference for this investigation and it is in respect that we wish to gather information from you in respect of Mr O'Brien. These include:

1. **(a) To determine if there have been any patient referrals to Mr A O'Brien which were un-triaged in 2015 or 2016 as was required in line with established practice / process.**

   (b) To determine if any un-triaged patient referrals in 2015 or 2016 had the potential for patients to have been harmed or resulted in unnecessary delay in treatment as a result.

   (c) To determine if any un-triaged referrals or triaging delays are outside acceptable practice in a similar clinical setting by similar consultants irrespective of harm or delays in treatment.

   (d) To determine if any un-triaged patient referrals or delayed tri-ages in 2015 or 2016 resulted in patients being harmed as a result.

2. **(a) To determine if all patient notes for Mr O'Brien's patients are tracked and stored within the Trust.**

   (b) To determine if any patient notes have been stored at home by Mr O'Brien for an unacceptable period of time and whether this has affected the clinical management plans for these patients either within Urology or within other clinical specialties.

   (c) To determine if any patient notes tracked to Mr O'Brien are missing.

3. **(a) To determine if there are any undictated patient outcomes from patient contacts at outpatient clinics by Mr O'Brien in 2015 or 2016.**

(b) To determine if there has been unreasonable delay or a delay outside of acceptable practice by Mr O'Brien in dictating outpatient clinics.

(c) To determine if there have been delays in clinical management plans for these patients as a result.

4. **To determine if Mr O'Brien has seen private patients which were then scheduled with greater priority or sooner outside their own clinical priority in 2015 or 2016.**

5. **To determine to what extent any of the above matters were known to line managers within the Trust prior to December 2016 and if so, to determine what actions were taken to manage the concerns.**

We expect the meeting to last between 60 and 90 minutes so I would be grateful if you could make yourself available for this period of time.

If you have any queries please call me on Personal Information redacted by the USI, otherwise we will see you on 5 June.

Regards,

Siobhan

Mrs Siobhan Hynds
Head of Employee Relations
Human Resources & Organisational Development Directorate
Hill Building, St Luke's Hospital Site
Armagh, BT61 7NQ
Tel: Personal Information redacted by the USI Mobile: Personal Information redacted by the USI Fax: Personal Information redacted by the USI

Click on the above image for SharePoint: Employee Engagement & Relations information

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Forde, Helen

From: Lawson, Pamela [redacted]
Sent: 04 December 2020 10:49
To: Forde, Helen
Subject: RE: Datix for missing charts

Helen – please see below

14/01/2019 – 1 chart
17/10/16 – 1
08/05/13 – 1
20/05/13 – 1
16/05/13 – 1
31/05/13 – 2
14/06/13 – 1
22/08/13 – 3
23/08/13 – 2
27/08/13 – 3
30/08/13 – 2
16/09/13 – 1
18/09/13 – 1
15/10/13 – 1
20/09/13 – 1
03/10/13 – 6
14/10/13 – 1
15/10/13 – 1
04/11/13 – 1
15/11/13 – 6
11/12/13 – 6
08/01/14 – 2
09/01/14 – 2
21/01/14 – 3
24/01/14 – 3
11/02/14 – 2
02/04/14 – 2
08/04/14 – 4
23/04/14 – 2
24/07/14 – 1
01/08/14 – 1

From: Forde, Helen
Sent: 04 December 2020 08:52
To: Cunningham, Andrea; Lawson, Pamela
Subject: Datix for missing charts
Importance: High

Do you remember when AOB took charts home we did a Datix out and were then told to stop this.

Well out of the urology review that is one of the things that is coming out as being useful. So this would be for charts that can't be found – how many a week do you think that would be?

Any thoughts on this?

Helen Forde
Head of Health Records
Admin Floor, CAH

Personal Information redacted by the USI
Personal Information redacted by the USI

Subject: FW: CHART WITH AOB

-----Original Message-----
From: Carroll, Anita [redacted]
Sent: 15 October 2013 11:28
To: Forde, Helen [redacted]
Subject: FW: CHART WITH AOB

For info

From: Trouton, Heather
Sent: 14 October 2013 19:01
To: Carroll, Anita
Subject: RE: CHART WITH AOB

I emailed him with the details but no response.

I will try to get to see him personaly this week.

Heather

From: Carroll, Anita
Sent: 14 October 2013 09:44
To: Trouton, Heather
Subject: FW: CHART WITH AOB

Heather Another one for AOB have you managed to speak to him yet anita

From: Forde, Helen
Sent: 14 October 2013 09:39
To: Carroll, Anita
Subject: FW: CHART WITH AOB

See below – sll happening with charts a t Mr O'Brien's house. Thanks.

Helen Forde
Head of Health Records
Admin Floor, CAH
[redacted]

From: Lawson, Pamela
Sent: 14 October 2013 08:36
To: Forde, Helen

Subject: FW: CHART WITH AOB

Another IR1 going in for this one.

P

From: Mills, Barbara
Sent: 14 October 2013 08:32
To: Lawson, Pamela
Subject: RE: CHART WITH AOB

He brought chart in on Friday and its now tracked to his clinic in Armagh for to-day. I had to go up on Friday to speak to Noleen & then had to speak to Sarah out in Thorndale to finally locate chart.

From: Lawson, Pamela
Sent: 11 October 2013 09:58
To: Mills, Barbara
Subject: RE: CHART WITH AOB

Any word on this chart Barbara?

P

From: Mills, Barbara
Sent: 09 October 2013 13:26
To: Lawson, Pamela
Subject: CHART WITH AOB

Hi Pamela,
This chart tracked to Monica but not there or in his office. Noleen to ask AOB

Personal Information redacted by the USI

Ta Barbara