Urology Services Inquiry

UROLOGY SERVICES INQUIRY

According to an email (see TRU-320009 to TRU-320010) received by the Inquiry on 17 May 2023 the date highlighted below should read April 2023. Anotated by the Urology Services Inquiry.

USI Ref: Notice 98 of 2022

Date of Notice: 26th September 2022

Addendum Witness Statement of: Ms Sharon Glenny

I, Sharon Glenny, wish to make amendments and additions to my response to Section 21 Notice Number 98 of 2022. These are as follows:-

1. At paragraph 5.4(c)(iv) (WIT-81733), I have stated '*I provide operational support to the AD and HOS within IMWH Division –Caroline Keown (AD), Wendy Clarke, HOS for IMWH'*. This should state '*Following a temporary structure change in April 2022 agreed by the then Director, Trudy Reid, to permit my role to focus on Cancer and Clinical Services only (see attachment 1. 20221216 – Email trail re 4th OSL post), I no longer provide operational support to the AD and HOS within IMWH Division. This is now being provided on temporary basis by Carolyn Beck who took up post on 3 April 2023'.*

2. At paragraph 8.2 (WIT-81741*), I have stated ' The last KSF/PDP I had was on 25 June 2018 when I was OSL in SEC, carried out by Heather Trouton, AD at the time. However, due to operational and COVID pressures I have not had a performance review undertaken since that time, but have a date for this to be completed on 9 November 2022 with Barry Conway, AD for CCS.'* This should state '*The last KSF/PDP review I had was on 17th November 2022 with Barry Conway, AD for CCS. Prior to this due to operational and COVID pressures I have not had a performance review undertaken since 25 June 2018 when I was OSL in SEC, carried out by Heather Trouton, AD at the time. Please see attachment 2. 20221117 S Glenny KSF & PDP.*

3. At paragraph 10.6 (WIT-81743), the table is incorrect as the numbers in the second column should be swapped with the third column.

Urology Services Inquiry

4. At paragraph 22.15 (WIT-81765), I want to add '*All posts within the Cancer Tracking Team are now funded by SPPG, 11.6 wte funded recurrently and 2.43 funded non-recurrently. On 24 January 2023 the Trust received an allocation letter of £106,404 CYE increasing the tracking staff by 3.0 wte recurrently (please see 3. 20230124 Cancer tracking SHSCT). Subsequently, the Trust then received a further allocation letter on 3 February 2023 recognising that the Trust had gone at risk to appoint 5.43 cancer trackers, the allocation letter of 24 January 2023 had confirmed recurrent support for an additional 3 wte and in recognition of the on the ground pressure, this letter confirmed that SPPG would make available a further non-recurrent allocation of £86,187 CYE to close the gap (please see 4. 20230203 Alloc letters Cancer Strategy slippage SHSCT).*

5. At paragraph 22.17 (WIT-81765), I want to add '*The Cancer Information & Audit Officer is now in post, Mark Quinn commenced on 28 November 2022'.*

6. At paragraph 19.3 (WIT-81757), I have stated '*The Referral and Booking Centre, under the management of Katherine Robinson, Head of Acute Booking and Secretarial Services had a process in place to escalate delays in triage outcomes to the OSLs*.' I want to add to references after this sentence. '*Please see 16. 20140217 - email re triage of referral process from AC and 17. 20140217 email re triage of referral process from AC A1.'*

7. At paragraph 26.3 (WIT- 81775), I have stated "*In order to mitigate risk, a decision was taken by Martina Corrigan (HOS for urology) to accept the GP priority code to avoid unnecessary delays to patients receiving appointments and to permit the Referral and Booking Cycle to appoint patients to the relevant clinics*." This should state "*In order to mitigate risk, I was informed by Martina Corrigan (HOS for urology) that a decision was taken to accept the GP priority code to avoid unnecessary delays to patients receiving appointments and to permit the Referral and Booking Cycle to appoint patients to the relevant clinics. I am unsure of the exact date, but it was sometime around April 2014. Anita Carroll, Assistant Director for Functional Support Services, had stated in her email at point 6 above (16. 20140217 – email re triage of referral process from AC) that she had suggested to Heather Trouton 'that we should move to the position of accepting the GP categorisation on referrals if these are not triaged and returned in 1 week'"*

Urology Services Inquiry

8. At paragraph 28.2 (WIT-81779), I have stated *'In order to mitigate risk, a decision was taken by Martina Corrigan (HOS for urology) to accept the GP priority code to avoid unnecessary delays to patients receiving appointments and to permit the Referral and Booking Cycle to appoint patients to the relevant clinics. I am unsure of the exact date the decision was made by the HOS, but I had suggested it as an option to mitigate risk on 25 November 2013 as referenced in the attached email.'* This should state *"In order to mitigate risk, I was informed by Martina Corrigan (HOS for urology) that a decision was taken to accept the GP priority code to avoid unnecessary delays to patients receiving appointments and to permit the Referral and Booking Cycle to appoint patients to the relevant clinics. I am unsure of the exact date, but it was sometime around April 2014. Anita Carroll, Assistant Director for Functional Support Services, had stated in her email at point 6 above (16. 20140217 – email re triage of referral process from AC) that she had suggested to Heather Trouton 'that we should move to the position of accepting the GP categorisation on referrals if these are not triaged and returned in 1 week'. I am unsure of the exact date the decision was made, but I had suggested it as an option to mitigate risk on 25 November 2013 as referenced in the attached email.*

9. I would also like to attach additional documents in relation to the following areas:-

Encompass

a. Please see *5. 20230307 encompass update Vol. 6* – Jacqueline Clarke is the Southern Health and Social Care Trust Lead on the Encompass programme.

b. Please see 6. 20220810 encompass Go Live Timeline – In April/May 2025, the Encompass programme will go live in the Southern Trust.

c. Please see 7. 20230209 Memo to All HSC Staff – UPDATE ON ENCOMPASS PROGRAMME – This is a memo from Peter May regarding the Encompass programme.

Digital Dictation

d. Please see 8. 20101210 SHSCT Digital Dictation SOR v1 0 FINAL – Original statement of requirements for digital dictation.

e. Please see 9. 20110301 SHSCT_Digital_Dictation_PID_v0 4_BMENEELY – Project Initiation document for Digital Dictation.

f. Please see 10. 201106 Digital Dictation Project Plan

g. Please see 11. 20121120 Email re Digital Dictation Training for Clinical Staff – email chain from Sharon Glenny to the Urology team regarding training on digital dictation.

DARO Reporting

h. Please see 12. 201006 Update Presentation for Review of A&C - An update presentation which was prepared to give some information around the initial findings of the A&C Review and where DAR was first mentioned in June 2010

i. Please see 13. 201010 DARO SOP - The original DARO SOP developed by the Operational Support Leads (OSLs) as part of the A&C Review from October 2010

j. Please see 14. 201010 – Presentation to A&C Staff re DARO - A presentation which was taken out to the A&C teams in October 2010 to educate staff around the use of DARO

k. Please see 15. 20100928 A&C Review Pathway Issues Master Version 5 - A version of the pathway issues a master document which keeps an ongoing update on the issues raised through the A&C review process and progress made on taking these forward. Please see page 20 relating to Action 38 in respect of DARO.

l. Please see 18. 20130206 Email DARO Report - Urology Only - For Action – An example of a DARO report sent to the urology secretaries for action from the Service Administrators, Jane Scott in this instance.

Additional Documents in Relation to Section 5 of My Witness Bundle – Extractions from Section 21 Statements & Associated Documents

10. With reference to Simon Gibson – Extracts and Associated Attachments from response to S21 Notice No. 17 of 2022 WIT23739 Email of 3 October 2008 subject preparing urology referrals for triage, please see my response to him on the same date (19. *20081003 Email response to SG Re Preparing Urology Referrals for Triage).* Please also see email from Mr Mackle, Associate Medical Director from 7 October 2008 in relation to Mr O'Brien's triage (20. *20081007 Email from EM re urology referrals)*

11. With reference to Aldrina Magwood – Extracts and Associated Attachments from response to S21 Notice No. 54 of 2022 WIT- 35972 paragraph 67.6 and her recollection

of delays in accessing referral letters from Mr O'Brien and his secretary being reported by me, please below examples of emails, documentation and reports where referrals/triage were raised. Please see:

21. 20061123 Email from AM re referral process

22. 20061123 Email from AM re referral process A1

23. 20061123 Email from AM re referral process A2

24. 20070109 Email to AM Update on Urology ICATS

25. 20070109 Email to AM Update on Urology ICATS A1

26. 20070423 Email to AM Re Stats for February

27. 20070423 Email to AM Re Stats for February A1

28. 20070423 Email to AM Re Stats for February A2

29. 20070423 Email to AM Re Stats for February A3

30. 20070423 Email re Urology ICATS Highlight Report

31. 20070403 Email re Urology ICATS Highlight Report A1

32. 20070403 Email re Urology ICATS Highlight Report A2

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

Statement of Truth

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

Signed: [redacted]
Personal Information redacted by the USI

Date: 12th May 2023

Sharon Glenny Addendum Statement

Index

Glenny, Sharon

From: Conway, Barry
Sent: 16 December 2022 12:48
To: Glenny, Sharon; Neill, Ruth
Cc: Connolly, Orna
Subject: RE: 4th OSL Post

Ruth,

This is a priority post linked to creating capacity to deal with the work linked to the Urology Public Inquiry, so grateful if we can get this one expedited.

Thanks for your help as ever.

Barry.

Mr Barry Conway
Assistant Director – Acute Services – Cancer & Clinical Services
Email – Personal Information redacted by the USI
Mobile number - Personal Information redacted by the USI

From: Glenny, Sharon <Personal Information redacted by the USI>
Sent: 16 December 2022 12:36
To: Neill, Ruth <Personal Information redacted by the USI>
Cc: Conway, Barry <Personal Information redacted by the USI>; Connolly, Orna <Personal Information redacted by the USI>
Subject: FW: 4th OSL Post
Importance: High

Hi Ruth

Barry raised this with me again this morning, we really need this pushed advertised asap in line with pressures in cancer services.

Could you let me know when this is likely to be ready?

Thanks

Sharon

From: Connolly, Orna <Personal Information redacted by the USI>
Sent: 15 December 2022 14:50
To: Glenny, Sharon <Personal Information redacted by the USI>
Subject: RE: 4th OSL Post

Sharon
I asked Ruth in our team to have a look at it for you. Ruth Neil, let me check with her again for you.

Orna

From: Glenny, Sharon <Personal Information redacted by the USI>
Sent: 15 December 2022 14:16
To: Connolly, Orna <Personal Information redacted by the USI>
Subject: RE: 4th OSL Post

When you say this was passed to Ruth – which Ruth is that? I haven't heard anything more about this either and I really need to get it pushed on

Sharon

From: Connolly, Orna <Personal Information redacted by the USI>
Sent: 13 December 2022 13:59
To: Glenny, Sharon <Personal Information redacted by the USI>
Subject: RE: 4th OSL Post

welcome

From: Glenny, Sharon <Personal Information redacted by the USI>
Sent: 13 December 2022 12:55
To: Connolly, Orna <Personal Information redacted by the USI>
Cc: Conway, Barry <Personal Information redacted by the USI>
Subject: RE: 4th OSL Post

Thanks Orna

Sharon

From: Connolly, Orna <Personal Information redacted by the USI>
Sent: 13 December 2022 12:36
To: Glenny, Sharon <Personal Information redacted by the USI>
Cc: Conway, Barry <Personal Information redacted by the USI>
Subject: RE: 4th OSL Post

Sharon
I have passed on to Ruth to look at for you as working on urgent alignments with Lynn and know you want this sorted also urgently.

Orna

From: Glenny, Sharon <Personal Information redacted by the USI>
Sent: 13 December 2022 10:52
To: Connolly, Orna <Personal Information redacted by the USI>
Cc: Conway, Barry <Personal Information redacted by the USI>
Subject: FW: 4th OSL Post
Importance: High

Hi Orna

Just wondering if you had a chance to look at this yet?

We are desperate to get this out.

Thanks

Sharon

From: Glenny, Sharon
Sent: 07 December 2022 14:51
To: Connolly, Orna <Personal Information redacted by the USI>
Cc: Stevenson, Fiona <Personal Information redacted by the USI>; Conway, Barry <Personal Information redacted by the USI Personal Information redacted>
Subject: FW: 4th OSL Post

Hi Orna

As discussed just now, Fiona had asked me to link with you re the attached JD and bringing it up to date in the correct format as well as ensuring the specific is in keeping with current requirements. Please bear in mind that the recruitment pool is likely to be from an A&C background originally.

Many thanks for your help.

Sharon

From: Conway, Barry <Personal Information redacted by the USI>
Sent: 30 November 2022 20:35
To: Glenny, Sharon <Personal Information redacted by the USI>
Cc: Stevenson, Fiona <Personal Information redacted by the USI>
Subject: RE: 4th OSL Post

Sharon – yes, keep the existing JD. It will be the workplan that will be different.

Barry.

From: Glenny, Sharon <Personal Information redacted by the USI>
Sent: 29 November 2022 09:16
To: Conway, Barry <Personal Information redacted by the USI>
Cc: Stevenson, Fiona <Personal Information redacted by the USI>
Subject: RE: 4th OSL Post

Hi Barry

I thought we were going to keep this a generic JD?

S

From: Conway, Barry <Personal Information redacted by the USI>
Sent: 29 November 2022 09:11
To: Glenny, Sharon <Personal Information redacted by the USI>
Cc: Stevenson, Fiona <Personal Information redacted by the USI>
Subject: FW: 4th OSL Post

Sharon,

See below.

Ok to proceed.

Can you make the adjustments as noted by Trudy please and link with Fiona?

Thanks, Barry.

From: Reid, Trudy <Personal Information redacted by the USI>
Sent: 27 November 2022 20:50
To: Conway, Barry <Personal Information redacted by the USI>; Stevenson, Fiona <Personal Information redacted by the USI>
Subject: RE: 4th OSL Post

Barry I am in agreement, we should update the JD to ensure it meets our needs and reflects the Trust current lay out and general requirements
Something about unscheduled care needs added and it should reflect IMWH as well as MUSC

Fiona could one of the HR team review the format and current general requirements

Regards,
Trudy

From: Conway, Barry <Personal Information redacted by the USI>
Sent: 23 November 2022 10:09
To: Reid, Trudy <Personal Information redacted by the USI>; Reid, Cathrine <Personal Information redacted by the USI>
Cc: Carroll, Ronan <Personal Information redacted by the USI>; Keown, Caroline B <Personal Information redacted by the USI>; Burke, Mary <Personal Information redacted by the USI>; Wells, CharlotteAnne <Personal Information redacted by the USI>
Subject: FW: 4th OSL Post
Importance: High

Good morning Trudy, Cathrine and AD colleagues,

In the context of the Urology PI and ongoing challenges around performance (both Elective and USC), I am keen that we put in place some additional Operational Support Lead Capacity to help us navigate our way through the next 12 months.

Some of you will know that historically we had 4 OSL posts, however in recent years we have worked of 3. With all the challenges now around performance in general, additional support in this team will provide much needed support and better place us for delivering improvements. With your agreement the plan is to use some non recurrent funding which I had asked for initially from the Urology PI to support cancer services for an additional OSL post for 1 year in the first instance (I had funding allocated for a band 6 for 18 months which I haven't not used to date).

With this additional OSL post we would plan to:

- Have a dedicated OSL for CCS Division in the context of the Urology PI and to support recovery of cancer performance along with the Radiology / Haematology / Laboratory servives etc..
- Have an additional OSL that would focus on IMWH but would also create capacity in the team to focus on - Unscheduled Care Performance (which historically they haven't been able to do) and the areas that Sharon has noted below

If you are content, I will ask Sharon to issue an EOI before end of this week for this additional post.

I think this will help us all in terms of performance and provide some capacity for focussing on USC performance which we all know is a priority alongside elective performance.

Hopefully you will be in agreement and we can discuss at the huddle today if required.

Barry.

From: Glenny, Sharon <Personal Information redacted by the USI>
Sent: 22 November 2022 11:02
To: Conway, Barry <Personal Information redacted by the USI>
Cc: McAreavey, Lisa <Personal Information redacted by the USI>; Scott, Jane M <Personal Information redacted by the USI>
Subject: 4th OSL Post
Importance: High

Hi Barry

Further to our discussion with Trudy re the temporary 4th OSL post, please see below the distinct areas for 4th post. I have attached a JD which was used to advertise a temporary post back in 2017 for ATICS/Surgery, but the main duties of the post have not changed since I came into post in 2007.

OSL Support for:

- IMWH Division
- ED and Unscheduled Care – there is no real dedicated OSL support for this, despite the operational pressures associated with ED and flow
    - Lisa focuses on elective side of MUSC
- Locum medical rotas for MUSC
- WLMU agenda for elective, including admin and clinical validation
    - Katherine remains focused on out-patient side of WLMU and validation
- Review Backlog Reporting and action plans

Trudy was keen that this person would provide some focus on any new performance ask of the Trust that was appropriate for this particular person to take on, so this role will likely evolve and change over the course of time.

Kind regards

Sharon

Part A

Appendix 1

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: CCS & IMWH Operational Support Lead, Band 7 **Staff Number:** Personal Information redacted by the USI

Is Professional Registration up to date? ____NA__

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? **Post Outlines can be accessed via Trust Intranet (KSF link)** **YES** [X] **NO** [ ] **Have Post Outline levels been achieved:** **YES** [X] **NO** [ ] **If no, record below what action to be taken:**	**S** Personal Information redacted by the USI [redacted]

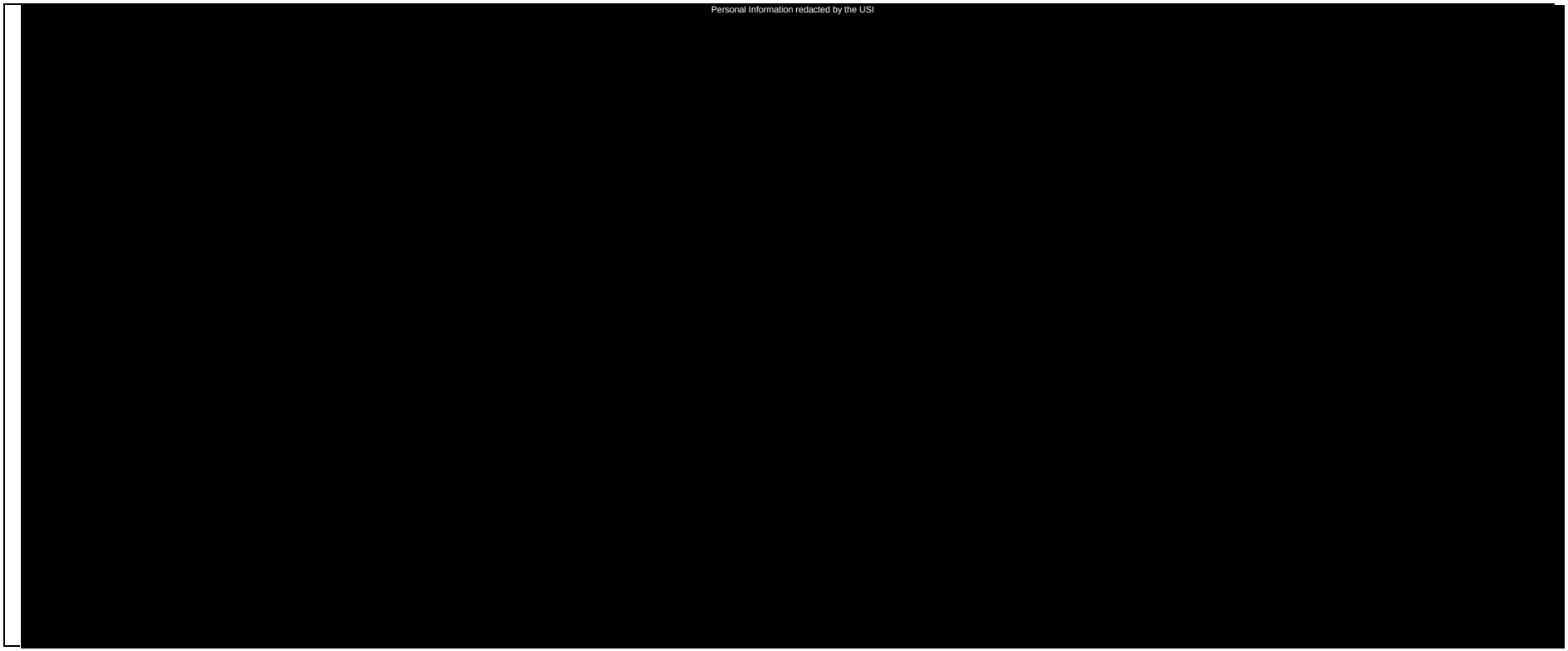
Personal Information redacted by the USI

Line Manager's Feedback on staff members performance over past year:

Personal Information redacted by the USI

Objectives for Next Year:

Personal Information redacted by the USI



Reviewee Staff Name (Print) _____Sharon Glenny_____ Signature _____ Date __16/11/2022__

Reviewer Manager/Supervisor (Print) ____Barry Conway_____ Signature _____ Date __17/11/2022_

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	Corporate Induction	**Complete**	
	Departmental Induction/Orientation	**Complete**	
	Equality, Good Relations and Human Rights – Making A Difference		
	Fire Safety	**15/11/2022**	**Valid until 14/11/2023**
	Infection Prevention Control	**30/08/2022**	**Valid until 29/08/2024**
	Information Governance Awareness	**30/08/2022**	**Valid until 29/08/2025**
	Cyber Security Awareness	**30/08/2022**	**Valid until 29/08/2025**
	Moving and Handling	**10/05/2018**	**Valid until 10/05/2021**
	Safeguarding People, Children & Vulnerable Adults		
Role Specific Essential Training	Basic ICT	**NA**	
	Control of Substances Hazardous to Health (COSHH)	**NA**	
	Food Safety	**NA**	
	MAPA (level 3 or 4)	**NA**	
	Professional Registration	**NA**	
	Right Patient, Right Blood (Theory/Competency)	**NA**	
	Waste Management	**NA**	
Best practice/ Development (Relevant to current job role)	SHSCT Fraud Awareness SHSCT Recruitment & Selection Refresher Consider a leaderships programme which to prepare for career progression Attend suitable one day courses and conferences which are applicable to CCS scope of work	**30/08/2022** **30/08/2022** **Calendar year 2023** **ongoing**	**Valid until 29/08/2024** **Valid until 29/08/2025**

Reviewee Staff Name (Print) _____Sharon Glenny_____ Signature _____ Date __16/11/2022__

Reviewer Manager/Supervisor (Print) ____Barry Conway_____ Signature _____ Date __17/11/2022_

PLEASE SEND COMPLETED PART B TO:
VWAC, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ OR EMAIL: [redacted]

From
Cara Anderson,
Assistant Director of Commissioning

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Strategic Planning and Performance Group
12-22 Linenhall Street
Belfast
BT2 8BS

Tel: 0300 555 0115
Email: Personal Information redacted by the USI
Date: 24th January 2023

By email
Lesley Leeman
Director of Planning & Performance,
SHSCT

Dear Lesley,

CANCER TRACKING RESOURCE

In recognition of the growing demand on tracking services, SPPG can confirm a recurrent allocation of £106,404 CYE to enable the Trust to expand its tracking resource. This equates to 3WTE Band 4 trackers and increases the funded establishment to 11.6WTE. It is our expectation that this additional resource will support timely tracking and closure of cases, reporting of accurate cancer waits and safety netting of patients that may have had their pathway suspended or delayed due to COVID.

The Trust is expected to complete a review of the impact of investment (Post Project Evaluation), and this should be submitted to the HSCB by 31st July 2023. A copy of the PPE template is included with this correspondence for your convenience.

As funding is directly linked to activity it is important to ensure that all activity associated with this service is recorded as part of the Trust's monitoring processes. If the commissioned outcome is not achieved the SPPG reserve the right to reconsider this investment.

If you have any queries please do not hesitate to contact me(Personal Information redacted by the USI).

Y
Personal Information redacted by the USI
Cara Anderson
Assistant Director, Hospital & Community Care

cc Barry Conway (SHSCT)
Sharon Glenny (SHSCT)
Karen McKay (SPPG)
Sinead McAteer (SPPG)
Emma McKee (SPPG)

From
Cara Anderson,
Assistant Director of Commissioning

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Strategic Planning and Performance Group
12-22 Linenhall Street
Belfast
BT2 8BS

Tel: 0300 555 0115
Email: [redacted]
Date: 3rd February 2023

By email
Lesley Leeman
Director of Planning & Performance,
SHSCT

Dear Lesley,

CANCER TRACKING RESOURCE

Th business case submitted recently in relation to cancer tracking resource noted that the Trust had gone at risk to appoint an additional 5.43 cancer trackers. A recent allocation letter confirmed recurrent support for an additional 3WTE (£106,404 FYE). In recognition of the on the ground pressure I confirm that SPPG will make available a further non-recurrent allocation of £86,187CYE.

If you have any queries, please do not hesitate to contact me ([redacted]).

Yours sincerely,

[redacted]

Cara Anderson
Assistant Director, Hospital & Community Care

cc Barry Conway (SHSCT)
Sharon Glenny (SHSCT)
Sinead McAteer (SPPG)
Emma McKee (SPPG)

encompass update

South Eastern Trust Go-Live date announcement

A significant date for all our diaries. On November 9th 2023 South Eastern Trust will be the first Trust in Northern Ireland to Go-Live with the new electronic patient record system, Epic.

This is a once-in-a-generation opportunity to make best use of significant investment to replace outdated systems and transform how we provide care. HSCNI is in the forefront of this digital transformation, being the first region to adopt the system across all Trusts and the first in the UK to include social care on this platform.
The roll out of encompass will enable improved, safer, and better-quality care for patients. Central to this transformation is the introduction of a new, comprehensive electronic patient record (EPR) system, supplied by renowned health software developers Epic.

The team at South Eastern Trust will lead the way in November and as a system we will support them in this massive endeavour. They in turn, will provide learning and expertise which HSC can take forward into the encompass roll out across the other Trusts in 2024 and 2025.

encompass is the greatest investment we've ever made in health and social care, and we need it to be successful. We all want to give the citizens of Northern Ireland a world class Health and Social care system and encompass will support that ambition.

For an overview of the programme please visit - https://encompassni.hscni.net/

SUPER USER PAY-IT-FORWARD, PAY-IT-BACK SELECTION HAS BEGUN!

Implementing encompass across Northern Ireland will be an incredible achievement, one which will only be successful with the help of all our staff. Every Trust will be tasked with forming a team of Super Users. Super Users are staff who will receive additional and early Epic training to support their colleagues before, during and after the encompass Go-Live.

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encompass
DELIVERING CARE TOGETHER

DIGITAL DISPATCHES – ENCOMPASS, THE COUNTDOWN TO GO-LIVE!

Episode 20 of Digital Dispatches was hosted by Senior Responsible Officer Dr Dermot Hughes and Programme Director Dr Veronica Devlin, where they reflected on the achievements of 2022 and looked ahead to 2023. They were also joined by Northern Trust Social Work encompass lead, Teresa O Donnell, who outlined the extensive work that is underway across Social Care with provider Epic.
You can find the video on the DHCNI YouTube channel copy and paste this link https://www.youtube.com/watch?v wVpwf0eXgdY

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MEET SOME OF THE TEAM

Find out more about the staff bringing encompass to your area:

Western Trust Chief Nursing and Midwifery Information Officer, Garrett Martin

Dr Shiva Screenivasan, Deputy Chief Information Officer.

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NORTHERN TRUST MEDICAL INFORMATION OFFICER UPDATE

We are pleased to announce that we have successfully recruited 20 acute Medical Information Officers (MIOs) in Northern Trust across clinical areas

The MIO role is to support the implementation of the encompass programme and provide leadership to their clinical colleagues to enhance engagement and communication as we prepare for encompass Go-Live.

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Super User activity has begun!

Pay it forward, pay it back

Implementing encompass across Northern Ireland will be an incredible achievement, one which will only be successful with the help of all our staff. Every Trust will be tasked with forming a selection of Super Users.
Super Users are staff who will receive additional and early Epic training to support their colleagues before, during and after the encompass Go-Live.

As we Go-Live with Epic at each Trust we will be using an approach called 'Pay-it-forward, Pay-it-back.' Each Trust will aim to fill as many shifts as possible with Super Users from their own Trust but if there are gaps in support, we will be looking to recruit colleagues from other Trusts to support over the go-live period.

Pay it Forward, Pay it Back gives us an opportunity to utilise our talented staff across every Trust to make each encompass Go-Live a success.

In time, each Trust will understand their gaps in their Super User selection and go out to the other four Trusts to ask for support to fill the gaps for over go-live.
Under the scheme, Trusts "paying if forward" will send a small group of Super Users to support the first 2-4 weeks of go-live.

Belfast, Western, Southern and Northern Trust are now recruiting for PIF/PIB Super Users for South Eastern Trust's Go-Live. South Eastern Trust have had a fantastic amount of their staff come forward to be a Super User so there is only a small amount of PIF/PIB Super Users needed from other Trusts. Therefore, if your role is needed you will be approached by the encompass team to see if you would like to be involved.
If you have any questions about PIF/PIB please contact your encompass PMO.

Digital Dispatches – encompass, the countdown to Go-Live!

"The encompass programme, it's a transformation programme which has an Epic electronic patient record at its heart. Fundamentally, it's about changing how everyone in Health & Social Care really works to share information together, and how information is available to both staff across all of health and social care and to patients".

This was the message from Senior Responsible Owner Dr Dermot Hughes as he and Programme Director Dr Veronica Devlin reflected on the achievements of 2022 and looked ahead to 2023 in a recent Digital Dispatches webinar.

They were also joined by Northern Trust Social Work encompass lead, Teresa O'Donnell, who outlined the extensive work that is underway across Social Care with provider Epic. Teresa explained how encompass will bring significant gains for social work staff and to those who use social care services.

Veronica commented "that although people get very focused on the Go Live events themselves, they're very exciting, they're very important, but actually, it's really just the beginning of a tenyear journey effectively, where we can continuously improve how we share information and how we use that information to the benefit of patients and service users and staff in Northern Ireland.
If you missed the live lunchtime webinar and want to hear more about encompass, you can watch the recording by copying and pasting the following link into a browser:
https://www.youtube.com/watch?v=wVpwf0eX9dY

The encompass programme team hosted the most recent Digital Dispatches (3 March).
encompass Communications Lead, Abi Hewings spoke about Super Users. Andrew Palmer, Belfast Business Change Manager discussed Pay-it-forward, Pay-it-Back and Nicola O'Neil, Senior Project Manager talked about all things Epic Training. Thank you to everyone who attended. If you were unable to, please keep an eye out for communications to watch the recording.

Meet some of the Western encompass team!

Garrett Martin - Chief Nursing and Midwifery Information Officer

I have been in post since July 2022 and I am really excited to be the nursing and midwifery professional lead for encompass implementation in the Trust. I truly believe that encompass will positively transform how we deliver care to patients and the public in Northern Ireland. As an operationally and clinically led transformation, enabled by state-of-the-art technology, encompass will help staff to deliver safer and improved care experiences for patients.

Health and Social Care is constantly changing, with nurses and midwives often at the heart of innovation and new ways of working. The encompass programme is a once-in-a-generation change, offering the opportunity to make best use of the significant investment needed to replace outdated systems and transform how care is provided.

The new electronic patient care record system for every citizen in Northern Ireland implemented through encompass is a proven technology, used globally across many healthcare systems. This will provide the opportunity to improve communication, minimise duplication and lead to more consistent and improved care outcomes.

Dr Shiva Screenivasan, Deputy Chief Information Officer

The WHSCT encompass team recently welcomed the regional encompass team to the Emergency Department of the South West Acute Hospital to have a first hand look at workflows and challenges that may be faced by implementing new systems. Watch the full video for further information on encompass.

Encompass | Dr Shiva Sreenivasan - YouTube

encompass
DELIVERING CARE TOGETHER

Northern Trust Medical Information Officer update

We are pleased to announce that we have successfully recruited 20 acute Medical Information Officers (MIOs) in Northern Trust across the clinical areas below. The MIO role is to support the implementation of the encompass programme and provide leadership to their clinical colleagues to enhance engagement and communication as we prepare for encompass Go-Live

Division	Clinical area
Medicine & Emergency Medicine	ED Antrim
	ED Causeway
	General Medicine Antrim
	Specialist Medicine Antrim
	Cardiology
	Medicine Causeway
Surgical & Clinical Services	Surgery / ENT Antrim
	Surgery Causeway
	Anaesthetics / ICU Antrim
	Anaesthetics / ICU Causeway
	Gastroenterology
	Dental
	Radiology
	Labs / Haematology
Mental Health & Learning Disability	Acute
	Community
Nursing, Paediatrics, Women's Services and Corporate Support	Obstetrics / gynaecology
	Paediatrics
Children's & Young People	CAMHS
Community Care	Palliative care

Trust Connections

Belfast Health and Social Care Trust

caring supporting improving together

BHSCTencompassPMO@belfasttrust.hscni.net

Trust Lead: Ruth Marks

The Loop: Click here or scan the QR code

Northern Health and Social Care Trust

Care • Compassion • Community

encompassNHSCTPMO@northerntrust.hscni.net

Trust Lead: Lorraine Gordon

StaffNet: Click here

South Eastern Health and Social Care Trust

Encompass.SetPMO@setrust.hscni.net

Trust Leads: Sean Dooher & Julia Fitzhenry
SharePoint: Click here

Download our app SETConnect to stay connected!

Southern Health and Social Care Trust

Quality Care - for you, with you

encompass.SHSCTPMO@southerntrust.hscni.net

Trust Lead: Jacqueline Clarke

SharePoint: Click here

Western Health and Social Care Trust

encompass.PMO@westerntrust.hscni.net

Trust Lead: Paula McGuinness

Visit the new Staff Hub for more information

encompass

DELIVERING CARE TOGETHER

encompass.info@hscni.net

Senior Responsible Officer: Dr Dermot Hughes
Interim Programme Director: Veronica Devlin

Website: Scan the QR code

In a much-anticipated decision, a timeline has been agreed to for all encompass go-lives through 2025. While specific dates are still to be determined, the timeline and order of the Trusts has been established.

The following sequence will be utilised:

- South Eastern Trust: September/October 2023
- Belfast Trust: April/May 2024
- Northern Trust: September/October 2024
- Southern & Western Trust: April/May 2025

How was this decision made?

South Eastern and Belfast Trusts were previously identified as the first and second Trusts to go live, and now the remaining Trusts have been scheduled. encompass Strategic Assurance Group (SAG) and encompass Programme Board identified a variety of decision-making criteria, including flows of patients between Trusts, reducing risk of patients on multiple systems, ease of implementation, and impact on other programmes and ICT systems in order to define the order. Supporting data was then reviewed for all criteria to make the decision.

Why are Southern and Western Trusts going live at the same time?

Given the importance of encompass and the benefits associated with the flow of information between Trusts, Southern and Western Trusts will go live together in the spring of 2025. This decision was made by looking at the sizes and experiences of a number of other organizations who use Epic across the UK, Canada and elsewhere. By the time of the Southern and Western implementations, Northern Ireland will have extensive experience from three previous trusts and grown the numbers of expert users.

Where can I go to learn more about encompass?

Want to learn more about encompass? Check out the encompass website (https://encompassni.hscni.net/) to learn more about what encompass will mean for you, patients, and service users, and to stay up to date on what's happening in the programme.

MEMO

From the Permanent Secretary and HSC Chief Executive

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

From: Peter May

Ref: SGM-0076-2023

Date: 09 February 2023

To: All HSC Staff

Update on Encompass Programme

I am delighted to be able confirm that South Eastern Health and Social Care Trust will be the first Trust in Northern Ireland to Go-Live with encompass on 9 November 2023.

As you will be aware, there has been significant work undertaken across HSCNI to enable us to get to this point and I am proud that Northern Ireland will be the first region to adopt the system across all Trusts and the first in the UK to include social care on this platform.

This is a once-in-a-generation opportunity to replace outdated systems and transform how we provide care.

The team at South Eastern Trust will lead the way in November and as a system we will support them in this massive endeavour. They in turn, will provide learning and expertise which HSC can take forward into the encompass roll out across the other Trusts in 2024 and 2025.

Our new electronic patient record (EPR) system is supplied by health software developers, Epic. Going live with Epic across our acute and community-based health services will be a significant change for staff - having one electronic patient record system means that information will no longer be stored in multiple places, staff will no longer need to use paper documents or fill in duplicate forms. It allows staff to see the right information at the right time, all in one place.

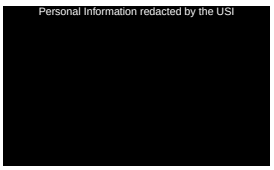
Once rolled out across Northern Ireland, it will also mean that records will be accessible no matter which hospital a patient is being treated in.

While continued efforts have seen staffing numbers across the HSC increase, demand

for services continues to outpace that expansion. encompass, along with other digital advances have the potential to play an important role in closing that gap.

We all want to give the citizens of Northern Ireland a world class Health and Social care system and encompass will support that ambition.

Best wishes,



PETER MAY

Southern Health and Social Care Trust

Digital Dictation

Statement of Requirements

Version 1.0

FINAL DRAFT

10th December 2010

Contents

1: Introduction

1.1 Purpose of this Document

1.1.1 This document describes the requirements for a Digital Dictation Solution for Southern Health and Social Care Trust (SHSCT).

1.1.2 The purpose of this document is to provide a Final Statement of Requirements against which the shortlist of 4 suppliers (hereafter referred to as Bidders) should submit their tender response for evaluation.

1.1.3 The aim of this procurement is to obtain a digital dictation system for all acute services to modernise current dictation processes. The product should be capable of being extended to other disciplines such as AHP's, social workers, and other professional groups over time. The provider should be capable of providing speech recognition in the future should the Trust decide to introduce this system in the future.

1.2 Glossary of Terms

1.2.1 The following general terms have been used throughout this document for consistency:

- SHSCT – Southern Health and Social Care Trust or 'the Trust';
- HSC – Health and Social Care sector in Northern Ireland;
- HP – Hewlett-Packard Limited;
- AHP – Allied Health Professionals; and
- CTCC – Community Treatment & Care Centre.

1.2.2 The following operational terms have been used throughout this document for consistency:

- Author – User who is creator of audio file (dictation);
- Transcriber – User who prepares type-written copy of the audio file; and
- Routing – Delivery of the audio file (dictation) to a scheduled or pre-set recipient.

1.3 Southern Health and Social Care Trust

1.3.1 The Southern Health & Social Care Trust (henceforth referred to as "the Trust") is a leading provider of health and social care services in Northern Ireland. It delivers, in partnership with key stakeholders, a wide range of health and social care services that make demonstrable improvements in the health and well being of the population through person centred, safe and effective care that ensures best value for money.

1.3.2 The Trust was established on 1st April 2007 by a merger of four existing legacy Trusts (Armagh & Dungannon, Craigavon & Banbridge, Newry & Mourne and Craigavon Acute) and is one of five Health and Social Care Trusts within Northern Ireland.

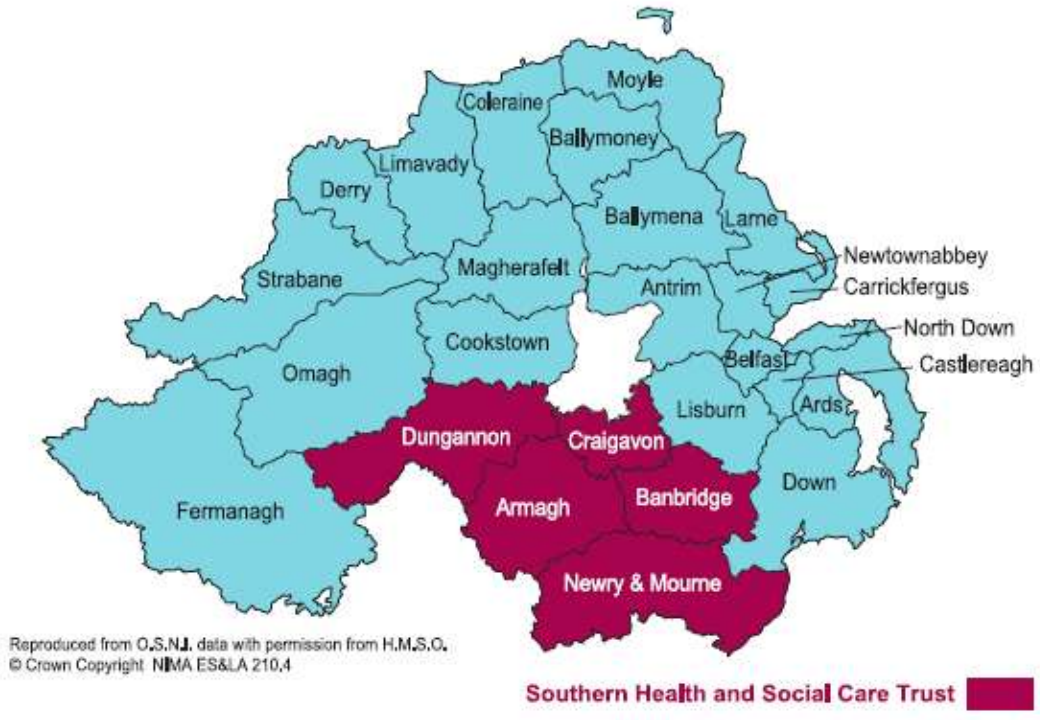
1.3.3 The Trust is an integrated organisation, incorporating acute hospital services, community health and social services and serves a population of approx 300,000 people.

1.3.4 The Trust covers the Northern Ireland local government districts of Armagh, Dungannon, Craigavon, Banbridge, Newry & Mourne.

1.3.5 The main hospital bases are: Craigavon Area Hospital, Daisy Hill Hospital and South Tyrone Hospital with Community bases located in many local towns including Armagh, Banbridge and Lurgan.

1.3.6 In addition to its geographical spread, there is also a noticeable diversity in its population characteristics, embracing areas of relative wealth and prosperity as well as pockets of considerable deprivation and need.

1.3.7 Map showing districts included in the SHSCT.



1.4 Trust Vision and Values

1.4.1 The Trust vision is to be a leading provider of health and social care. To deliver, in partnership with key stakeholders, a wide range of health and social care services that will make demonstrable improvements in the health and wellbeing of the population. In doing so they will constantly review their services to ensure they are modern and fit for purpose.

1.4.2 The Trust Core values include:

a) All our work will focus on improving and sustaining the health and wellbeing of the people we serve;

b) We will deliver safe and effective care and deliver value for money;

c) We will work in partnership with patients/clients/carers, key stakeholders and our population;

d) Our services will be person centred and flexible in meeting the needs of the individual;

e) We will provide services which are easy to use and to understand;

f) We will strive for excellence in all we do;

g) We will value our staff;

h) We will be clear, straightforward and open in all we do; and

i) We will provide a truly integrated service, using where appropriate multi-professional teams, allowing patients and clients to cross organisational boundaries seamlessly.

1.5 Goldblatt McGuigan

1.5.1 Goldblatt McGuigan are providing support to SHSCT in this procurement process as part of the HSC Business Services Organisation's Technology Partner Agreement with HP.

1.5.2 SHSCT are progressing this procurement through the Technology Partnership Agreement with HP, where HP is acting as a procuring authority for SHSCT. Although the solution supply and support will be for SHSCT, the primary contract will be between HP and the successful Bidder.

2: Scope and Objectives

2.1 Objectives of the Project

2.1.1 The main objective of implementing Digital Dictation within the Trust is to improve the efficiency of producing clinical correspondence via the transfer of voice dictations from tape media to a digital environment.

2.1.2 The system will combine the processes of storing, archiving and distributing voice data for the transcription by secretarial staff across the Trust, where clinicians can send audio files to sectaries for transcription.

2.1.3 The project's key objectives are defined as:

i. To improve the efficiency of clinical administration procedures.

ii. To allow clinical letters to be easily prioritised.

iii. To allow the centralised storage for Trust correspondence for incorporation into the document management system (Patient Centre) creating a central patient record.

iv. To allow dictations to be evenly distributed.

v. To avoid backlogs of clinical correspondence through improved management information provision.

vi. To reduce the risk of mislaying or losing tapes.

vii. To allow original dictations to be stored and embedded in future document management systems.

viii. To replace obsolete technology and eliminate tapes.

ix. To allow multi-site working and utilise resources across the Trust.

x. To easily prioritise letters for typing.

xi. To standardise dictation hardware across the Trust.

xii. To provide a paperless clinical correspondence service to GPs, reducing paper costs.

2.1.4 The targeted benefits associated with the implementation of a Digital Dictation System are:

i. Reduce the risks associated with tape media, therefore improving patient information security.

ii. Provide high quality, clear and more efficient system for secretarial and administrative staff to use.

iii. Improve sound quality.

iv. Provide an alternative to tape which will be phased out as a recording media over the next few years.

v. To allow more even distribution of typing across Trust resources through improved management information.

vi. To facilitate a paperless exchange of clinical letters to GPs.

2.1 Volumes

2.1.1 Acute Services within the Trust has approximately **212 Medical Staff** including Consultants, Staff Grades and Registrars.

2.1.2 There are a further **205 Junior Doctors** on a 6-12 month rotation.

2.1.3 To support the administrative needs of the clinicians, there are **250 secretaries / audio typists**.

2.1.4 Digital Dictation will be required across **2 main acute sites**, Craigavon Area Hospital in Portadown and Daisy Hill Hospital in Newry.

2.1.5 In addition there are a number of **satellite sites** where Out-patient Clinics are held and patients seen as Day Cases where digital dictation would be required. Typically these are in facilities in:

- South Tyrone Hospital, Dungannon;
- Banbridge Poly Clinic;
- Portadown CTCC;
- Armagh Community Hospital;
- Kilkeel Primary Care Centre; and
- Lurgan Hospital.

2.2 Current Dictation Process

2.2.1 Currently all services across the Southern Trust use some form of tape based dictation, with the exception of Radiology and Laboratories. Historically the Clinicians dictate letters for the secretaries or audio typists for transcription via the physical transfer of tape.

2.2.2 Following Out-patient Clinics, the tapes on which the clinician has recorded are attached to the Patient's charts and are transferred to the secretary / typists by the portering staff.

2.2.3 There may be some notes left for typists to prioritise certain clinical letters.

2.3 IT Infrastructure

2.3.1 The Digital Dictation solution will be hosted in the Trust Data Centres at Craigavon Area Hospital. **Appendix A** provides an overview of the Trust Data Centre configuration and database platform.

2.3.2 Bidders should recommend the minimum required server infrastructure, factors such as WAN speeds, database infrastructure or system design may dictate a distributed platform although a centralised configuration, where applicable, would be preferred from a support and maintenance perspective.

2.3.3 In April 2009 the Trust awarded a contract to BT for Infrastructure Consolidation and Application Harmonisation. The main aims were to harmonise four legacy infrastructure to one single network to allow users to work seamlessly across the sites; to reduce costs and to provide ICT services which can be managed efficiently and effectively. The current ICT infrastructure was harmonised in July 2010, however migration of users to this infrastructure commences in October 2010 and is due for completion in December 2011.

2.3.4 Each of the legacy Trusts has implemented a form of directory services for use within their "Legacy" environments. Three of these environments are based upon **Microsoft Active Directory** (Armagh & Dungannon, Craigavon Area Hospital, Newry & Mourne) and the fourth on **Novell eDirectory** (Craigavon & Banbridge).

2.3.5 A single Southern Trust Active Directory has been developed, however as indicated above users will not be fully migrated to this Trust wide until December 2011.

2.3.6 Windows 2007 and Microsoft Office 2010 will be the Trust's standard desktop from December 2011.

2.4 Scope of Solution

2.4.1 The current scope of solution deployment is for Acute Services Consultant and Junior Doctors across the main acute hospital sites and is for clinical correspondence only.

2.4.2 The supplier will be responsible for the provision of all hardware related to the digital dictation solution i.e. microphones, transcription kits and any associated kit, holsters, docking stations, cables etc.

2.4.3 The supplier will be responsible for the installation and configuration of all hardware and software as described in their response to the SOR and is responsible for the support and upgrade of same.

2.4.4 The functional scope of the solution includes the creation of audio files (dictation), workflow routing of audio files, transcription, automatic population of patient details (via integration with other Trust systems) and routing of documents.

2.5 Out of Scope

2.5.1 The following groups of users are outside of the scope of this deployment – Allied Health Professionals, Paediatric Services and Community Professional Clinicians.

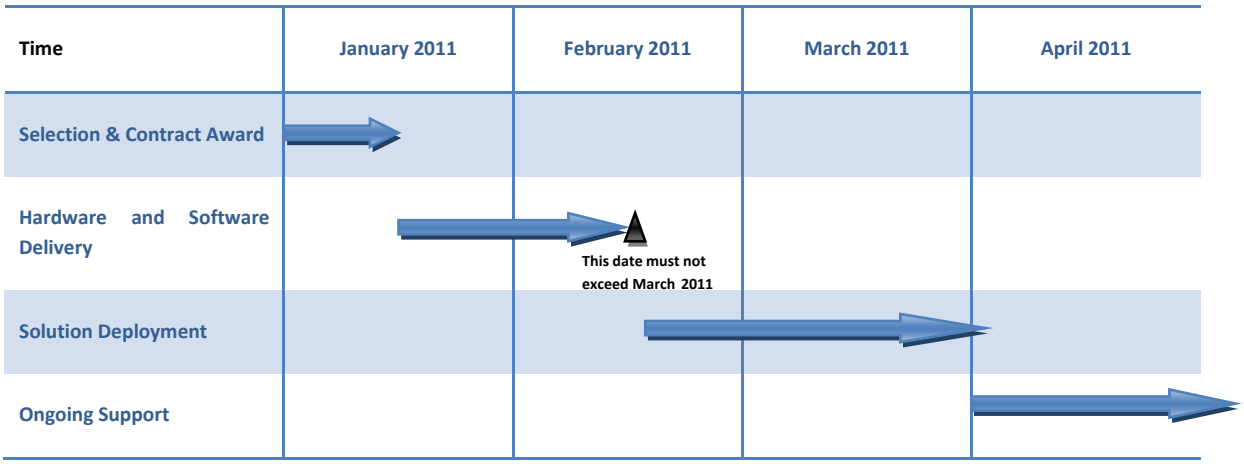
2.5.2 General administration dictations are outside of the scope of the solution deployment.

2.5.3 The provision of all server hardware and Microsoft SQL platform, if required, is out of scope for the supplier to provide. Noting information, for example minimum server specification requirements, which bidders must provide in response to Section 3.8 Technical Requirements.

2.5.4 The functional scope of the solution does NOT include use of digit dictation on other mobile devices (e.g. Blackberry, iPhone etc.) or voice recognition (future requirement).

2.6 Proposed Project Implementation Timetable

2.6.1 The table below depicts the project high level implementation plan and key milestones:



2.6.2 Bidders should be aware that they would be required to deliver hardware and software to the Trust Prior to **31st March 2011** at the very latest. Failure to meet this date may result in funding secured for the project being withdrawn and possible cancellation of the contract.

2.6.3 Implementation should commence ASAP after hardware and software delivery, including GP system integration and PAS and HCI interfaces to allow scanning of barcodes demographic details.

3: Solution Requirements

3.1.1 The requirements for the Digital Dictation Solution have been prioritised using the MoSCoW approach, i.e. each requirement will receive one of the following priorities:

- **Must have (M)** – requirements that are fundamental to the system. Without them the system will be unworkable or project objectives would not be achieved. The 'Must-haves' define the minimal usable subset.
- **Should have (S)** – important requirements for which there is a work-around in the short term and which would normally be classed as mandatory in less time or budget constrained developments. The system will still be useful and usable without them.
- **Could have (C)** – requirements that can more easily be left out of the system under development.
- **Would like to have but not in this iteration (W)** – for those requirements that can wait until a later release or future system development.

3.1.2 Unless otherwise indicated, solution requirements should be considered as **MANDATORY**. Proposed solutions must provide these requirements at a minimum. These requirements can be met by the Bidders 'standard' solution or by a customisation. If the requirement would be met by a customisation of the solution, Bidders should indicate this in their responses.

3.2 General

General requirements are those which must be evident in all subsequent requirement sections.

Ref:	Title	Requirement	Priority
3.2.1	Robust	The system must be robust and built on an industry standard platform. Development must conform to best practice.	M
3.2.2	Modular	The system must be modular so that any future additional requirements could be easily applied with minimal rebuild of the existing system.	M
3.2.3	Ease of implementation	Any system must be able to be implemented by a straight forward setup, configuration and deployment.	M
3.2.4	Intuitive	The application must reflect good practice with respect to layout and navigation (i.e. meet users' intuitive expectations with respect to navigation and menu positioning).	M
3.2.5	User Interface	The system must provide a graphical user interface. This must be a consistent intuitive user-friendly interface in terms of menus, functions, toolbars, data entry, editing and navigation.	M
3.2.6	Error Messages	The system must always display easily understood error messages where applicable.	M

Ref:	Title	Requirement	Priority
3.2.7	Response Times	The system should offer a target response time for all online processing of one second. The proposed standard is: • 90% of all response times to be one second or less; • 98% of all response times to be three seconds or less; and • 100% of all response times to be five seconds or less (excluding complex reports if applicable). Bidders are invited to comment on the practicality of meeting the target response times.	S

3.3 Dictation User (Author) Requirements

This section defines the requirements for usage of the digital dictation solution for users creating dictations:

Ref:	Title	Requirement	Priority
3.3.1	Basic Functions	The digital dictation system must include pause, rewind, forward and play functions.	M
3.3.2	Default Routing	The system must provide a user default routing function. The system must enable a dictation author to set a default transcription user for the allocation of all jobs to them.	M
3.3.3	User Defined Routing	The system must provide user defined pathways i.e. an author can direct dictation to a defined secretary.	M
3.3.4	Author Amend Routing	The system must provide re-direct functionality, which will enable authors to amend the user that a dictation has previously been routed to.	M
3.3.5	Recall	The system must provide recall Functionality where an author can recall dictation after it has been sent.	M
3.3.6	Default Priority	The system must enable default prioritisation of dictations, based on author.	M
3.3.7	Changing Priority	The system must provide functionality to enable an author to change the prioritisation of dictations.	M
3.3.8	Off-Line Dictation	The system must provide functionality to enable an author to work off-line and download digital audio recording through a docking station.	M
3.3.9	Automatic Synchronisation	Synchronisation of off-line dictations should be automatic and take place without the need for the user to log onto the system.	S
3.3.10	Notes to Transcription	The system must enable dictation users to include note for the transcription user, for example specific instructions relating to that transcription.	M
3.3.11	Voice Commands	The system may provide functionality that enables dictation users to control dictation recording software using voice commands.	C
3.3.12	Direct Job	The system must enable a dictation author to choose or direct a job to a specific transcription user.	M

3.4 Transcription User Requirements

This section defines the requirements for usage of the digital dictation solution for transcribers:

Ref:	Title	Requirement	Priority
3.4.1	Play Back	The digital dictation system must provide high quality play back function, supporting pause, rewind, forward and play functions.	M
3.4.2	Play Back Volume	The system must allow users to control the volume of digital dictation play backs	M
3.4.3	Job List	The system must provide user job list functionality.	M
3.4.4	Job Information	The system must provide the following information for all jobs on work lists: • Author, • Patient details (including Health & Care Number); • Length of dictation; and • Date and time of dictation.	M
3.4.5	Start / Stop Function	The system must provide start / stop functionality where one dictation can be stopped and another started. The system must enable a user to restart the dictation again when required. The system must enable a user to identify dictations which have been stopped before completion.	M
3.4.6	Urgent Job Alerts	The system must provide an alert function which would alert a user that an urgent job has been added to their work list.	M
3.4.7	Medical Terms	The system must provide access to an integrated Medical Dictionary and Medical Thesaurus.	M
3.4.8	Workflows	The Digital Dictation System must provide controlled workflows both to distribute dictation audio recording and the resulting transcribed correspondence for checking / verifying, digital signature and distribution to recipients. It must conform to legal admissibility standards (Electronic Communication Act 2000).	M
3.4.9	Correspondence Pathway Configuration	The system must enable the definition of clinical correspondence pathways for users to be controlled by configuration. Specific users must be able to update and amend this pathway configuration without support from the supplier.	M
3.4.10	Automatic Population of Information	The system must be able to automatically populate details into transcribed documents, based on the document templates. The information to be automatically populated will come from other Trust systems, as defined in Section 3.9 System Integration. This information will include: • Patient Demographics; • Clinic Details; and • GP Details.	M
3.4.11	Use of Templates	The system must enable the configuration of which document templates to use based on user profile, for example speciality or per clinician.	M
3.4.12	Document for Verification	The system must enable the transcription user to set the document status as for verification / signature by the author.	M
3.4.13	Electronic Document Distribution	The system must enable the transcription user to send a copy encrypted copy electronically to the recipient through a secure pathway. Pathway must be auditable from end to end.	M

Ref:	Title	Requirement	Priority
3.4.14	Electronic Document Storage	The system must enable an electronic versions of documents to be created and stored in Patient Document System (iSoft Patient Centre). Data to be automatically populated into the documents must be passed from the Digital Dictation solution to the document being created in Patient Centre, based on defined templates.	M

3.5 Administration Staff Manager

This section defines the requirements to support the management of dictation job work lists:

Ref:	Title	Requirement	Priority
3.5.1	Re-allocation	The system must enable an Admin Manager user to re-allocate jobs to different work lists.	M
3.5.2	Inter-Site Re-allocation	The system must enable an Admin Manager to view work lists across sites and re-allocate jobs across sites.	M
3.5.3	Restriction of Jobs	The system must enable an Admin Manager to allow restriction of work to different secretarial groups	M
3.5.4	Distinguishing Document Type	The system must enable users to easily distinguish between discharge letters, clinic letters and general admin letters.	M

3.6 Management Reporting

This section defines the system report requirements:

Ref:	Title	Requirement	Priority
3.6.1	Standard Reports	The system must have standard management reports to allow full visibility of workloads. This suite of standard reports should indicate elements such as number of jobs outstanding.	M
3.6.2	Ad-hoc Reports	System must provide means of creating ad hoc reports either through reporting functionality or use of another reporting system such as Crystal Reporting.	M

3.7 User Hardware

This section defines the requirements for provision of user hardware for both dictation and transcription:

Ref:	Title	Requirement	Priority
3.7.1	Dictation User Hardware	The solution must include the provision of all digital dictation user hardware required by users to use the system, including: • **270 Static speech mikes** (connected to PC) with recording, editing and barcode reader functionality with UBS connection; and • **10 Mobile speech mikes** with recording, editing, priority setting and barcode reading functionality.	M
3.7.2	Barcode Scanning	The solution must include bar coding scanning functionality for ALL dictation user hardware provided.	M
3.7.3	Microphone Specification	Bidders must outline the make and model of the static and mobile speech mikes they are planning to supply as well as providing the full technical specification for each of the models.	M
3.7.4	Transcription User Hardware	The solution must include the provision of all appropriate digital dictation transcription user hardware required by users to use the system, including: • **250 x Transcription Kits** (Headphone with USB connectivity and Foot Control pedals with USB connectivity).	M
3.7.5	Hardware Kit	The solution must include all items relating to static / mobile mikes and transcription kits that are required to operate the solution, for example mobile units must also include docking stations, connection cables, holsters etc. **Bidders should itemise all hardware in their response to 4.2 Final Cost Response to enable like-for-like comparison.**	M
3.7.6	Speech Mike Cleaning	Speech mikes (both mobile and static) must conform to Infection Control requirement, e.g. cleaning with disinfectant products. Bidders must confirm that all speech mike devices are able to be regularly wiped down by the end-user with either a damp cloth in order to remove physical debris and/or by detergent wipes for the cleansing of areas such as key pads. Bidders must confirm that this is an acceptable method of cleaning their devices and that it will not impair the equipment functionality or cause harm to users. If not, Bidders should be able suggest an alternative cleaning procedures in order to ensure that a clean working environment can be maintained.	M
3.7.7	Mobile Mike Encryption	Mobile speech mikes must have minimum security level, encrypted to DS2 file format to 128 bit encryption.	M
3.7.8	Hardware Durability	All user hardware proposed as part of the solution must be durable and suitable for daily use.	M

Please note: SHSCT do not have requirement for the use of PDA, Blackberry or Smartphone technology.

3.8 Technical Requirements

This section defines the technical requirements for the installation of the Digital Dictation software:

Ref:	Title	Requirement	Priority
3.8.1	Client Software Deployment	Software client must be capable of being deployed to PCs using Active Directory / Group Policy, AppV or other similar technology. AppV is the Trust's preferred deployment methodology.	M
3.8.2	Hardware and network requirements	Bidders must detail what server, SAN and desktop hardware and network infrastructure is required to support the proposed solution in terms of desktops, servers, LAN and WAN. Bidders must include the number of virtual processors, memory and disk space that will be required.	M
3.8.3	Supporting Software Requirements	Bidders must detail what supporting software licences are required, for example application, operating system, middleware and third party software licences.	M
3.8.4	Performance	The system must be capable of handling the volume of system users defined. Concurrent user rates can be 100%	M
3.8.5	Solution Hosting	This solution will be hosted in the SHSCT Datacentres as described in **Appendix A**. Bidders must describe how their solution will operate in this hosted structure.	M
3.8.6	Fail Over	The system must be capable of operating if one side of the mirrored servers has failed. Bidders must detail how they propose to make the solution resilient across the 2 Datacentres. If the solution has multiple layers, Bidders must specify for each tier how this will be achieved.	M
3.8.7	Disaster Recovery	Bidders must specify how a disaster recovery situation will be managed.	M
3.8.8	Housekeeping Activities	Bidders must identify any regular or ad hoc housekeeping facilities that need to be performed. Actions to be taken and the circumstances or frequency must be described.	M

3.9 System Integration

This section defines the requirements for integration between the Digital Dictation System and a number of systems both within the Trust and with Primary Care Clinical Systems:

Ref:	Title	Requirement	Priority
3.9.1	Health Care Index (HCI)	The system must interface with the **Health & Care number regional system** which contains an Index of all Patients. The interface is one-way, data inward. The system will verify the scanned patient HCI number against the HCI system and populate demographic details.	M
3.9.2	PAS Integration	The system must interface with the SHSCT PAS (Isoft Clinicom PAS) in order to retrieve patient clinic and GP details (based on Health & Care Number), following scanning of the HCI number. Southern HSC Trust PAS is made up of one database, hosted on a consolidated server in the **Belfast Data Centre**. The interface is one-way, data inward, possibly through Clover Lead Info Broker.	M

Ref:	Title	Requirement	Priority
3.9.3	GP Clinical System Integration	The system must be able to provide an interface to the following GP clinical systems, to enable the distribution of clinical correspondence directly TO Primary Care and create a seamless process for delivery of clinical correspondence from secondary care to primary care: 1. EMIS; 2. Vision; 3. Murloch; and 4. iSoft. These interfaces would be one-way, data outward interfaces, based on patient HCI number and GP Cypher Code on the correspondence (GP information originally from PAS).	M
3.9.4	Patient Document System	The system must interface with the Patient Document System (iSoft Patient Centre) to enable patient details to be automatically populated from the Digital Dictation solution into the document being created in the Patient Document System.	M

3.10 System Security Requirements

The section details system security requirements:

Ref:	Title	Requirement	Priority
3.10.1	Secure Log On Functionality	The system must be secure and only accessible to authorized users. A secure username and password screen is required. a) Only Systems Administrator can create user accounts. b) Only Systems Administrator can disable accounts. c) Password to expire after 3 months if password update not undertaken. d) Log on should be linked to system Log on (ie Single Sign On) e) User prompt to change password at first login. f) Account locks after 3 unsuccessful logon attempts. g) Last log-on date and time stored for each user. h) Users able to log out of system	M
3.10.2	Sign On	The system must manage sign on through Active Directory. The last logon date and time must be stored for each user.	M
3.10.3	Audit	The system must have an audit facility to determine what records users have accessed on the system, by user ID and password. The information retained by the system must be suitable to facilitate investigation of any data breach and also facilitate System Administrator spot checks to audit appropriate use of the system.	M
3.10.4	Session Timeouts	The system must automatically log users out of the system if the system has been idle for **5 minutes**, to prevent other users from viewing the application without having to log in.	M
3.10.5	Privilege setting	The system must support the setting up of user groups with defined privilege sets. Groups of staff: • Authors • Secretaries • Audio Typists • Staff Management Administrator • System Administrator	
3.10.6	Security of Mobile Devices	Mobile Speech Mikes must be password protected and encrypted to industry standards (DS 2).	

3.11 On-Going System Support

This section defines supplier requirements for on-going support of the solution post-deployment:

Ref:	Title	Requirement	Priority
3.11.1	Response Time	1st line calls will be reported to the Trust's local IT helpdesk and then forward to the supplier if the issue cannot be resolved. The supplier must provide an initial assessment of all problems reported to them within 4 hours of issue being logged with them.	M
3.11.2	Support Response	Any critical issues logged with the supplier will require the supplier to respond within one hour. There should be hourly updates on progress on problem resolution. **All critical issues should be resolved within 8 hours.** If required, onsite supplier attendances to logged calls should be within 24 hours. If required, replacement user hardware should be made available as appropriate until faulty equipment is fixed / replaced.	M
3.11.3	Support Hours	Support for the solution will be governed by a service level agreement. System support must be provided for a minimum of 8.00a.m. to 6.00p.m. Monday to Friday.	M
3.11.4	Single point of contact for support	A single point of contact must be provided through which all support calls relating to any element of the Digital Dictation Solution provided will be directed (i.e. software and user hardware issues all supported via the same channel and process).	M
3.11.5	Logging Support Calls	The supplier must provide a process for logging support calls to which they will assign a reference number and status which will trace the issue from the fault being identified to it being closed and resolved to client satisfaction.	M
3.11.6	Remote Support	In order to investigate and resolve support calls, the supplier must be capable of providing remote access support of the solution, which will be accessible by the supplier using a N3 connection.	M
3.11.7	Environment	System support must include support in a Windows 7, Microsoft Office 10 environment as well as Windows XP and Office 2003 which is currently used. Windows 7 and Microsoft Office 10 will be the Trust's standard desktop from December 2011.	M
3.11.8	Hardware Replacement / Support	All hardware which must be refreshed within 5 years must be costed into the bidder's response.	M
3.11.9	Software Upgrades	Bidders are asked to provide details of how they would deliver a comprehensive support and maintenance package for their proposed solution to cover the application software. Please include details of the frequency, mechanism and responsibility for the delivery of patches and upgrades. If there are various options, these should be detailed.	S
3.11.10	Business Recovery Plan	The System provider must have an effective and proven business recovery plan in place in respect of all its service offerings and this must be evidenced in their response.	M

3.12 Training

This section defines the user training and training materials to be provided by the supplier:

Ref:	Title	Requirement	Priority
3.12.1	End User Training	The supplier must provide end user training for all digital dictation users (both dictation users and transcription users). . This training must be provided within reasonable time ahead of deployment.	M
3.12.2	Train the Trainer	The supplier must provide 'train the trainer' training suitable for the Trust to deliver training to new staff post implementation.	M
3.12.3	e-Learning	The supplier must provide an e-learning tool / module for authors, transcribers and admin managers and system manager roles.	M
3.12.4	Training Material	User training reference material should be made available to users in the form of help guide(s). Guides should be tailored for different user roles.	S
3.12.5	IT Support Training	The supplier must provide IT support training to nominated IT Support staff in the use of system administration functionality including setting up new users, amending document templates and workflow configurations and any other IT administrator functions. This training must be provided within reasonable time ahead of deployment.	M

3.13 Solution Deployment

This section defines the supplier requirements with respect to the deployment of the solution within the SHSCT:

Ref:	Title	Requirement	Priority
3.13.1	Delivery Lead Time	Bidders must confirm their LEAD TIME in number of working days between contract award and their ability to deliver hardware and software to the Trust. **Bidders are asked to confirm if they are able to commit to the delivery of hardware and software prior to 31st March 2011, and what the LATEST date of order would be in order for them to be able to guarantee delivery before this date.**	M
3.13.2	Project Manager	The supplier must nominate an individual who will act as their Project Manager and single point of contact during the development and implementation of the system.	M
3.13.3	Project Manager Experience	The Bidders nominated project manager should be suitably trained and experienced in managing projects, for example PRINCE2 practitioner certified.	S
3.13.4	Technical Configuration Design	The supplier must produce a technical configuration design for any areas of the system which will be configured to meet specific SHSCT requirements, for example workflows. This technical design must be reviewed and accepted by the client, prior to commencement of testing stage.	M
3.13.5	Testing	The system must be fully functionally and configuration tested. Acceptance signoff will be by the client project team and as per an agreed acceptance process.	M
3.13.6	Pilot Deployment	A pilot system may be established to run in parallel with the current processes before the full live system roll out. This would be used by a limited number of users. The pilot would be used as proof of concept to ensure that the system is working correctly before full deployment.	M

Ref:	Title	Requirement	Priority
3.13.7	Deployment Support	The supplier must provide roll-out support during the implementation of the new system. This must include onsite support for the setting up of the new system on servers and responding to any stabilisation issues.	M

3.14 Future Requirements

This section defines requirements which are not part of the scope of the current solution, but which may be solution requirements in the future so that the selected solution should be compatible or expandable to meet these future requirements:

Ref:	Title	Requirement	Priority
3.14.1	Speech Recognition	Bidders should demonstrate in their response how they could deliver speech recognition in the future	M

4: Supplier Response

4.1 Response Content

4.1.1 Bidder Responses must be provided in the following format and submitted by email to Personal Information redacted by the USI before **12 noon on Thursday 23rd December 2010**. Responses must be in MS Word, MS Powerpoint or Adobe PDF file formats only. Failure to respond as instructed may result in Bidders being excluded from further consideration. Bidders are requested to provide the following information in response to this statement of requirements:

4.1.2 **Management Summary:** A brief management summary of the proposal should be provided describing the approach and plans for satisfying and supporting the requirements of the project, highlighting important features (3 x A4 pages at a maximum will suffice).

4.1.3 **Understanding The Requirements:** The bidders must provide a detailed explanation of their proposed solution in the context of a clear statement of an understanding of the requirements. This must include any methodologies that will be employed, the functional benefits of the solution and any limitations or restrictions of the proposed solution. (5 x A4 pages at a maximum will suffice).

4.1.4 **Response to Requirements:** Bidders must respond to each of the requirements, explaining HOW the proposed solution meets each of the requirements, as defined in *Section 3 Solution Requirements*. Bidders should use this document's numbering system in responding to requirements. **A simple statement that a requirement will be met is not acceptable, sufficient detail must be provided on how the requirement will be met.**

4.1.5 Responses to requirements should include (or reference separate sections or appendices) specific confirmations and evidence if requested within the requirement, for example requirement 3.7.3 requests Bidders to outline the make and model of the static and mobile speech mikes they are planning to supply as well as providing the full technical specification for each of the models.

4.1.6 **Requirements Not Met as Standard:** Please note that failure to meet a mandatory requirement may result in elimination from the selection process. If the proposed standard solution does not fully meet any of the mandatory requirements, this should be clearly highlighted and a detailed proposal for customisation, alternative option or workaround provided.

4.1.7 **Reference Site**: Bidders should provide 2 appropriate reference sites to support their bid. Reference sites may be telephoned or visited as part of the evaluation process. Reference sites provided by bidders must demonstrate previous experience in a Health environment, preferable of an implementation of a similar size to the SHSCT. For each reference site, bidders must provide:

- Company name;
- Deployment location;
- Date Supplier's Solution introduced;

- Contact details (named contacts, phone number and e-mail details);
- Similarities between reference site requirements and the SHSCT's requirements and reasons why this site is being provided as a reference site; and
- Benefits realised by the customer from the implementation (e.g. efficiency in creation of documents, turnaround of correspondence, improved information governance, improved sound quality etc.).

4.1.8 **Implementation Plan:** Bidders must provide a detailed plan for delivery of their proposed solution, covering the number of weeks from contract award to full implementation. The plan should include:

- The project management approach to be adopted;
- The quality assurance controls that will be adopted;
- Type, volume of training and days dedicated;
- Timetable for delivery, installation and deployment support of system (including confirmation of achieving SHSCT required delivery dates); and
- Implementation and planning assumptions made.

4.1.9 **Terms and Conditions:** Bidders must provide copies of the following documents and confirmation of acceptance of:

I. Standard Terms and Conditions for Supply;

II. Standard Terms and Conditions for Support (if separate);

III. Standard Licensing Agreement; and

IV. Supplementary Conditions (Appendix B) - comment on areas where may have difficulty accepting (see para 4.6.3)

4.1.10 **Cost:** The bidder must complete the Pricing Schedule (section 4.2) to show the total cost of the proposed solution, including all components necessary to implement it. The bidder must make clear what, if any, elements of the functionality will not be covered within their quoted cost and which would be available at extra cost. The bidder must also detail any of this extra cost in the Pricing Schedule.

4.1.11 Where an area of functionality is described in the response to requirements and does not state "This area of functionality is available at an extra cost" the functionality must be provided at no extra cost.

4.1.12 **Consultancy:** The bidder must provide a 'rate card' which states the rates at which consultancy would be charged for additional work beyond the initial requirement.

4.2 Final Cost Proposal

4.2.1 Bidders should detail their BEST AND FINAL cost proposal. Any assumptions made should be clearly defined. Costs should be broken down by individual item where possible.

4.2.2 Any additional items or options which the supplier recommends should be detailed separately.

Area	One Off Cost (£)	Annual Support Cost (£)	Comment / Notes
User Dictation Hardware			Broken down by item, see requirements and quantities in section 0.
User Transcription Hardware			Broken down by item, see requirements and quantities in section 0.
Any Other Hardware			Please define any additional hardware required to operate solution separately. Please note Technical Requirements in section 0 regarding Datacentre Hosting.
Digital Dictation Solution User Software Licensing (e.g. per unit)			Please detail as appropriate.
Digital Dictation Solution Site Software Licensing (e.g. per server)			Please detail as appropriate.
Any Other Software Licences (including any 3rd party)			Please define any additional software required to operate solution separately. This excludes operating system software, but should include ALL other software required for example databases, reports.
Integration with HCI			Please provide a final cost for this integration based on the information defined in the requirements in section 3.9
Integration with PAS			Please provide a final cost for this integration based on the information defined in the requirements in section 3.9
Integration with listed GP Clinical Systems			Please provide a final cost for these integrations based on the information defined in the requirements in section 3.9
Integration with Patient Document System			Please provide a final cost for this integration based on the information defined in the requirements in section 3.9
Installation / Testing			Please provide as much detail / breakdown as possible.

Area	One Off Cost (£)	Annual Support Cost (£)	Comment / Notes
Deployment Support			Please define number of days deployment support proposed.
Training			Please define number of days training proposed. Please see requirements in 0, this training is end user training.
On-going Support and Maintenance			Please detail as appropriate.
Other Costs (please specify)			Please define any other costs which are required to deploy and operate the proposed solution.
TOTAL			

All costs should be quoted excluding VAT.

4.2.3 **Supplier Rate Card:** Bidders should provide hourly / daily rates for any additional resources which may be additionally required e.g. post implementation.

Role	Cost / Hour (£)	Cost / Day (£)	Comment / Notes

4.3 Requirement Clarifications

Personal information redacted by USI

4.3.1 All clarification requests must be co-ordinated through **Emma Reid** Please note that direct requests to the Evaluation Panel from Bidders for information or clarifications at any stage of the procurement process may result in the Bidder being disqualified from the process.

4.3.2 Bidders are requested to provide all clarification requests in writing. Written responses to clarifications will be provided and shared with all Bidders as appropriate for transparency.

4.3.3 If clarifications are requested from Bidders, following response submission, we request that each Bidder undertakes to provide responses to any clarifications in as timely a manner as possible.

4.4 Solution Evaluation

4.4.1 Please note that this is the formal scoring of Bidders' responses to the Final Statement of Requirements. Evaluation scores will consider the evidence of the solution's acceptability demonstrated in the bidder submitted response.

4.4.2 Based on the total score, the contract will be awarded to the highest ranked bidder.

4.4.3 Bidders will be evaluated against the following model:

Area	Criteria	Evaluation Weighting
Understanding of Requirements	Understanding of SHSCT's requirements and how the bidder and its solution will address them	5%
Functional and Technical Requirements	How the Bidder will meet the Functional and Technical requirements	25%
Solution Deployment	Demonstration of ability to work with SHSCT to deliver successful outcome	10%
On-going Support Requirements	Demonstration of ability to provide suitable supporting structures post deployment	10%
Cost	Total Bid Cost as Defined Below	50%
TOTAL		100%

4.4.4 Marks for non-financial requirements will be based on the following scoring and weighted accordingly:

Excellent solution that meets all the requirements. Indicates an excellent response and presentation/demonstration with sound supporting evidence and no weaknesses.	5
A good solution that meets the requirements with good supporting evidence and few weaknesses.	4
Meets Requirements. The solution generally meets the requirements, but lacks sufficient supporting evidence or has some weaknesses.	3
A response with reservations. Lacks convincing evidence of the solution's suitability. Medium risk or solution has many weaknesses.	2
An unacceptable response with serious reservations. Limited evidence that the solution can meet requirements. High risk that the solution will not be acceptable.	1
Response fails to meet stated mandatory requirements. Solution is not acceptable.	0

4.4.5 Cost score is based on the **Total Bid Cost** as defined below:

- Total Bid Cost = Total One-Off Cost + Total Recurring Cost x **3 Years**

4.4.6 The 'Total One-Off Cost' will include all licence costs, design and deployment, implementation and testing, and training; whereas 'Total Recurring Cost; will include all support costs.

4.4.7 The bidder with the LOWEST Total Bid Cost will be allocated FULL MARKS (50%). All other bids are awarded a score based on a pro-rata basis:

4.4.8 The overall % scores from each area will be added together to get the final score for your response.

4.5 Post Tender Activities

4.5.1 Following evaluation, bidders will each be notified of the outcome, it is anticipated that this will be within 4 weeks following the receipt of responses.

4.5.2 SHSCT reserve the right at this stage to undertake bidder reference site visit(s) for the preferred bidder prior to award of contract.

4.5.3 Bidder de-briefs will be provided to all bidders as required.

4.5.4 HP reserves the right to use the bids received as the basis for discussions with bidders about the potential of meeting similar requirements within HSC Trusts other than SHSCT; where such a requirement arises it will have no bearing on the evaluation of bids to meet this requirement and award of contract for SHSCT.

4.6 Contracting

4.6.1 SHSCT are progressing this procurement through a Technology Partnership Agreement with HP, where HP is acting as a procuring authority for SHSCT. Although the solution supply and support will be for SHSCT, the primary contract will be between HP and the successful Bidder.

4.6.2 It is currently anticipated that Bidders Standard Licensing and Terms & Conditions, which should be provided by Bidders, will be used as basis for contracting.

4.6.3 In addition, the **Supplementary Conditions at Appendix B** will also form part of the contract; Bidders are asked to note these supplementary conditions and comment on areas they may have difficulty accepting. It should be noted that these supplementary conditions include mandatory government contract conditions to cover relevant legislation, security and data protection; as such, there are a number of these terms that will be non-negotiable.

4.6.4 Please note the **HSC ICT Security Policy at Appendix C** which is referred to through 'Appendix A SHSCT Datacentre Infrastructure' and 'Appendix B Supplementary Conditions'.

5: Appendix A – SHSCT Datacentre Infrastructure

5.1 Trust Datacentre Infrastructure

5.1.1 The Trust server infrastructure is a High Availability hardware configuration designed to host Trust infrastructure on a 24 x 7 x 365 basis. All the hardware components used are of enterprise class quality with no inherent single points of failure.

5.1.2 The platform is sited across 2 Datacentres based at Craigavon Area Hospital; one Data Centre is in the main Hospital facility and the second Data Centre is located outside the main hospital in a purpose built facility. The 2 Datacentres contain identical hardware components and are interconnected via multiple high bandwidth IP connections and multiple high capacity fibre channel links for data traffic across the Storage Area Network (SAN).

5.1.3 The database solution for the Trust is based upon Microsoft SQL Server 2008 (SQL 2008) which provides best of breed end-to-end database management for applications and services. SQL Server 2008 Enterprise is a comprehensive data platform that provides enterprise-class scalability, performance, high availability for running secure, business critical applications. The highly available solution is delivered by means of Microsoft Cluster technology (SQL 2008 Enterprise 64 bit on each node) -the core server technology is the HP BL460 Generation 6 blade.

5.1.4 All applications hosted on this platform are installed on a “stretched” server cluster with 1 server node located in each of the Datacentres. It is a requirement of the installation process that any hosted application must be capable of running from either Datacentre, at 100% of capacity, in the event that one of the datacentres is either partially or completely down for maintenance purposes. This failover process is tested prior to go-live, and invoked again a number of times throughout the year during scheduled maintenance windows.

5.1.5 Environmental controls include 2 x 30kW UPS units, 3 x Air Conditioning units, along with smoke, heat, humidity detectors, FM200 fire suppression and extraction system, leak detection, physical security controls.

5.2 SAN Infrastructure

5.2.1 HP LeftHand P4500 G2 SAS storage system will be utilised to store all application data for Trust systems and any future proposed solution. The HP LeftHand P4500 Virtual SAN Appliance Software (VSA Software) is a VMware Certified SAN/Storage device and virtual appliance that provides complete SAN functionality for VMware vSphere without external SAN hardware.

5.2.2 The 2 sites are interconnected via 4 x 10 GB dark fibre links which follow separate paths between the sites.

5.3 Contractor requirements

5.3.1 Bidders of third party applications which are to be hosted in the Trust data centres must adhere to the following guidelines:

5.4 Security

5.4.1 The HSC Security Policy defines best practise in Information and Communications Technology (ICT) throughout the HSC. Contractors must comply with this policy. Two areas of specific interest are the HSC Code of Connection and physical access to the Trust data centres. **The HSC ICT Security Policy is included in Appendix C.**

5.4.2 The code of connection defines the guidelines on how third party suppliers must connect to the HSC network. A number of connection options are available, the preferred method being N3. Contractors must become signatories to this code to enable remote access to the Trust network for maintenance purposes.

5.4.3 Physical access to the two Trust data centres is tightly controlled and it is envisaged that suppliers rarely, if ever, require staff on-site within the computer rooms. Should exceptional access be required then the supplier must raise a Service Request through the Trust Service Desk where existing Change Control procedures will be invoked to review requirement, determine risk, and grant authorisation if deemed acceptable.

5.5 Change Control

5.5.1 All changes to hardware, software, configurations and applications within the Trust data centres is subject to the Trust ITIL compliant, Change Control procedures which should be factored in to project planning timescales.

5.6 Hardware

5.6.1 The Trust has an existing contract in place with BT for the procurement of servers and services as part of the Trust Harmonisation Project. A regional HSC contract through HP as the Technology partner is also available. All server hardware destined to reside in the Trust data centres will be purchased from either framework contract.

5.6.2 In order to maximise available resources, applications should be hosted on virtual servers based on VMware clusters. The contractor will be responsible for specifying the appropriate configuration required and the Trust responsible for the subsequent purchase and physical installation. The contractor is then responsible for the logical configuration and subsequent support. Where the contractor determines that a hardware fault exists then the fault will be the responsibility of the Trust who will escalate this with the relevant hardware supplier.

5.6.3 All hardware outside of the datacenters is the responsibility of the Contractor, however the Trust retains the right to purchase said hardware from existing supply contracts where deemed advantageous.

5.7 Infrastructure

5.7.1 Contractors will utilise the existing Trust LAN / WAN network, the Datacenter SAN with its attached storage and Tape Library as an integral part of their proposed solution. The Contractor must specify IP bandwidth requirements both for the Datacenter itself and over the LAN / WAN to each client device.

5.7.2 The Contractor must specify how much of the iSCSI SAN Fabric capacity their solution will utilise; the amount of SAN storage must also be cleared defined based on yearly requirements. The solution must clearly differentiate between physical storage, logical storage and mirrored storage requirements.

5.7.3 The Contractor must utilise the existing automated HP Tape Libraries for backup of SAN based data. The tape libraries are managed by HP DataProtector and must be incorporated into the solution where required. The solution must clearly state the amount of data to be backed up on a daily basis, the number of tapes required on an annual basis to cater for this requirement and any additional requirements for regular archiving of data. Data Protector uses an incremental backup method and that only modified files are backed up on a daily basis. Disk to disk level backup maybe available if required – this should be specified if recommended.

5.8 Upgrade Policy

5.8.1 All hardware and software should be maintained at a currently supportable level. Existing policy is to perform a major upgrade cycle on an annual basis with minor upgrades on a 6 monthly cycle where required.

5.8.2 Application software upgrades should only be implemented when a new release has stabilised in the production environment. Exceptions to this rule must be justified on a case by case basis by the supplier.

5.9 Support

5.9.1 The Datacenter infrastructure and Trust LAN / WAN are currently supported by internal server infrastructure and comms team 9am to 5pm, Monday to Friday.

5.9.2 On-call comms server/comms support is also provided on a 6pm – 9pm basis Monday – Friday and 9am – 9pm Sat and Sunday.

5.9.3 The Trust also has a 24x7 service support Team that can be contacted in order to log any faults and resolve minor incidents

5.9.4 All faults are recorded on the Trust Service Desk system (INFRA) for local action or forwarding to 3rd Party suppliers. All external faults or service requests must be logged on the Trust INFRA system in the first instance.

6: Appendix B – Supplementary Conditions

[See separate attachment]

7: Appendix C – HSC ICT Security Policy

[See separate attachment]

Southern Health and Social Care Trust

Project Initiation Document

Digital Dictation

Version 0.4

1st March 2011

Document History

Document Owner The owner of this document is: Barrie Meneely

Document Location This document is only valid on the day it was printed and the electronic version is located …

Document Status The current status for this document is ***DRAFT***

Revision History Date of next revision:

Version number	Revision date	Previous revision date	Summary of changes	Changes marked
0.4	01/03/11	28/02/11	Updated Implementation Plan	

Approvals This document requires approvals to be signed off and filed in project files

Name	Signature	Responsibility	Date of issue	Version

Distribution This document has been distributed as follows

Name	Responsibility	Date of issue	Version
Catherine Weaver	HoS	01/03/11	0.4
Siobhan Hanna	Project Assurance	01/03/11	0.4

Table of Contents

Purpose

The purpose of the PID is to define the project, to form the basis for its management and the assessment of overall success.

The Project Initiation Document has two primary uses:

- To ensure that the project has a sound basis before asking the Project Board to commit to make any major commitment to the project
- To act as a base document, against which the Project Board and Project Manager can assess progress, risks, issues, change and ongoing viability questions

1. Introduction

1.1 Background

One of functions within the NHS which has been subject to little change in recent years is that of the medical secretarial function and the way in which clinical letters are produced. The SHSCT is currently experiencing delays in the production of clinical letters. The impact of this is to compromise patient care, increased workload and generate dissatisfaction to patients, General Practitioners (GPs) and staff. Any solution which addresses these issues and ensures effective use of existing resources and capacity is considered to be beneficial.

Increasing demands will add pressure to the existing analogue service. A change, therefore, needs to occur which will allow for future technical development and provide users access to transcription data across the hospital. Implementing digital dictation will in addition allow the storage of letters in a central location which are accessible to any user with the relevant permissions.

All Trusts are now required to achieve a targets of Referral to Treatment Time (RTT) and implicit in this is the need to monitor waiting times at each stage of the patient pathway in order to ensure achievement of the target. Any administrative delay will be counted in the wait i.e. waiting for internal referral letters to be processed. It is therefore crucial to the achievement of this target that backlog for typing and any other administrative work are reduced or eliminated and the implementation of digital dictation will help facilitate this. The Ministerial Target that the HSC Board and Trust's have to adhere to is as follows:

"by March 2011, the HSC Board and Trusts should ensure no patient waits longer than 9 weeks for a first outpatient appointment and 9 weeks for a diagnostic test, the majority of inpatients and day cases treated within 13 weeks and no patient waits longer than 36 weeks for treatment".

Digital dictation is the electronic equivalent of an analogue/cassette based dictation. It uses a recording system to store dictated reports as digital files into the existing integrated hospital IT framework. The medical secretary/audio typist still types the reports/ letters etc. and the digital device has similar functions to a tape recorder, i.e. fast forward, rewind and playback. The key objective of the system is to provide a quicker more efficient service based on real time data. This would enable the Trust to meet national targets and ensure administrative and clerical processes support care pathways.

Within the SHSCT Directorate of Acute Services, it is envisaged that this system will be used by 212 Clinical Staff, including Consultants and Senior Medical Staff who dictate letters and reports. In addition, over 200 Junior Doctors will also use this functionality to record dictations.

Whilst the majority of the Clinics are held on the two main sites of Craigavon Area Hospital and Daisy Hill Hospital, additionally there are a number of satellite sites where Out-patient Clinics are held and patients seen as Day Cases where digital dictation would be required. Typically these are in facilities in:

South Tyrone Hospital, Dungannon,

Banbridge Poly Clinic,

Portadown CTCC

Armagh Community Hospital

Currently all services across the Southern Trust use some form of tape based dictation, with the exception of Radiology and Labs.

Also requiring access to the system for the purpose of transcription are Secretaries and Audio Typists. Across the Acute Directorate there are 250 staff currently in these roles.

1.2 Objectives of Project

The main objective of implementing a Digital Dictation system within the Trust is to improve the efficiency of producing clinical correspondence via the transfer of voice dictations from tape media to a digital environment.

The system will combine the processes of storing, archiving and distributing voice data for the transcription by secretarial staff across the Trust, where clinicians can send audio files to secretaries for transcription.

The project's key objectives are defined as:

- To improve the efficiency of clinical administration procedures.
- To allow clinical letters to be easily prioritised.
- To allow the centralised storage for Trust correspondence for incorporation into the document management system (Patient Centre) creating a central patient record.
- To allow dictations to be evenly distributed.
- To avoid backlogs of clinical correspondence through improved management information provision.
- To reduce the risk of mislaying or losing tapes.
- To allow original dictations to be stored and embedded in future document management systems.
- To replace obsolete technology and eliminate tapes.
- To allow multi-site working and utilise resources across the Trust.
- To easily prioritise letters for typing.
- To standardise dictation hardware across the Trust.
- To provide a paperless clinical correspondence service to GPs, reducing paper costs.

1.3 Authority for the Project

This project has been authorised by SMT.

2. Project Definition

2.1 Key Deliverables

The key deliverables for the project will be:

Deliverable 1: User Specification - Project Manager to prepare a System Specification and Statement of Requirements

Deliverable 2: Business Case – Corporate Planning Division, Directorate of Performance and Reform to prepare Business Case

Deliverable 3: Procurement, Installation and Configuration of Digital Dictation software

Deliverable 4: Procurement and deployment of additional hardware for dictation and transcription.

Deliverable 5: A process map will be produced for all participating specialties within the Acute Directorate.

Deliverable 6: Risk Log – Project Manager to create a Risk Log for recording and monitoring all risks. To be created at the Initiation stage of the project.

Deliverable 7: Issue Log – Project Manager to create an Issue Log for recording and monitoring all issues. To be created at the Initiation stage of the project.

Deliverable 8: Project Plan – Project Manager to create a Project Plan for the project. This will be created at the Initiation Stage of the project.

Deliverable 9: Highlight Reports – Project Manager to create monthly highlight reports covering work packages for all groups

Deliverable 10: A comprehensive Training Strategy to include End User Training, Train the Trainer, an e-Learning module, IT Support Training and a Training Manuals

Deliverable 11: Work packages – Project Manager to create Work packages to clearly define roles and responsibilities of project groups.

Deliverable 12: Communication Strategy - Develop standard communication for staff and service users, including e-brief articles and newsletter articles

Deliverable 13: Benefits Review Plan - Project Manager to create a Benefits review Plan so benefits of the project can be measured.

Deliverable 14: Post Project Evaluation - Project Manager to carry out a post project evaluation at the end of the project.

2.2 Constraints

The constraints on this project are as follows:

Constraint 1: The availability of the capital and revenue funding as identified within this business case that is necessary to implement this project.

Constraint 2: The availability of the suitable resource to fulfill the roles identified in this business case to implement the preferred option.

Constraint 3: The solution must be capable of being implemented in a way that causes minimum disruption to services on each site and does not pose a risk to the timely and accurate production of Clinical correspondence

Constraint 4: Capacity availability within the Trust - Additional resources including project management and training will be required to ensure that the system is rolled out efficiently and used to maximum capacity within the Trust. There will also be a need for Operational Service Leads, who have knowledge of the services and will assist with developing the process.

Constraint 5: Security & Confidentiality - All IM&T initiatives within the Trust must comply with security and confidentiality legislation such as the Data Protection Act, the NHS Policy on Openness and the Caldicott Report.

The system must also conform to the HSC ICT Security Policy and be maintained to comply with any changes to this policy.

Constraint 6: Training & Development - System users will require training and development to be made available on the new system. Induction for new on a recurring basis staff must also be considered, as well as refresher training.

Constraint 7: Infrastructure Constraints - The solution must be capable of overcoming infrastructural constraints. Connection to the HPSS network must be considered for satellite sites.

Constraint 8: Staff Resistance - Some analogue system users may be resistant to change particularly staff with limited ICT skills which must be able to be overcome by the potential usability of the new system and a comprehensive training package.

Constraint 9: IT Strategy - Any solution implemented by the Trust must comply with the Trust's IT strategy and existing Regional technical standards and policies.

Constraint 10: IT Harmonization – Consideration must be given to the ongoing harmonization project within the SHSCT. At present 4 legacy domains are being rationalized into a single Southern Trust domain. This will impact on the users ability to logon to the Trust infrastructure across sites to access such applications as Digital Dictation

2.3 Assumptions

The project is predicated on the following assumptions:

- Funding is available and continues throughout the life of the project
- System available to meet the requirement set out in the Statement of Requirements to provide an integrated Digital Dictation System.
- Resources available to assist the project implementation team.
- Current / planned IT infrastructure will support implementation of a Digital Dictation System

2.4 Exclusions

Exclusions from this Project include the Labs and Radiology Departments within the Acute Services Directorate. Both areas already incorporate a digital dictation system within bespoke applications hosted there.

In addition Acute Paediatrics and Older People & Primary Care specialties will also be excluded from this implementation.

Due to bandwidth restrictions on the HPSS network it is not possible at present to operate the Digital Dictation System in Kilkeel Primary Care Centre or Crossmaglen.

2.5 Interfaces

The other projects and pieces of work that interface with this project are:

Interface 1: Clinicom PAS. The digital Dictation system must interface with the Clincom PAS which contains an Index of all Patients. The interface is one-way, data inward. The system will verify the scanned patient Hospital number against the patient index and populate demographic details, including H&C number.

Interface 2: GP Systems. The system must be able to provide an interface to the following GP clinical systems document management systems, to enable the distribution of clinical correspondence directly to Primary Care and create a seamless process for delivery of clinical correspondence from secondary care to primary care:

1. PCTI Docman
2. Apollo 2 EDRMS.

These interfaces would be one-way, data outward interfaces, based on patient HCI number and GP Cypher Code on the correspondence (GP information originally from PAS).

Interface 3: Patient Document System. The system must interface with the Patient Document System (iSoft Patient Centre) to enable patient details to be automatically populated from the Digital Dictation solution into the document being created in the Patient Document System.

2.6 External Dependencies

This project is externally dependant the ability of the digital dictation system to interface with the GP EDRMS Systems, Clinicom PAS and Patient Centre

2.7 Tolerance

The tolerances for this project are:

Timescale – The workflow mapping exercises are to be commenced by end of March 2011. Interfaces between the relevant system to be completed by end of June, with a pilot to commence by July 2011 for a period of 4 weeks. The

complete rollout of the Digital Dictation system to be complete by end of October 2011

Budget – As outlined in Business Case is £249k

2.8 Benefits

The benefits associated with the implementation of a Digital Dictation System will:

- Reduce the risks associated with tape media, therefore improving patient information security.
- Provide a high quality, clear and more efficient system for secretarial and administrative staff to use.
- Improve sound quality.
- Provide an alternative to tape which will be phased out as a recording media over the next few years.
- To allow more even distribution of typing across Trust resources through improved management information.
- To facilitate a paperless exchange of clinical letters to GPs.
- Include the availability of online Medical Dictionaries

3. Approach/Process/Execution and Plan

3.1 Approach

The project will commence with initial focus on the development of interfaces with Clinicom PAS and the two GP EDRMS systems (PCTI Docman and Apollo 2). Once the interfaces are complete the Project will run a pilot within one speciality across the Trust to allow the complete process and localities to be tested. This pilot will run for a period of 4 weeks.

Following evaluation of the pilot the Trust will then rollout the Digital Dictation System speciality by speciality across all of the sites. The rollout will be complete by end of October 2011.

3.2 Initial Project Plan/Milestones

- Relevant Hardware and software installation –
- Interface development with Clinicom PAS and GP EDRMS Suppliers.
- Pilot testing period of 4 weeks
- Pilot evaluation
- Initiation of Rollout
- Project Closure

4. Contingency Plans

In the event of any failures in the system, dictations can be saved locally to PC desktops and when service resumes these can be released to the Server. In the event of PCs being unavailable, analogue dictation systems can be used.

5. Project Organisation Structure

5.1 SRO

The Senior Responsible Owner for the project is Simon Gibson, Assistant Director of Acute Services

5.2 Project Manager

The Project Manager for the project is Barrie Meneely, ITS Programme Management

5.3 Project Steering Group

The Project Steering Group will consist of the following members:

Simon Gibson - Assistant Director of Acute Services – Best Care Best Value

Barry Conway - Assistant Director of Acute Services – Medicine and Unscheduled Care

Heather Trouton - Assistant Director of Acute Services – Surgery and Elective Care

Anne McVey - Assistant Director of Acute Services – Integrated Maternity, Women's Health and Neonatology

AMDs – Dr Eamon Mackle, Dr Philip Murphy, Martina Hogan

Siobhan Hanna – Assistant Director of Informatics.

5.4 Project Implementation Group

The Project Implementation Group consists of the following members:

Name	Division/Organisation
Barrie Meneely	
Catherine Weaver	
G2 Speech Rep	
Clinical Rep	
Secretarial Rep	
Sharon Glenny Phyllis Richardson	
Staff Side	
Louise Devlin	
Eileen Murray	

5.5 Workgroup Membership

IT Workgroup

John McCambridge	IT Infrastructure Manager
Edith Doyle	IT Service Desk Manager
Louise Boyd	IS Training

Work Process Subgroup

OSLs	

Secretary	
Admin Manager	
Supplier Rep	

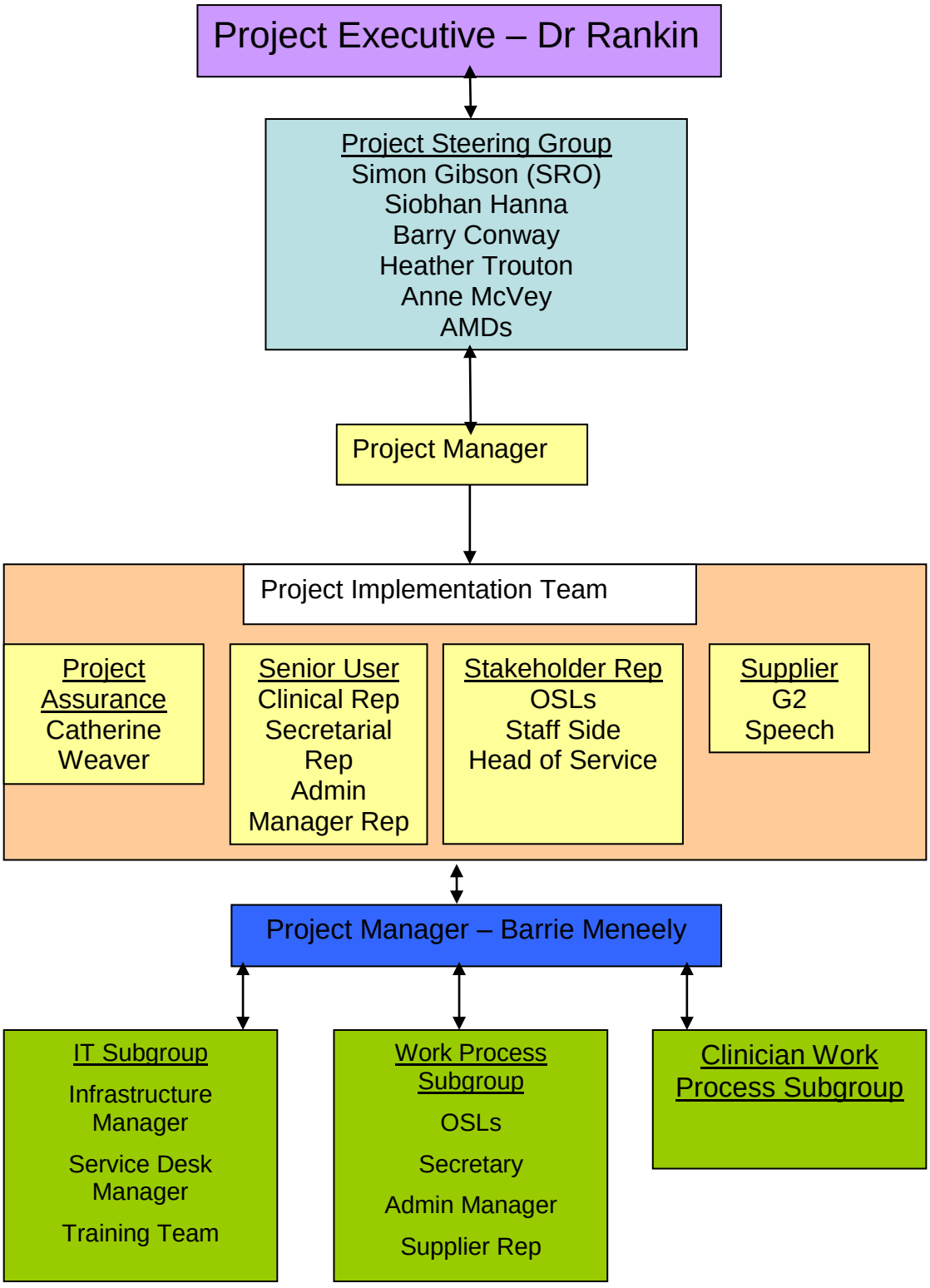
Clinician Work Process Subgroup

5.6 Assurance panel

The following members will provide assurance to the project

Siobhan Hanna		

5.7 Project Structure



5.6 Project Filing Structure

The electronic project files will be kept within the Trust's agreed fileplan structure – IT/Projects

The paper project files will be kept by the Project Manager

6. Communication and Stakeholders

6.1 Communication method

(This is a key component in any change initiative

The key communications channels are: eBrief, A&C Staff meetings and Medical Staff meetings.

6.2 Stakeholders

The stakeholder map at Appendix A sets out the following:

a. The identity of the stakeholder;
b. The nature of the stakeholder's interest in the project;
c. The stakeholder's information requirements;
d. The channels through which these requirements will be met;
e. The timing of such communications.

7. Reporting Cycle

7.1 Project Initiation

The project will formally start when the SRO and Project Implementation Team have approved this project document.

7.2 Reporting Periods

The Team will meet the Project Manager weekly in the first instance

The Project Manager will meet the Project Executive weekly in the first instance

7.3 Decision Points

The following sets out the points when key decisions must be taken:

Workflow workshops

Pilot Sites

7.4 Exception Reporting

Exception reporting will be carried out by the Project Manager as required.

7.5 Project Issues

Project issues may be raised by anyone with an interest in the project at any time.

The Project Manager will manage the issue log.

The initial Issue log is attached at Appendix B

7.6 End Project Notification

The project will be formally closed by the SRO when all sites have received the relevant hardware, software has been successfully installed, and all relevant staff have received adequate training and are competently using the system.

8. Risk Assessment

The risks relevant to Project are contained in the initial risk log at Appendix C.

Appendix A: Stakeholder Map

Key to Relationship Column:

A: Role is Affected/Changed by Programme, or Programme contributes to success of external organisation or project.

B1: Directly Benefits from the Programme

B2: Indirectly Benefits from the Programme

C1: Directly Contributes to the Programme

C2: Indirectly Contributes to the Programme

Stakeholder	*Interest*	*Relationship*	*Notes*	*Info Requirements*	*Channel*	*Timing*
Medical Secretary	User					
Audio Typist	User					
Admin Manager	User					
OSLs	User					
Consultants	User					
Junior Doctors	User					
IT Staff	Supplier stakeholder					
GPs						
System Supplier – G2 Speech	Supplier					

Appendix B: Initial Issue Log

No	Name	Description	Owner	Action & Progress	Action Date	Status
001	Infrastructure Readiness	Mr Hylands explained that it is not possible to have the servers required for DD in place until BT, as part of the ongoing harmonisation, have completed other essential infrastructure modifications.	Head of IT	Mr Hylands to provide an update on timescales		OPEN
002	User Authentication	Requirement for Consultants to logon using own user account at different sites. IT have advised that this will not be possible until a successful migration across to the Southern Trust platform for these users has taken place	Head of IT	Head of IT confirmed CAH users to be migrated first. This is to be complete by June 2011.		OPEN

Appendix C: Initial Risk Log

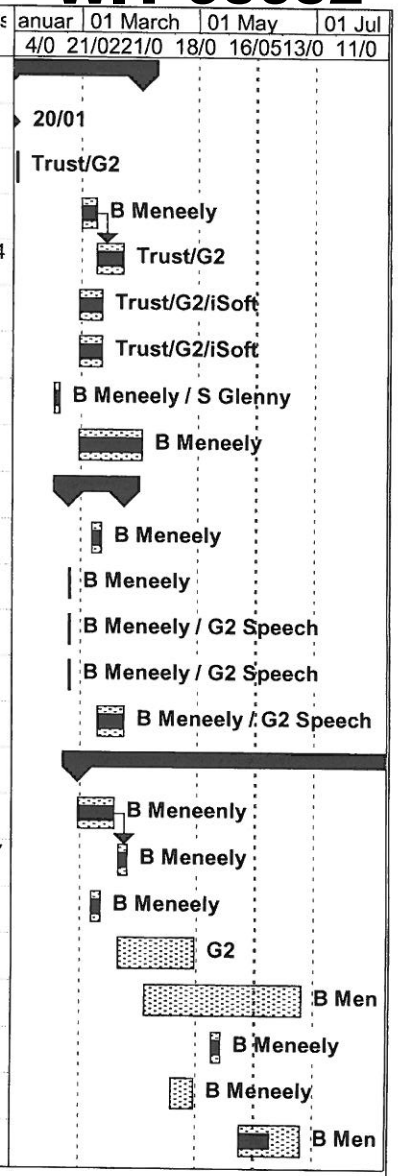
No	*Risk Description*	*Example Scenario*	*Impact*	*Likelihood*	*Owner*	*Management Strategy*	*Resource Requirements*	*RAG Status (Red Amber, Green)*
001	Poor communication between project and service		**MODERATE**	**UNLIKLEY**	**B Meneely**	Communication Strategy targeting all staff involved via eBrief and Staff meetings with clear Agendas and accurate timely minutes.	Feedback to staff groups, team meetings. Updates on eBrief. Meetings with stake holders. Provision of updates on Intranet. Global emails from Director of Acute Services. Emails to Clinicians and Secretaries, Audio Typists	**GREEN**
002	Poor communication within Project Team		**MODERATE**	**UNLIKELY**	**B Meneely**	Understanding amongst Project Steering Group and Implementation Group of Organisational Plan. Work Packages to be issued to IT Subgroup, Work Process Subgroup and Clinician Work Process Subgroup with highlight reports tabled on a monthly basis at Project Board	Work packages, clear roles and responsibilities, project plan. Regular highlight reports, reports to Project Board	**GREEN**

No	Risk Description	Example Scenario	Impact	Likelihood	Owner	Management Strategy	Resource Requirements	RAG Status (Red Amber, Green)
003	Loss of key staff involved in Project		High	unlikely	Simon Gibson Siobhan Hanna	Recruitment for Band 4 Systems Admin (IT) and Band 6 Server Manager	Provision of written work packages, updates on progress to Project Board, Highlight Reports. Communication with Project Manager. Ensure Issue Log is created and shared.	AMBER
004	No support from service		High	Likely	Simon Gibson	Meeting with Services and feedback considered and actioned appropriately	Involvement of staff within service, regular updates at staff meetings. Project Implementation Group to include wide ranging membership	RED
005	Inability to release staff for training due to service pressures		Possible	High	Simon Gibson	Staff to be trained in advance of go-live. Service must enable staff to be released to attend training. This will include Super Users within IT and IS. Services must provide contingency to ensure services are maintained during the training period.		RED

No	*Risk Description*	*Example Scenario*	*Impact*	*Likelihood*	*Owner*	*Management Strategy*	*Resource Requirements*	*RAG Status (Red Amber, Green)*
006	Non acceptance of role by clinicians		HIGH	UNLIKELY	Simon Gibson	Communication with Clinicians. Involvement of Clinicians with decision making. Evidence of benefits of change.	Clinicians included in Project Implementation Group and will receive all relevant communication. Attendance of Steering Group at Medical Staff Meetings	AMBER
007	Non acceptance of role by Secretaries and Audio Typists		HIGH	UNLIKELY	Simon Gibson	Communication with these groups to ensure they have adequate representation and are involved in decision making process.	Secretarial staff to have representative on Project Implementation Group alongside Staff Side and Admin Manager representatives	AMBER
008	Inability to link with GP Systems		HIGH	UNLIKELY	Supplier	Communication between Suppliers of GP Systems and Digital Dictation Supplier. Communication with GPs to highlight benefits for their work processes.		AMBER
009	Funding to support the development of a link to GP systems		MODERATE	UNLIKELY	Siobhan Hanna			GREEN
010	Accessibility of USB Speech Mikes and Transcription Kits		LOW	UNLIKELY	Supplier		At present USB ports locked down as a security precaution. IT to test new hardware and ensure full functionality is achieved.	GREEN

No	*Risk Description*	*Example Scenario*	*Impact*	*Likelihood*	*Owner*	*Management Strategy*	*Resource Requirements*	*RAG Status (Red Amber, Green)*
011								

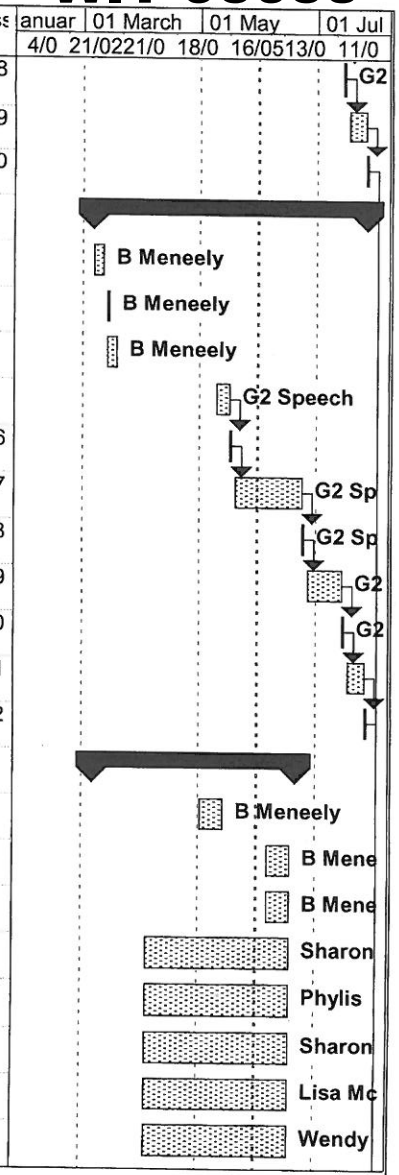
ID	Task Name	Duration	S...	Finish	decess
1	**Project Planning & Kick-Off**	**52 days?**	**Thu 20/01/11**	**Fri 01/04/11**	
2	Setup Project Team	0 days	Thu 20/01/11	Thu 20/01/11	
3	Project Technical Meeting	1 day	Wed 26/01/11	Wed 26/01/11	
4	Organise Fortnightly Project Team Meetings	6 days	Tue 01/03/11	Tue 08/03/11	
5	1st Project Workflow meeting (pilot Specialty)	10 days	Wed 09/03/11	Tue 22/03/11	4
6	1st Interface Meeting	10 days	Mon 28/02/11	Fri 11/03/11	
7	Confirm Interface Spec	10 days	Mon 28/02/11	Fri 11/03/11	
8	Detailed List of Pilot Users	3 days	Tue 15/02/11	Thu 17/02/11	
9	Identify Consultation Rooms for Pilot Specialty	25 days?	Mon 28/02/11	Fri 01/04/11	
10	**Project Deliverables**	**21 days?**	**Wed 23/02/11**	**Wed 23/03/11**	
11	Project Mandate	5 days?	Mon 07/03/11	Fri 11/03/11	
12	Project Structure	1 day?	Wed 23/02/11	Wed 23/02/11	
13	Project Initiation Document	1 day?	Wed 23/02/11	Wed 23/02/11	
14	Project Plan	1 day?	Wed 23/02/11	Wed 23/02/11	
15	Work Packages	10 days?	Thu 10/03/11	Wed 23/03/11	
16	**Communication**	**195 days?**	**Mon 28/02/11**	**Fri 25/11/11**	
17	Develop Project Communication Strategy	15 days?	Mon 28/02/11	Fri 18/03/11	
18	Engage with Communication Team	5 days?	Mon 21/03/11	Fri 25/03/11	17
19	Develop e-brief article announcing project	5 days?	Mon 07/03/11	Fri 11/03/11	
20	Supplier to develop Promotional material	30 days?	Mon 21/03/11	Fri 29/04/11	
21	PM & supplier to attend Staff Briefings (A&C, Medical meetings)	60 days?	Mon 04/04/11	Fri 24/06/11	
22	Develop e-brief article - Pilot	5 days?	Mon 09/05/11	Fri 13/05/11	
23	Promotional Material distributed to staff	10 days?	Mon 18/04/11	Fri 29/04/11	
24	Engage with Southern Trust Practice Managers Association - Sharon Clarke	24 days?	Tue 24/05/11	Fri 24/06/11	



Task
Milestone
Summary
Rolled Up Task
Rolled Up Milestone
Rolled Up Progress
Split
External Tasks
Project Summary
Group By Summary
Progress
Deadline

Received from Sharon Glenny on 12/05/2023. Annotated by the Urology Services Inquiry.

ID	Task Name	Duration	Start	Finish	decess
49	Test Integration Phase 2	1 day?	Fri 15/07/11	Fri 15/07/11	48
50	Internal Integration Work following Phase 2 testing	7 days	Mon 18/07/11	Tue 26/07/11	49
51	Final Integration testing phase	1 day	Wed 27/07/11	Wed 27/07/11	50
52	**GP EDRMS interface**	**103 days?**	**Mon 07/03/11**	**Wed 27/07/11**	
53	Determine Interface requirements	5 days?	Mon 07/03/11	Fri 11/03/11	
54	Schedule Meeting G2 Speech and EDRMS supplier	1 day?	Mon 14/03/11	Mon 14/03/11	
55	Meeting between G2 Speech / Trust / EDRMS supplier	5 days	Mon 14/03/11	Fri 18/03/11	
56	Prepare functional specification for integration schedule of works	5 days	Tue 10/05/11	Mon 16/05/11	
57	Schedule work to carry out integration	1 day	Tue 17/05/11	Tue 17/05/11	56
58	Carry out integration work	25 days	Fri 20/05/11	Thu 23/06/11	57
59	Test Integration Phase 1	1 day	Fri 24/06/11	Fri 24/06/11	58
60	Internal Integration Work following Phase 1 testing	14 days	Mon 27/06/11	Thu 14/07/11	59
61	Test Integration Phase 2	1 day?	Fri 15/07/11	Fri 15/07/11	60
62	Internal Integration Work following Phase 2 testing	7 days	Mon 18/07/11	Tue 26/07/11	61
63	Final Integration testing phase	1 day?	Wed 27/07/11	Wed 27/07/11	62
64	**Site Survey**	**76 days?**	**Mon 07/03/11**	**Mon 20/06/11**	
65	Site Survey CAH & BPC Outpatients (including Gynae)	10 days?	Mon 02/05/11	Fri 13/05/11	
66	Site Survey DHH Outpatients (including Gynae)	10 days?	Mon 06/06/11	Fri 17/06/11	
67	Site Survey STH & ACH Outpatients	10 days	Mon 06/06/11	Fri 17/06/11	
68	Consultants Office PC, Secretary PC, Audio Typist PC Ward PC Pilot	55 days?	Mon 04/04/11	Fri 17/06/11	
69	Consultants Office PC, Secretary PC, Audio Typist PC Ward PC- Host Name and	55 days?	Mon 04/04/11	Fri 17/06/11	
70	Consultants Office PC, Secretary PC, Audio Typist PC Ward PC Surgical - Host N	55 days?	Mon 04/04/11	Fri 17/06/11	
71	Consultants Office PC, Secretary PC, Audio Typist PC Ward PC - Host Name anc	55 days?	Mon 04/04/11	Fri 17/06/11	
72	Consultants Office PC, Secretary PC, Audio Typist PC Ward PC - Host Name and	55 days?	Mon 04/04/11	Fri 17/06/11	



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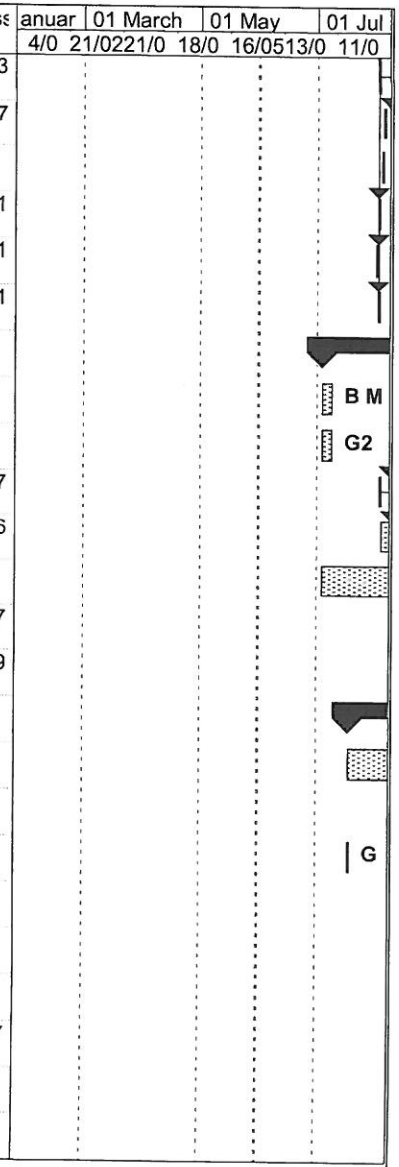
Rolled Up Milestone
Rolled Up Progress
Split
External Tasks
Project Summary
Group By Summary
Progress
Deadline

Received from Sharon Glenny on 12/05/2023. Annotated by the Urology Services Inquiry.

ID	Task Name	Duration	Start	Finish	decess
97	Train the System Admin Training	1 day	Tue 02/08/11	Tue 02/08/11	63
98	Train the Admin & Clerical Staff	1 day	Fri 05/08/11	Fri 05/08/11	97
99	Train Medical Staff	1 day	Thu 04/08/11	Thu 04/08/11	
100	Train Admin Managers	1 day	Tue 02/08/11	Tue 02/08/11	51
101	Train the IT Department - technical training	1 day	Mon 01/08/11	Mon 01/08/11	51
102	Train the Project Management Team training	1 day	Tue 02/08/11	Tue 02/08/11	51
103	**Pilot**	**53 days**	**Mon 04/07/11**	**Wed 14/09/11**	
104	Create user accounts for Pilot and config	5 days	Mon 04/07/11	Fri 08/07/11	
105	Deploy interface files and configure MediSpeech	5 days	Mon 04/07/11	Fri 08/07/11	
106	Test Pilot User Systems	1 day	Wed 03/08/11	Wed 03/08/11	97
107	4 week Pilot on live system with PAS and GP EDRMS integration	25 days	Thu 04/08/11	Wed 07/09/11	106
108	FIloor Walking in pilot specialty	26 days	Mon 04/07/11	Mon 08/08/11	
109	Post pilot meetings	5 days	Thu 08/09/11	Wed 14/09/11	107
110	Sign Off on Pilot	0 days	Wed 14/09/11	Wed 14/09/11	109
111	**Rollout to other Specailties**	**75 days?**	**Mon 18/07/11**	**Fri 28/10/11**	
112	Workflow workshops	20 days	Mon 18/07/11	Fri 12/08/11	
113	Configuration of system for other specialties	25 days	Mon 29/08/11	Fri 30/09/11	
114	Training for other areas to be planned	1 day?	Mon 18/07/11	Mon 18/07/11	
115	Rollout to Other Specialties??	20 days	Mon 03/10/11	Fri 28/10/11	
116	**Project Closure**	**11 days?**	**Mon 31/10/11**	**Mon 14/11/11**	
117	Project Closure Meeting	1 day?	Mon 31/10/11	Mon 31/10/11	
118	Project Evaluation	1 day?	Mon 07/11/11	Mon 07/11/11	117
119	Lessons Learned Report	1 day?	Mon 14/11/11	Mon 14/11/11	
120	Formal Project Closure	1 day?	Mon 14/11/11	Mon 14/11/11	



Task
Milestone
Summary
Rolled Up Task
Rolled Up Milestone
Rolled Up Progress
Split
External Tasks
Project Summary
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Progress
Deadline

Glenny, Sharon

From: Glenny, Sharon
Sent: 27 April 2023 15:56
To: Glenny, Sharon
Subject: FW: URGENT Digital Dictation Training for Clinical Staff

-----Original Message-----
From: Meneely, Barrie <[redacted]>
Sent: 20 November 2012 12:08
To: Glenny, Sharon <[redacted]>
Subject: RE: URGENT Digital Dictation Training for Clinical Staff

Will do

Barrie Meneely
ITS Programme Management
Tel: [redacted]
Email: [redacted]

ITS Programme Management - Sharepoint Link

From: Glenny, Sharon
Sent: 20 November 2012 11:59
To: Meneely, Barrie
Subject: FW: URGENT Digital Dictation Training for Clinical Staff

Hi Bazza!

Would you pass this on to Patrick!

Thanks

Sharon

From: Elliott, Noleen
Sent: 20 November 2012 11:13
To: Glenny, Sharon
Subject: RE: URGENT Digital Dictation Training for Clinical Staff

Sharon,

Yes, I have notified Mr Connolly.

Noleen

From: Glenny, Sharon
Sent: 20 November 2012 10:04
To: Elliott, Noleen
Subject: FW: URGENT Digital Dictation Training for Clinical Staff

Hi Noleen

Would this suit Mr Connolly?

Sharon

From: Meneely, Barrie
Sent: 20 November 2012 10:02
To: Glenny, Sharon
Subject: RE: URGENT Digital Dictation Training for Clinical Staff

What about Wednesday afternoon at 2pm in Thorndale?

Barrie Meneely
ITS Programme Management
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

ITS Programme Management - Sharepoint Link

From: Glenny, Sharon
Sent: 19 November 2012 21:59
To: Meneely, Barrie
Subject: FW: URGENT Digital Dictation Training for Clinical Staff
Importance: High

Hi Barrie

Would there be any chance of this being added to the training schedule please.

Thanks

Sharon

From: Elliott, Noleen
Sent: 16 November 2012 17:28
To: Glenny, Sharon
Subject: FW: Digital Dictation Training for Clinical Staff

Sharon,

Mr Connolly is in Thorndale all day Wednesday 21st November 2012 and is available for training then.

Noleen

From: Elliott, Noleen
Sent: 16 November 2012 09:58
To: Connolly, David
Subject: FW: Digital Dictation Training for Clinical Staff

David,

Can you let me know when would be the best time for training.

Noleen

From: Glenny, Sharon
Sent: 13 November 2012 17:11
To: Elliott, Noleen
Cc: Conway, Maria
Subject: RE: Digital Dictation Training for Clinical Staff

Hi Noleen

Would Mr Connolly be available anytime between Monday 19th – Wednesday 21st November?

I have copied Maria in as she will be able to organise your training.

Sharon

From: Elliott, Noleen
Sent: 08 November 2012 14:20
To: Glenny, Sharon
Subject: FW: Digital Dictation Training for Clinical Staff
Importance: High

Sharon,

Mr David Connolly requires refresher training. He will be unavailable in the afternoon of 22nd November due to MDT meeting.

PS. I have not received any training as yet as I have just been appointed urology secretary in August 2012.

Regards.

Noleen

Mrs Noleen Elliott
Mr Connolly's Secretary
Office 13
Level 2
MEC
CAH

Tel: Personal Information redacted by the USI

From: Conway, Maria
Sent: 07 November 2012 11:28
To: Cooke, Elaine; Cowan, Anne; Geraghty, Fiona; Hamilton, Pamela L; Mulholland, Angela; Wortley, Heather; Dignam, Paulette; Elliott, Noleen; Hanvey, Leanne; McCorry, Monica; Troughton, Elizabeth; Heslip, Jennifer; MAXWELL, Sharon; McCullough, Pat; McStay, Sarah; Mulligan, Ruth; OReilly, Janice; Renney, Cathy; Richardson, Shirley
Subject: FW: Digital Dictation Training for Clinical Staff
Importance: High

Hi everyone

Just a reminder RE: digital dictation training for Clinical Staff – dates etc. are below. Please forward details of consultants and their medical teams to Sharon Glenny for 1) training already attended, 2) training/refresher still required.
(Apologies if this e-mail has been forwarded to you already by the Heads of Service).

Many thanks,
Maria

Maria Conway (Mrs)
Service Administrator
Surgery & Elective Care
Acute Services
Lead Nurses' Office - Surgery
Admin Floor
Craigavon Area Hospital

Tel: Personal Information redacted by the USI
(Mornings only - Mon to Fri)

From: Glenny, Sharon
Sent: 02 November 2012 11:02
To: Anderson, Judith; Conway, Maria; Corr, Sinead; Rafferty, Lauri; Scott, Jane M
Cc: Reid, Trudy; Devlin, Louise; Corrigan, Martina; Nelson, Amie
Subject: Digital Dictation Training for Clinical Staff
Importance: High

Dear All

Further to our A&C meetings last Wednesday with all A&C staff, I am now able to confirm that G2Speech will be back in the Trust on Monday 19th November to Wednesday 21st November to deliver training to any clinical staff who have not yet received this. There may be an option for Thursday 22nd November, but if we can try to keep to the other days this would be appreciated.

This will be the last 3 days of training that the company can provide under the current contract, therefore it is essential that we try to work with the company to have as many or all clinical staff trained. During our meeting, we discussed the secretarial staff encouraging their consultants and associated medical teams to attend this training. The company are happy to provide this training in consultant offices, clinics, etc as they have found that actual training sessions were poorly attended.

The OSLs are keeping a schedule for agreed suitable times for G2Speech to meet with the clinical teams. I would be grateful if each secretary could let me know if their consultant and medical team has already attended training and if training is still required, if there is a suitable time during the offered 3 days which G2Speech could provide this. An early response would be very much appreciated.

Kind regards

Sharon

Mrs Sharon Glenny
Operational Support Lead
Surgery & Elective Care
Tel: Personal Information redacted by the USI
Mobile: Personal Information redacted by the USI

Review of Admin and Clerical

June 2010 Update

Southern Health and Social Care Trust

STAFF REPRESENTATION ON WORKING GROUP

- 20 Members in Total – 12 of which were staff representatives
- Included nominations from each site to represent phase 1 staff
- Secretaries
- Ward clerks
- Audio typists

Southern Health and Social Care Trust

PURPOSE OF WORKING GROUP

- Staff representatives and unions to outline the involvement of the admin and clerical teams in the patient pathway from referral to discharge
- Refine the process – removing unnecessary steps in the patient journey while still delivering safe, quality care to patients
- To have one model for all acute sites within the Trust

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WORKING GROUP MEETINGS

- The first meeting to map patient pathway held on 12 May 2010.

- Subsequent meeting held on 19th May and 21st June 2010 to refine process and remove areas that did not add value to the patient journey

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PROCESS MAPPING OUTCOME

- Initially 164 steps identified – 63 issues were raised during discussions.
- 2nd meeting reduced the number of steps in the patient pathway to 122 - 44 issues.
- Subsequent meetings have been and will continue to be held to discuss the 44 issues raised and work towards solutions

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COMMON THEMES

- Similar problems existed on all sites
- Some sites had examples of good practices that were identified for the pathway eg Patient centre and file master
- Issues that caused common delays in service were identified - fragmented communication between departments
- Difficulty in accessing results – goverance, DAR function
- Difficulty in tracking charts outside of core working hours
- Pressures in cancelling clinics at short notice – responsibility for this
- Different procedures from legacy Trusts

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PROPOSED WAY FORWARD

- Agreement - main patient pathway – June
- Process mapping of sub pathways during July-August
  - Diagnostics
  - Health Records/Reception
  - Cancer
  - Referral and Booking Centre
  - Scheduling
- Feedback to main Working group – with representatives from sub working groups - August

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INTERFACE WITH MANAGEMENT, MEDICAL AND NURSING STAFF - ISSUES

- Working Group put forward suggestions to Dr Rankin of best practice re: filemaker, patient centre, lab results and communication with GP's
- Issues from the working group have been highlighted with relevant staff
- Medical staff - re cancellation of clinics and specifying review date
- Nursing staff re: tracking of charts out of hours and information to ward clerk concerning review
- OSLs standardisation of patient documentation
- AD's/ HoS implementation of new work processes to improve patient flow

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Questions?????

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Quality Care - for you, with you

DRAFT

ADMINISTRATIVE & CLERICAL Standard Operating Procedure No.

Title	Discharge Awaiting Results – Outpatients (DARO)	
S.O.P. Number		
Version Number	v1.0	**Supersedes:** v0.1
Author	Operational Support Leads	
Page Count	9	
Date of Implementation	November 2010	
Date of Review	November 2011	**To be Reviewed by: OSL's**
Approved by		

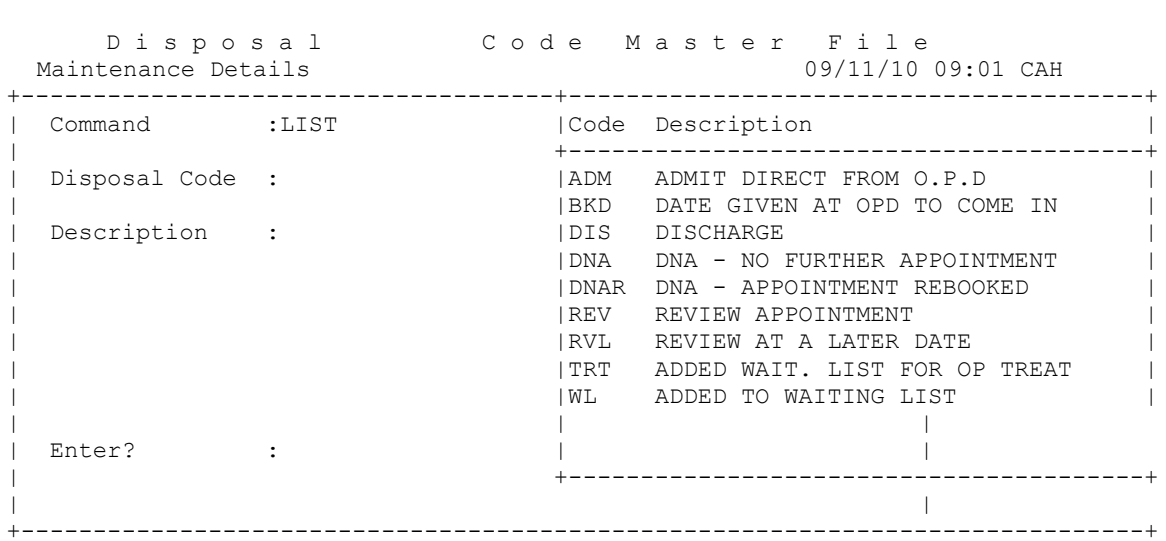
Standard Operating Procedure (S.O.P.)
Discharge Awaiting Results (DARO)

At the end of an outpatient clinic all attendances and disposals (AADs) must be recorded on PAS. Recording “Attendances and Disposals” is an essential part of the outpatient flow, and is required for statistical analysis of clinic outcomes and activity, and can be used for future planning of services and determining capacity & demand. Using “AAD” can also be used as a “failsafe mechanism” by secretarial staff, so as to ensure that all patients who were booked to a specific clinic have had their attendance recorded; to ensure that letters have been dictated and typed for each patient; to ensure that the correct outcome is recorded for each patient – i.e. to ensure that patients are not “lost” in the system and that patients are added to WL for procedures or added for further OP review in the future.

If a patient has attended a clinic and is awaiting results before a decision is made regarding further treatment, the following process must be followed:

Recording Clinic Disposals on PAS

1) ensure all attendances for the clinic have been recorded on PAS using function “AAD” (Attendances and Disposals) – if function “ATT” (Appointment Attendance) has been used by reception staff to record the attendances immediately after the clinic, the attendance codes will default in (i.e. ATT, DNA, CND, WLK)
2) ensure all disposals are now recorded for each patient - the disposal codes which are used within the Trust are shown below:



3) If a patient is awaiting results prior to a decision regarding follow up treatment being made, they must be recorded as a discharge (DIS) **and not** added to the OP Waiting List for review.

4) All outcomes/disposals should be recorded on PAS for each patient. For those patients who have had a disposal code of DIS, WL, BKD, DNA or WL recorded, you will then be prompted to select each patient individually for discharge (when you enter "Yes" – when using AAD function).

```
    R e c o r d       A t t e n d a n c e   a n d   D i s p o s a l
  Outpatients                                          09/11/10 09:12 CAH
+-------------------------------------------------------------------------------+
| Clinic: CS1      Doctor:    CS1      Date: 25/10/2010  Session: 08:00-13:00  |
|                                                            |                  |
|Time  Status   Case Note No Name                  Attd      Disp Grade        |
|08:45 OP REG   CAH12345     BLOGGS, J              ATT      :REV :            |
|08:45 OP DSCH  CAH23456     GREEN, J              :ATT      :WL  :            |
|08:45 OP DSCH  CAH10000     SMIITH, M             :ATT      :DIS :            |
|09:00 OP DSCH  CAH45678     THOMPSON, P           :ATT      :DIS :            |
|09:00 OP REG   CAH56789     BROWN, C              :ATT      :REV :            |
|09:15 OP REG   CAH67890     WEIR, M               :ATT      :RVL :            |
|09:15 OP REG   CAH78900     MACKLE, C             :ATT      :RVL :            |
|09:15 OP DSCH  CAH54321     SLOAN, E              :ATT      :WL  :            |
|09:20 OP REG   CAH43210     MCKEOWN, G            :ATT      :REV :            |
|09:25 OP REG   CAH10101     CLARKE, J             :ATT      :RVL :            |
|09:25 OP REG   CAH10000     BLACK, N              :ATT      :REV :            |
|09:30 OP DSCH  CAHE0000     WHITE, D              :ATT      :WL  :            |
|                                                              |                |
|                                                              |                |
+-------------------------------------------------------------------------------+
```

For those patients who require test results before a decision is made regarding follow-up treatment:

Record using function "AAD" on PAS –

- Record "Discharge On" (discharge date) as the date of the clinic.
- Record Disposal "Reason Code" as ***DARO (Discharge Awaiting Results - Outpatients)***
- Record an appropriate comment in the "Reason Text" field – for example:

    - Await MRI results
    - Await CT scan/x-rays/barium enema/ultrasound etc.
    - Await injection
    - Await blood results
    - Await urodynamics
    - Await histology results
    - Await physiotherapy treatment
    - Await Anaesthetic Assessment

Recording an appropriate comment is vital, so that the reason for discharge and what results are awaited for the patient are known to relevant staff.

Example:

```
       D W           O u t p a t i e n t   D i s c h a r g e
  Referral Details                                  09/11/10 09:23 CAH
 ++Name+-------------------------------------------------------------------------+
++ SMITH, MARY                                        Casenote CAH10000       ++
|+-------------------------------------------------------------------------------+|
|  Consultant          :GENS       A GENERAL SURGEON            |
|  Specialty           :GSUR       GENERAL SURGERY(C)                          |
|                                                              |
|  Category            :NHS        NHS not formal              |
|  Ref By              :GPR        GP ROUTINE REFERRAL (N)                     |
|  Referral Date       :24/10/2008                             |
|  Ref comment         :SG OPD 28.10.08                        |
|  Reason for Ref      :ADV        ADVICE AND CONSULTATION                     |
|                                                              |
|  Priority Type       :1          Routine                     |
|                                                              |
|                                                              |
|  Discharge Date/Time :25/10/2010 12:42                 |
|  Reason Code         :DARO    DCHARGED AWAITING RESULTS OUTPTS       |
|  Reason Text         :AWAIT ULSTRASOUND RESULTS                                |
|                                                              |
+-------------------------------------------------------------------------------+
```

UPDATING PAS AS PER CONSULTANT DECISION - *Add patient to Inpatient/Day Case Waiting List*

When the results are returned to the secretary, and the Consultant has determined that the patient needs to be added to the WL (inpatient or daycase) for a procedure, the OP DSCH **must** be updated:

1) Use function “ODD” (Outpatient Delete Discharge)
2) Type in the casenote number, and ensure the correct patient has been selected.
3) Select the correct OP episode.
4) The discharge details will be displayed for the patients (as shown below).
5) At the prompt ***“Are you sure you want to delete?”*** type in “Yes”.

The OP episode will now be re-opened.

6) Now use function “OD” (Outpatient Discharge) and select the now re-opened OP REG.
7) Record “Discharge On” (discharge date) as the date the tests were carried out.
8) Record Disposal “Reason Code” as ***WL***
9) Record a comment in the “Reason Text” field, “added to WL”

10) Enter “Yes”
11)This OP episode will now have the status of “OP Dsch”.

****This will ensure that the patient is removed from your DARO list.****

Example:

```
      D W          O u t p a t i e n t   D i s c h a r g e
  Referral Details                                  09/11/10 09:23 CAH
 ++Name+-------------------------------------------------------------------+
++ SMITH, MARY                                    Casenote CAH10000       ++
|+-------------------------------------------------------------------------+|
|  Consultant          :GENS       A GENERAL SURGEON            |
|  Specialty           :GSUR       GENERAL SURGERY(C)                        |
|                                                              |
|  Category            :NHS        NHS not formal               |
|  Ref By              :GPR        GP ROUTINE REFERRAL (N)                   |
|  Referral Date       :24/10/2008                              |
|  Ref comment         :SG OPD 28.10.08                         |
|  Reason for Ref      :ADV        ADVICE AND CONSULTATION                   |
|                                                              |
|  Priority Type       :1          Routine                      |
|                                                              |
|                                                              |
|  Discharge Date/Time :01/11/2010 15:42                |
|  Reason Code         :WL    ADDED TO WAITING LIST                    |
|  Reason Text         :ADDED TO WL PER MR MACKLE                            |
|                                                              |
+-------------------------------------------------------------------------+
```

UPDATING PAS AS PER CONSULTANT DECISION - *Patient can be discharged – review not required:*

When the results are returned to the secretary, and the Consultant has determined that the results are normal and the patient does not require further investigation/review, the OP DSCH **must** be updated:

1) Use function “ODD” (Outpatient Delete Discharge)
2) Type in the casenote number, and ensure the correct patient has been selected.
3) Select the correct OP episode.
4) The discharge details will be displayed for the patients (as shown below).
5) At the prompt ***“Are you sure you want to delete?”*** type in “Yes”.

The OP episode will now be re-opened.

6) Now use function “OD” (Outpatient Discharge) and select the now re-opened OP REG.
7) Record “Discharge On” (discharge date) as the date the tests were carried out.
8) Record Disposal “Reason Code” as ***DGP – Discharge to GP***

9) Record a comment in the “Reason Text” field, e.g., “per Mr Murnaghan 22/11/10”
10) Enter “Yes”
11) This OP episode will now have the status of “OP Dsch”.

****This will ensure that the patient is removed from your DARO list. ****

Example:

```
      D W          O u t p a t i e n t   D i s c h a r g e
  Referral Details                                  09/11/10 09:23 CAH
 ++Name+-------------------------------------------------------------------+
++ SMITH, MARY                                    Casenote CAH10000       ++
|+-----------------------------------------------------------------------+|
|  Consultant          :GENS       A GENERAL SURGEON            |
|  Specialty           :GSUR       GENERAL SURGERY(C)                     |
|                                                              |
|  Category            :NHS        NHS not formal              |
|  Ref By              :GPR        GP ROUTINE REFERRAL (N)                |
|  Referral Date       :24/10/2008                             |
|  Ref comment         :SG OPD 28.10.08                        |
|  Reason for Ref      :ADV        ADVICE AND CONSULTATION                |
|                                                              |
|  Priority Type       :1          Routine                     |
|                                                              |
|                                                              |
|  Discharge Date/Time :01/11/2010 15:42               |
|  Reason Code         :DGP    DISCHARGED TO GP                      |
|  Reason Text         :OP DSCH PER MR MACKLE                         |
+--------------------------------------+-------------------------------+
```

UPDATING PAS AS PER CONSULTANT DECISION – *Review patient at outpatient clinic*

If, following the test results, the Consultant determines that the patient is to be reviewed at the outpatient clinic; the secretary must delete the original discharge episode using ODD.

1) Use function “ODD” (Outpatient Delete Discharge)
2) Type in the casenote number, and ensure the correct patient has been selected.
3) Select the correct OP episode.
4) The discharge details will be displayed for the patient (as shown below).
5) At the prompt ***“Are you sure you want to delete?”*** type in “Yes”.

```
      D W          O u t p a t i e n t   D i s c h a r g e
  Referral Details                                  09/11/10 09:23 CAH
 ++Name+-------------------------------------------------------------------+
++ SMITH, MARY                                    Casenote CAH10000       ++
|+-----------------------------------------------------------------------+|
|  Consultant          :GENS       A GENERAL SURGEON            |
|  Specialty           :GSUR       GENERAL SURGERY(C)                     |
|                                                              |
|  Category            :NHS        NHS not formal              |
|  Ref By              :GPR        GP ROUTINE REFERRAL (N)                |
```

```
|  Referral Date       :24/10/2008                          |
|  Ref comment         :SG OPD 28.10.08                     |
|  Reason for Ref      :ADV        ADVICE AND CONSULTATION                  |
|                                                           |
|  Priority Type       :1          Routine                  |
|                                                           |
|                                                           |
|  Discharge Date/Time :01/11/2010 15:42                |
|  Reason Code         :DGP    DISCHARGED TO GP                      |
|  Reason Text         :OP DSCH PER MR MACKLE                                |
+---------------------------------------+                   |
|Are you sure you want to delete? :   |                                   |
+---------------------------------------+-----------------------------------+
```

****The OP episode will now be re-opened.****

You must now add the patient onto the OPWL for their review appointment (if review is required more than 6 weeks later).

6) Use function set “DWA” (District Wide Access)
7) Select function “OWL” (Waiting List Add/Revise/Del/List) and select the re-opened episode. Then you will see the following screen (which showed the last time the patient attended the clinic):

```
     D W          O P   W L   A d d / R e v / D e l / L i s t
  Existing Appointments                                09/11/10 09:45 CAH
 ++Name+-------------------------------------------------------------------+
++ SMITH, MARY                                      Casenote CAHB10000      ++
+-------------------------------------------------------------------------+
|    Status Department    Date      Day  Time   Clinic  Appt With Type     |
|    Site                (*Breach)  By  Date/Time     Rev Date/Time        |
+-------------------------------------------------------------------------+
|    OP WLB: CEMN      Con: EM        Spec: GSUR  Date Reqd:            REV  |
|    (NR) PB1D 23/08/10 CS1 BOOK SEPT                DC6 07/09/10    14:15  |
|                                                          |              |
|    ATT                25/10/2010 MON  08:45  CS1   CS1         NR       |
|           Bk from WL : CEMN       DC6 07/09/10 14:15                    |
|                          ** End of List **               |              |
|                                                          |              |
|                                                          |              |
|                                                          |              |
|                                                          |              |
+-------------------------------------------------------------------------+
   PRESS ENTER
```

8) then you must add the patient to the waiting list for their review appointment.
9) Enter the relevant Waiting List code. (then the Consultant and specialty codes will default in).
10) “Date Required” must be the timeframe the patient is to be reviewed in – this is now a mandatory field and cannot be by-passed.
11) Enter “Appointment Type” as Review.
12) In accordance with the new Regional PAS Technical Guidance, you must enter the Date Required in the “Comment” field – i.e if a patient

requires an appointment in December 2010, you must enter ***"DR 12/10"*** (as shown below)

13) Record appropriate comment in the "Procedure Type" field, so that the reason for review can be ascertained (please see screen dump below):

Examples

- "cancer monitoring – patient must be seen Dec 2010"
- "cancer patient – must be seen by EM in Dec 2010"
- "review with results of MRI"
- "review with histology results"
- "Anaesthetic Assessment complete – review to discuss surgery" etc.

Recording an appropriate comment can also assist in determining whether the appointment is an urgent or routine review.

14) Enter "Date on List" – this should be recorded as the date the test was carried out, and not "T" for today.

Please see screen dump below to illustrate the steps to be taken:

```
      D W          O P   W L   A d d / R e v / D e l / L i s t
  Appointment Pending Details                          09/11/10 09:45 CAH
 ++Name+-------------------------------------------------------------------------+
++ CARSON, MADELINE                                  Casenote CAHB14066       ++
|+-------------------------------------------------------------------------------+|
|                                                                                 |
| Command       :ADD                                                              |
|                                                                                 |
| WL Code       :CEMR                                                             |
| Consultant    :EM                                                               |
| Specialty     :GSUR                                                             |
|                                                                                 |
| Date Required   : 12/2010                                                       |
| Appointment type  :REV  REVIEW APPOINTMENT                                      |
| Transport code  :                                                               |
| Comment         :DR 12/10                                                        |
| Procedure Type  :**CANCER MONITORING - PT MUST BE SEEN IN DEC 2010**            |
| Category        :NHS  NHS not formal                                            |
| Date on List    :01/11/2010          Short Notice  :NO                          |
|                                                                                 |
|                                                                                 |
| Enter?          :                                                               |
+---------------------------------------------------------------------------------+
```

Please Note – a patient must not be added to the OP Waiting List if they are awaiting results and no decision has been made regarding their review date.

Management & Monitoring

A list of all patients who have been discharged using the reason code DARO can be produced by the OSL's/ Service Administrators and used as a failsafe mechanism for checking that all results are returned and that all charts taken are returned.

Out-Patient Reviews

Information Session to A&C Staff

October 2010

Out-Patient Review Waiting Lists New Technical Guidance

- All Trusts been issued with technical guidance for the management of patients on out-patient waiting lists
- PfA 2010/2011 sets a target to address the issue of patients waiting for review appointments
- Effective from September, however, some operational issues had to be resolved before roll out

Out-Patient Review Waiting Lists New Technical Guidance

- Patients with dates in the past
- Making an appointment < 6 weeks
- Making an appointment > 6 weeks
- Open Reviews

- Urgent Reviews
- Discharged Awaiting Results Outcome

Patients Awaiting Results Standard Operating Procedure

Patient Attendance and Disposal Following Clinic

- In the past, a number of staff were using the out-patient review waiting list as a means to manage the group of patients who were awaiting results before next appointment in out-patients
- This has caused an inflation in the actual numbers of patients requiring a review appointment and can lead to inaccurate capacity planning for the future
- In the future, this group of patients will be managed using the DARO disposal code on PAS

Episode Enquiry

Outpatient Referral Details 25/10/10 12:30 CAH

Name

Casenote CAH00000

Consultant :MMU MR M MURNAGHAN
Specialty :ORTH ORTHOPAEDICS(C)

Category :NHS NHS not formal
Ref By :CON CONSULTANT (R)
Referral Date :27/08/2010
Ref comment :REFER FROM # CLINIC L.H.
Reason for Ref :ADV ADVICE AND CONSULTATION

Priority Type :1 Routine

Discharged On :22/10/2010 10:58

Reason Code :DARO DCHARGE AWAITING RESULT OUTPTS

Reason Text :AWAIT MRI RESULTS

<Press Return>

Patients Awaiting Results Standard Operating Procedure

Decision On Receipt of Result

1. **Discharge Patient from Out-Patients**
2. **Add Patient to In-Patient or Day Case Waiting List**

- Revise the OD outcome using the ODD function on PAS
- Delete the discharge
- Use OD and select the re-opened OP Reg and OD the episode, using the appropriate reason code for discharge
- Date of discharge is the date the tests were carried out
- Enter in appropriate comment

This will ensure that the patient is now removed from your DARO list

Patients Awaiting Results Standard Operating Procedure

3. Review Patient at Out-Patient Clinic

- Revise the OD outcome using the ODD function on PAS
- Delete the discharge
- Use OWL and select the re-opened episode and add the patient to the review OP WL
- Date required must be the timeframe the patient is to be reviewed in
- Date added to the waiting list should be the date that the test was carried out and today the date the user is adding the patient to the waiting list, ie, T for today
- Record appropriate comment

QUESTIONS ???????

ACUTE SERVICES DIRECTORATE – ADMIN AND CLERICAL REVIEW

ACTION PLAN FOR ACHIEVEMENT OF FUTURE PATHWAY

Action Number	**SOURCE**	**Issue**	**Recommended Action**	**Recommended Lead**		**UPDATE**
1	Elective	Minor ops referrals not being dealt with in a consistent manner – some going to Personal Secretary and some going to Audio Typist South Tyrone Hospital	For secretaries who book their appointments – keep to original process, secretary responsible for having information available. For schedulers – sec/DPU adds to the list and send info to the schedulers who will hold information and it is their responsibility to ensure the information is available on the day.	Operational Support Leads (OSLs) in conjunction with Personal Secretaries/Audio Typists	PATHWAY ISSUE	Completed
2	Health Records & Scheduling	Direct access referrals being triaged twice and out-patient (OP) registrations not being closed down Who holds the information for the direct access patients to ensure that the relevant information is in the correct chart for admission	Develop and agree a standardised pathway for the management of direct access referrals.	OSLs in conjunction with Personal Secretaries/Audio Typists	PROCESS ISSUE	SOP Required Direct Access referral to be held in file by who ever schedules. The Scheduler will send referral to

Action Number	**SOURCE**	**Issue**	**Recommended Action**	**Recommended Lead**		**UPDATE**
						the appropriate site
3		GP sending multiple referrals for same patient to different consultants/sites	Communication to GPs regarding referral processes to the Trust	Director and AD	PATHWAY	Completed Dr Rankin discussed with Dr Beckett
4		GPs not sending referrals through the Referral & Booking Centre (R&BC) – some still sending directly to personal secretaries	Communication to GPs regarding referral processes to the Trust	Director and AD	PATHWAY	Completed Dr Rankin discussed with Dr Beckett
5		Medical rotas not being issued in a timely manner to allow for booking and scheduling of patients Updates to Rota not being relayed, list cancellation at short notice, having to book/cancel lists at last minute Receipt of anaesthetic cover not in good time (eg DHH no anaesthetist on rota, case mix & complex	Reinforcement to all medical staff of this requirement	Associate Medical Directors (AMDs) and AD's	PATHWAY	Include in future pathway
		Not getting 6 weeks notice for	Reinforcement to all	Associate Medical	PATHWAY	Protocol for

Action Number	**SOURCE**	**Issue**	**Recommended Action**	**Recommended Lead**		**UPDATE**
		consultant annual leave	medical staff of this requirement	Directors (AMD's) and AD's		cancelled clinics – amend form to reflect affect on all clinical activity during period of leave

Action Number	SOURCE	Issue	Recommended Action	Recommended Lead		
6		Booked clinics being cancelled due to short notice leave – uncertainty regarding responsibility for cancelling and rebooking patients – personal secretaries not confident due to infrequency	Clarified - R&BC should cancel and rebook short notice clinics	OSLs in conjunction with HoS Health Records	PATHWAY/ PROCESS ISSUE	Include in Pathway Agreed role of RBC – resource implication
7		Not all flows of waiting list addition patients being captured by the pre-operative assessment process ie. direct access patients, private patients and red flags	Undertake refresher training with personal secretaries in relation to the POA process and ensure that they are aware of the information flow to POA for these patients	OSLs	PROCESS ISSUE	Completed New guidance endoscopy doesn't need pre op
8		Medical staff not dictating clinic letters at the end of the clinic	Confirmation that the dictation forms part of the clinical session Reinforcement to all medical of this requirement	AMDs AMDs	OTHER	Work in progress
9		Charts not being written in by medical staff at clinic	Confirmation on the requirement for handwritten notes to be undertaken in the patient's record	AMDs	OTHER	Work in progress
10		Green forms not always	Agreed that green forms	HoS for Pre-Operative	PROCESS	SOP required

Action Number	SOURCE	Issue	Recommended Action	Recommended Lead		
		being returned to the personal secretaries to facilitate waiting list additions	are collated separately and forwarded to secretary immediately after the clinic	Assessment (POA)		Amie to update Pre op flow chart

Action Number	Timescale	Issue	Recommended Action	Recommended Lead		
11		Personal secretaries partially completing e-request for radiology examinations and also completing other diagnostic request forms on behalf of medical staff Issues with RIS and not reporting. Staff cannot see if report is 'pending to be reported' or if examination. Secretaries still receiving reports back from April 10.	E-requests for radiology and all other diagnostic request forms are to be completed by medical staff Contact details re Radiology information system support to be circulated for information Training to be set up for all A & C Staff	AMDs OSL's OSL C&CS	PATHWAY OTHER	
12		If a patient is a current in-patient and attends an OPD appointment then the chart is tracked with the rest of the clinic back to the personal secretary (block track), whilst the chart is returned to the ward with the patient	If the chart is moving with the patient it should not be tracked, as it will be brought back with the patient. However, if the chart leaves the ward without the patient it must be tracked.	HoS Health Records	PROCESS	SOP This is only an issue if the ward clerk tracks the chart to OPD. Where a patient is still an in patient we don't track the chart if moving from dept to dept

13		Turnaround time for consultants decision on rebooking DNA patients for OP/IP/DC – causes delay for the R&BC, Schedulers/secretaries to follow-up on these patients	Reinforcement to all medical staff to indicate follow-up actions for DNA in a timely manner <u>OP</u> Admin staff at reception to include full history of DNA/CNA in hospital notes for Consultant to make informed decision <u>Elective</u> Pro forma to be completed by ward clerks for all elective DNA (to include patient history). Send to secretary to raise with Consultant. Secretary to update PAS.	AMDs Helen Forde OSL's	PATHWAY	SOP Work in progress
14		Charts being removed from secretarial staff offices and not being returned to allow follow up by secretary Ongoing missing charts	Re-enforce importance of tracking casenotes between offices via SOP	OSLs/HoS Health Records	PROCESS	SOP
15		Personal secretaries ability to request charts (on-site and cross-site) from Health Records for <u>backlog filing</u> etc.	Confirmation of Health Records ability to facilitate these requests Agreement for filing cross site between secretaries/ward clerks	OSLs in conjunction with HoS Health Records	PROCESS	SOP - Productive Office <u>Charts on other sites</u>

			(not back filing) if chart tracked to the secretary <u>Current Filing</u> Chart tracked to another secretary - arrangement to be put in place between secretaries (no older than 2 weeks - current) – with covering note <u>Backfiling</u> Responsibility of secretary If chart in Medical Records on site– secretary responsible for going to records and filing correspondence/results <u>Charts for Consultant Perusal</u> Medical Records will only provide chart for consultant's perusal **Need plan for backlog of filing – to be addressed with AD's (to quantify problem)**			Need to identify staff on each site to file correspondence Ideal pathway all sites – if chart in Medical Records then MR to pull charts (resource issue to quantify) If loose correspondence to be filed and chart in sec office then agreement made to send correspondence to secretary to file

Action Number	SOURCE	Issue	Recommended Action	Recommended Lead		
16 Add to point 15		Filing up of <u>current</u> (not backlog) loose clinical information in charts when removed to another office	Agree across all staff/sites that the holder of the chart will file up loose clinical information when they are in possession of the chart	OSLs in conjunction with Personal Secretaries/Audio Typists/Ward Clerks **Need plan for backlog of filing – to be addressed with AD's (to quantify problem)**	PROCESS	SOP Ideal pathway all sites – if chart in Medical Records then MR to pull charts (resource issue to quantify) If loose notes to be filed and chart in secretary's office then agreement made to send notes
17, 18 , 20 see also 38		<u>Management of OP Reviews</u> - Patients being added to out-patient review waiting list with no 'date required' completed	Develop a protocol for the adding of patients to the out-patient review waiting list Undertake refresher training for all staff involved in this process	OSLs in conjunction with HoS for Health Records OSLs in conjunction with PAS Trainer	- PATHWAY	In process of implementation In line with regional technical guidance re management of OP reviews DARO etc

		- If booking review appointments not always selecting the appropriate OP waiting list (WL) episode – patient then appears to be still waiting on their review appointment - Patients are being booked on 'Protected Review' slots but the OP review (RV) waiting list episode is not being selected			PROCESS	
19		Review appointments following DSU/DPU attendance not being managed by DSU/DPU ward clerks	Train DSU/DPU staff to manage the review appointments post-surgery ie. <6/52 – agree and book appointment with patient prior to discharge and >6/52 – add to OP RV waiting list. (Resource issue). Secretary will be the failsafe – checking that	OSL for Cancer & Clinical Services in conjunction with PAS Trainer	PATHWAY	Audit completed – agree include in pathway ie less than 6 weeks appointment Resource Implications

			all patients have either received their appointment or have been added to the appropriate WL.			

Action Number	SOURCE	Issue	Recommended Action	Recommended Lead		
21		Patients attending multiple consultants within same specialty with multiple open registrations	Develop SOP	OSLs in conjunction with HoS Health Records OSLs in conjunction with PAS Trainer	PROCESS	SOP Put checking mechnanisms in place - needs included in SOP
22		Inconsistency in process of dealing with waiting list removals via patient choice (out-patient, in-patient/day case)	Agree the requirement to notify Consultant, GP and patient of patients choice to be removed from the waiting list Subject to agreement of requirement develop a standardised protocol	AMDs in conjunction with HoS/OSLs/HoS Health Records	PATHWAY	SOP Include in SOP
23		Validity of POA if the patient CNAs/DNAs their admission date – POA only valid for 13/52	Develop a standardised process for the notification to the POA team of a patient's requirement for updated POA following CNA/DNA	OSLs and HoS for POA	Amended PROCESS	Pre Op process to be amended
24		Tracker forms (fitness for discharge information) not being filled in by all nursing staff and ward clerks having to follow-up in order to complete patient discharge	Reinforcement to all nursing staff of their responsibility to complete the tracker in a timely and accurate manner to allow the ward clerk to record the information on PAS and complete the discharge	HoS and Lead Nurses	PATHWAY	Need SOP Raise with AD's

Action Number	SOURCE	Issue	Recommended Action	Recommended Lead		
25		Ward returns not being completed by nursing staff - particularly problematic with emergency admissions at the weekends	Reinforcement to all nursing staff of their responsibility to complete the ward return when admitting, transferring and discharging their patients to allow the ward clerk to record the information on PAS	HoS and Lead Nurses	PATHWAY	Completed Correspondence to All Ward Manager – re monitoring frequency of incomplete Ward Return
26		Wards experiencing difficulty in getting notes for elective admissions – notes are tracked to ward on PAS but notes have not reached the ward	Confirm the process for retrieval and delivery of notes for elective admissions	HoS for Health Records	PROCESS	Helen Forde to action - Agreed charts to be provided 24hr before admission for CEAW and Day Unit
27		Staff not able to access all necessary information on PAS due to password permissions	Update permission levels	OSLs in conjunction with PAS Systems Manager	PROCESS	Work in progress Raise with PAS System Manager/ include in training package
28		Waiting list addition practices – not always using the correct specialty / consultant .	Every ward/office to have a procedure manual in place to ensure all staff are aware of codes to be used, rules around the booking/forwarding charts	OSLs in conjunction with PAS Trainer Secretaries/ward clerks/audio typists	PROCESS	SOP Raise with PAS Systems Manager/ uniformity

			etc			across sites (link to TMS and Health Records)
29		PAD No Outcome Report not being routinely run and completed	Preadmission No Outcome report to be run on a weekly basis by the secretary or the scheduler (dependant on who books the admissions). To be added to the SOP's.	OSLs in conjunction with PAS Trainer	PATHWAY	Need SOP Undertake Training as required for PS, Schedulers

Action Number	SOURCE	Issue	Recommended Action	Recommended Lead		
31	Elective RBC	Not all OP referrals being managed through the R&BC eg. Red flags, TIA, Haematuria and TRUS biopsy, Haematology, Breast Family History CAH, Colorectal, Renal (visiting consultant in STH), Renal in DHH, RACPC, Ante Natal, Heart Failure, Nurse Led Respiratory, Nurse Led Smear, Urodynamics CAH, Orthoptics	Define and agree the outlying referrals that are not appropriate to go through the R&BC eg. red flags etc. Quantify the number of patients from those specialties whose referrals are not currently going through the R&BC 8.9.10 Agreed that the best place for the booking of appts is to be within the RBC with the exception of red flags / cancer related clinics/quick turnaround clinics/ & Obstetrics – with resources. Re Red Flag slots – need to discuss with PAS team re how to book non red flag pts to the red flag slots which are not required for red flag patients.	HoS in conjunction OSLs and the HoS Health Records	Generic - PATHWAY	Work in progress To be agreed

	Elective, RBC and Scheduling	Medication currently issued by A&C staff - new process will require medication/prep etc. to be sent directly to patient by Pharmacists	Need stock take of clinics/ Admissions where medication is sent out to patients. -	OSL's		New Guidelines – pharmacy send out medication – Implementation ??
32		No reception cover for clinics not held in main out-patient departments No reception cover for evening and weekend clinics	Quantify the number of clinics for which no reception cover is available – define which are substantive clinics as opposed to temporary additionality	OSLs in conjunction with HoS for Health Records	PATHWAY/ PROCESS	Need to quantify and identify person responsible for recording attendances

Action Number	SOURCE	Issue	Recommended Action	Recommended Lead		
33	OP	The green 'Waiting List Addition' form not being used by all specialties / all sites – key to POA and maintenance of IEAP timescale for adding patient to waiting list on PAS	Agree the standard use of the green 'Waiting List Addition' form for all specialties / all sites and agreed timescale for implementation. Jeanette to discuss with Barry Conway re green form being used.	HoS in conjunction with AMDs	PATHWAY	Work in progress Assistant Director to discuss with MUSC medical staff
34	OP	Not all patients present back to the reception desk for management of their review appointment: • <6/52 appointment to be booked with the patient before they leave • >6/52 appointment to be added to the waiting list by reception and booked at appropriate time by R&BC - personal secretary should only be the failsafe for this process	Identify the specialties that patients are not having their review appointment booked by the reception staff (for appointments <6/52 and >6/52) - Pain and T & O Develop a protocol for the management of review appointments which includes the processes to be followed for <6/52 appointment or >6/52 appointment (Clinic Outcome Sheet) Medical staff to be advised of protocol to be followed.	HoS/OSLs HoS/OSLs/HoS Health Records Interim Director	PATHWAY	New Process to be implemented SOP

Action Number	SOURCE	Issue	Recommended Action	Recommended Lead		
35 Add to point 34	OP	Not all specialties using the clinic sheet / pro-forma clinic outcome sheet to record clinic outcomes – this provides a failsafe for the personal secretaries to ensure that all patients are followed-up appropriately	Agree the standard use of the clinic outcome sheet for all specialties / all sites and agree timescale for implementation	HoS in conjunction with AMDs	PATHWAY	Work in progress
36 See 34 & 35	OP/secretary	Not all out-patients with procedures being clinically coded	Clarification that all out-patients with procedures are to be clinically coded on PAS Training for the groups of staff agreed to complete the coding	HoS in conjunction with Acting A/D for Performance and Contracts OSLs in conjunction with PAS Trainer	PATHWAY	Work in progress Need to include in Pathway Heather to liaise with Clinical Coding – Audrey McCausland
37	Secretary	Not all personal secretaries undertaking the completion of the 'Attendance and Disposal' functionality on PAS			PATHWAY	SOP

Action Number	SOURCE	Issue	Recommended Action	Recommended Lead		
38 See 17,18,& 20		<u>Management of Review Patients</u> Inability to monitor those patients awaiting test results and follow-up, if required – personal secretaries have no automatic systems available to monitor this – some have implemented manual systems which is a duplication of work	Develop a standardised appropriate reporting system to allow personal secretaries to regularly monitor and action test results / all sites / all specialties Develop a standardised protocol for the management of the patient's out-patient referral whilst test results are outstanding eg. added to OP RV waiting list or OD with comment - discharge awaiting results'	Review Backlog Group	PATHWAY/ PROCESS	SOP In process of implementation –new guidance to be issued (DARO)

Action Number	SOURCE	Issue	Recommended Action	Recommended Lead		
39	Ward	Backlog in lab results due to lab printer problems Doctors checking results from lab system and print off copy on the ward and sign off this copy Doctors not signing off the hard copy of results sent from the lab to the ward Ward clerks dispose of the printed copy and are still required to file hard copy from labs (which they cannot get signed off)	Scope the viability - Ceasing the hard copy of results being printed and sent up from the lab Ward clerks would be required to print results off at ward level from the lab system Doctors would be required to sign off the printed results on a daily basis which would facilitate the ward clerks to file in patient casenote	ADs in conjunction with HoS for Laboratory	- PATHWAY	Acute working group progressing this issue Discussions ongoing - Director/AMD to decide- Medical Staff view results on Labs system and take appropriate action at ward level, make note in CA2 in chart before discharging patient
40		Delay in receiving x-ray results from new system – delay in verification process – staff can no longer can see unverified reports	Review the delays in receipt of results and pursue ability to view unverified reports	HoS in conjunction with HoS for Radiology	PROCESS	Training session to be arranged for Admin Staff
41		Patient Centre not available on all sites – currently Craigavon Area Hospital and South Tyrone Hospital	Installation of Patient Centre on the Daisy Hill Hospital and Armagh Community Hospital sites	HoS in conjunction with HoS for Information Systems	PATHWAY	In progress – Implementation plans in place to roll out to DHH and ACH sites

42		Inability to transfer a patient on PAS from Daisy Hill Hospital to Craigavon Area Hospital – have to discharge and admit	Scope viability of amendments to PAS to facilitate the transfer of patients	HoS for Information Systems	OTHER	Legacy Problem Informatics working with DIS to provide solution

Action Number	SOURCE	Issue	Recommended Action	Recommended Lead		
43		Inability to electronic transfer clinical information eg. out-patient clinic and discharge letters to GPs	Scope viability of electronic transfer of clinical information to GPs	HoS in conjunction with HoS for Information Systems	PATHWAY	Implementation of Filemaker programme – Need clarification from File Maker Group re who admits patient on Filemaker
44		Use of multiple patient hospital casenotes and casenote numbers (site specific) ie. Craigavon Area Hospital, Daisy Hill Hospital etc. Use of specialty casenotes in addition to the hospital casenotes (? completeness of patient information in hospital casenote) eg. yellow chart for T&O, blue chart for neurology, nurse specialist notes	Scope the viability of using only one casenote and one casenote number and resources required to implement and timescale associated with implementation	Director of ASD/AMDs/ADs	OTHER	'Single Patient Single Chart' group

Note: When referring to personal secretary this applies either to personal secretary or audio typist/clerical officer with word processing

HEALTH RECORDS

Action Number	SOURCE	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		Update
1	H Records	STH hospital number appearing in admission pulling list when it should be CAH, and vice versa CAH numbers appearing on outpatient pulling lists for STH/DHH clinics	Vigilence on System when pre admitted and to included in SOP	OSL's/ Training	PROCESS	
2	H Records	Recent changes in recording WL info on PAS now means the procedure does not appear on the pulling list. This means the staff have to go through every PAD episode to find out what the patient is being admitted for, to ensure the admission information is in the chart.	Discuss with OSL's/Helen Forde and Mary McGeough to agree standard approach -		PROCESS	
3	Health Records	Transport issues between sites (*need to expand on examples of this)* Eg transport boxes need to be delivered directly to Health Records library and lifted directly from the Department	Raise with Transport Management	Helen Forde	PROCESS	
4	Health				PATHWAY	

Action Number	SOURCE	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		Update
	Records	Information for admission split across two charts – Health Records have to pull two charts for one admission in some specialities – mostly gynae in CAH – also for outpatients	Discussions to take place with HOS/ Clinical Team	Helen Forde		
5	Health Records	Short notice of admissions being added on, eg notified in CAH at 4pm of an admission at 8.30 am next morning in STH – pressure on health records staff to get chart – transport now gone – no-one in STH to prepare elective care pathway documentation	Formal process to close down requests for OP sessions and elective sessions	Discussions to be undertaken with OSL/HOS	PATHWAY	
6	Health Records	Large volumes of charts held in some secretaries offices – time consuming to go through all the charts	Validation of Charts and Implementation of DARO functionality.		PROCESS	
7	Health Records	Improved casenote tracking of charts in offices, eg charts tracked to results, discharges etc in office - would reduce time spent searching offices for charts	Productive Office	OSL's	PROCESS	

Action Number	SOURCE	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		Update
10	Health Records	If correspondence has to be filed in a chart which has not been raised (NCR), who is responsible for raising the chart?	Notify Health Records who will raise chart and forward to appropriate secretary	Helen Forde	PATHWAY	
11 See 1 Main Pathway	Health Records	Direct Access Admission – if a secretary has the information relating to a Direct Access admission how does this information get into Health Records, and how do Health Records know what DA information is available, or from whom?	Speciality secretary to file correspondence in chart prior to admission.	OSL/ Health Records	PATHWAY	
12	Health Records	Late additions to Kilkeel outpatient clinics are particularly difficult in getting the chart and referral letter to the off site clinic			PATHWAY	

- **REFERRAL AND BOOKING CENTRE**

Action Number	Timescale	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
1		Delay in referral letters coming back from triage – leads to delay when selecting patients.	*HoS to discuss with clinical teams re requirement to adhere to IEAP turnaround*		PATHWAY	
2		Triage of surgical letters in CAH takes place once a week – not in line with IEAP	*R & B C to discuss with Surgical HOS*		PROCESS	
3		Delay in the Under 18 Discharge form being returned from consultant/secretary. RBC staff have to chase up with secretary to ensure appropriate action taken re the under 18 patient.	*Raise with HOS*	Health Records/HOS	Generic – PATHWAY	
4		There are different rules for clinics re discharge of patients who don't respond to PB letters.	*Different Rules for each speciality – keep under review*	HOS	Generic – PATHWAY	
5						

Action Number	Timescale	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
		Referral letters don't always have an up to date telephone or mobile number. Causes difficulty if RBC staff need to contact the patient.	*Communication to GP's*		Generic – PROCESS	
6		Short notice clinics – cause disruption as all normal work has to be stopped to ensure short notice clinic is booked – made worse if clinic not on PAS and manual lists need to be filled in.	Suggest formal process to close down requests for clinics Raise with HOS/ AD		Generic - PATHWAY	
8		The format for creating clinic codes should be devised by the RBC to ensure they are meaningful.	*Advise HOS/OSL*		PROCESS	
9		Delay in getting information regarding cancelled clinics/reduced clinics as information goes first to Head of Service. Too many people involved in	*Process developed and subject to agreement*		Generic – PROCESS	

Action Number	Timescale	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
		process. RBC need to know of cancellations and reductions asap. Often have to follow up with Head of Service re decision.				
10		Haematology clinic should be booked by the RBC.	*Keep in Mandeville due to chemotherapy requirement*		PATHWAY	
11		Red Flags should be faxed through to the Red Flag fax and not posted to the RBC.	*Communication to be issued with GP's re where letters to be sent to*		PATHWAY	
12 See 31 elective		General Surgery patients triaged as colorectal not having their episodes updated on PAS so will still appear on PTL as Gen Surgery – RBC have to chase up information.	*As part of the decision making process re best place to book clinic is R & BC (with resources) – resolve issue*		PATHWAY	
13		Reducing clinics – lot of time spent in reducing clinics –	*Discuss with Heads of Service to see how to reduce time spent* *Speak to Helen Forde -*		PROCESS	

Action Number	Timescale	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
14		ENT reviews – lots of ward reviews which take up the slots calculated for reviews from the OP WL	*Discussion to take place re booking of ward reviews* *May be resolved when booking of less than 6 weeks ward reviews are booked by rbc*		PROCESS & PATHWAY	
15		Some secretaries and ward clerks do not have access to allow them to add to the OP WL and so phone the RBC to ask them to add to the WL.	*PAS team to be provided with access required by secretaries to allow them to add to OP WL, and have associated training*		PATHWAY	
16 See 14		Difficulties in calculating the capacity for reviews – RBC send for reviews, but slots filled and overbooked with ward discharge reviews, so on CBK looks like the clinic is overbooked but really the new patient slots are empty and the review slots are overbooked. Consultant may say not to overbook, so where do the RBC slot in the New patients who need to be seen as there is now no room for the patient.	*Discussion to take place re booking of ward reviews*		PROCESS	

Action Number	Timescale	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
17 See elective issues		Non adherence to 6/52 notification re cancelling/reducing a clinic.	*HoS to remind consultants of need for 6/52 notice for any cancellation of clinics*		PROCESS	
18		If a consultant has more than one secretary on the different sites then one secretary may tell the RBC that clinic cancelled, but secretary from another site doesn't – RBC have to be aware and follow this up.	*Process developed and to be agreed re pathway for cancelling a clinic*		PROCESS	SOP Pro Forma
19		Patient phones the secretary to enquire re their appointment – secretary doesn't provide information to the patient but transfers them to the RBC.	*Secretary should deal with the query as far as possible.* *??? correspondence dealing with queries re backlog review patients*		PATHWAY	
21		Filling cancelled slots – time consuming and can cause difficulties with getting charts	*Where possible fill appointment slot with patient from the site on which the clinic is held to assist with the retrieval of the*		PROCESS	

Action Number	Timescale	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
			chart .			
23		Lots of internal queries re recording issues, staff not having access to carry out certain functions so ask RBC to do them.	*Discuss with PAS team re functions that are needed for individual staff.*	OSL/PAS trainer	PROCESS	
24		PAS access – each password linked to a site, if you are booking a DHH appt but on the CAH access PAS will automatically change DHH number to CAH number – if not noticed puts wrong hospital number on the pulling list for records. Need to see if this could be changed in the PAS setup.	*PAS team to advise*		PROCESS	
25		Acknowledgement letter can only be printed under the CAH access – so if registering the DHH/STH letters have then to go into the CAH access to allow the	*PAS team to advise*		PROCESS	

Action Number	Timescale	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
		acknowledgement letter to be printed.				
26		Acknowledgement letter not available under Patient Letter History.	*PAS to advise*		PROCESS	
27		Have to re-scan referral letters to DHH for some clinics when letters have already been scanned to secretaries.	*Secretaries should send scanned copy to appointments* *Opthamology –problem - talk to HOS*		PROCESS	
28		Referral letter received with no speciality noted – RBC send to consultant they feel would be most appropriate but can be returned as not for that speciality – causes delay in the triage – GP's would need to always record the speciality on the referral letter.	*Discuss with HoS and recognition taken that RBC staff are not clinically trained on referral content.* *Communication required with GP's.* *Communication from AMD to medics that R & BC are not responsible for deciphering appropriate speciality*		PATHWAY	
29						

Action Number	Timescale	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
		RBC should not be expected to read referrals to determine who to send a medical/surgical referral to for triage.	*As above*		PATHWAY	
30		Referral letters should only be written on one side to make it easier for scanning.	*Communication with GP's. Will be resolved with implementation of electronic referral letter system to be implemented in 2010/2011.*		PATHWAY	

CANCER PATHWAY

Action Number	SOURCE	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
1		Delay in triaging (as per cancer pathway should be within 48 hours) – can take anywhere between 1-7 days). Problematic tumour sites include urology, skin and gynae	Communicate to Medical body and re-enforce – via Dr Loughran / AMD's		Generic - PATHWAY	
2		Delay in triaging when consultant is on annual leave	AMD's to discuss need for consultants to cross cover during A/L		Generic - PATHWAY	SOP
3		Multiple entry points for initial red flag referral i.e CAH fax, DHH fax, Ms Sloan's office for breast red flags and on occasions registration & booking office	Will be resolved once electronic referral system is implemented		Generic - PATHWAY	

4		Communication of diagnosis to GPs			Specific - PROCESS	
5		Breast team use their own records at breast symptomatic clinic, all notes are photocopied for CAH notes	Discussion with breast symptomatic team re using CAH notes as main record		Generic - PATHWAY	
7		Waiting list for surgery – are secretaries using red flag comments eg breast currently are not, listed as urgent	SOP to be written re guidelines for secretaries		PROCESS	
8		Adding to PAS waiting list as red flag for ongoing radiology/endoscopy, who should do this and how, also at triage and post Outpatient appointment. Preadmissions on PAS especially endoscopy.	Need further discussion with HoS/Sharon re PAD of patients Green form should be filled in and RF identified – need communication to consultant Ideally Cancer Team should follow patient through pathway i.e pre-admit		Generic – PATHWAY	To be discussed with secretarial staff – to agree way forward
9		Patient cancellations – what should the process be, e.g how many offers is the patient given and also how is cancel and rebook noted on PAS. Similar for DNAs	Finalise regional guidance for cancellations/DNA's of red flag patients and circulate	Cancer Team	Generic - PATHWAY	

10		No electronic system for endoscopy outcome suggestion – Theatre management system or access to endoscribe	Resolved – Trackers have access to Unisoft		- PROCESS	
11		Trackers again manually looking up charts in consultants offices for outcomes of clinics	In elective issues		PROCESS	
12		No electronic system for trackers to know that red flag radiology requested	Red flag can be identified and recorded on RIS Once Business objects module is complete, reports can be run		Specific - PROCESS	
13		Bowel prep needs to be posted out (barium enema) – incurs further delays. Suggestion give to patient at OPD. (Bowel prep is currently under discussion within the Trust)	New process being developed with pharmacy		Generic - PATHWAY	
14		Who books results review appointments after MDT	Ideally review appointments after MDT to be booked by Cancer Team – resources permitted		Generic – PATHWAY	Needs further discussion ie secretarial staff or cancer trackers

15		How /are patients appointments seen in Consultant offices recorded on PAS?	Raised in elective pathway		Generic – PATHWAY	- recorded as ward attenders - Some not recorded Suggest set up ad hoc clinic – Discuss with PAS
16		How are patients having pre operative radiotherapy for rectal cancer noted on the PAS waiting list to ensure that they get their surgery within the allocated time frame?	SOP to be written for clear guidelines		Specific – PATHWAY	?? Patients need to be pre op - after agree decision at MDT
17		Lung issue – lots of re-discussion at MDTs. Linked partially to delay in reporting of CT scans done in STH (red flags) and also other CT scans for staging and treatment.			Specific – PROCESS	

19		Need GPs to include up to date contact numbers (especially mobiles) on referral letters, particularly dermatology. Also GPs need to advise patients that red flag /urgent and also if patient going on holiday.	Communication with GPs – to discuss with AD's		Generic - - PATHWAY	
20		On receipt of referrals who should OP reg them? E.g. should all referrals received in booking centre be OP reg by them, even if they are not booking to ensure that none get lost.	Address with GPs – all red flags to be directed to Cancer Fax		Specific – PATHWAY	Electronics referral will resolve
21		Who is responsible to revise OP reg following triage and also after first appointments etc.	The receiving department		PATHWAY	

24		Overbooking of clinics resulting in the team being not able to use red flag slots – need a better system to ensure the breakdown of non red flag and red flag slots are adhered to when clinics are reduced/ suspended. Booking into red flag slots before they have been released by the cancer team.	Further discussion required with RBC and HoS		Generic – PATHWAY	Suggest have red flag slots on a separate clinic – to run on same day – reduce capacity on scheduled clinic Meet – cancer team, R & BC and PAS
25		Completion of clinic outcome sheets is not always happening at outpatients as a quick reference for tracking team re outcome of patients. (green sheet appears to have replaced this, but does not account for all the outcomes or new red flags).	In elective pathway		PROCESS	

Accident & Emergency

Action Number	Source	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
1		Time involved at reception searching for patient details on PAS and patient understanding of time taken to do this (Patient frustration)	*Patient Information/signage* *Respect Privacy and Be patient etc etc* *Security glass – problem two reception points* *Look at reception areas generally -*		PROCESS	
2		Non UK Nationals have to bring pro forma to cashier's office - this can hinder progress of patient through the system. Form only in English Language - needs to be in other languages	*Group Set up to look at this issue – chaired by Edel Corr*		PATHWAY	
3		Responsibility of A & Clerical staff to "isolate" patients eg chemo patients, chicken pox etc	*Clinical Decision – who responsible ???* *AD/OSL to resolve – laise with nursing/admin staff*		PATHWAY	
4		Patients being taken off Filemaker for TEST WARD	*NB - 2N Test Ward* *All A &E patients added to filemaker*		PATHWAY	
5		Need to discharge and admit inpatients transferring between CAH			PATHWAY	

Action Number	Source	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
		and DHH. Cannot transfer patient on PAS (Server Restrictions)				
6		Adding patients to Filemaker - CAH done by A & E Reception - DHH done by Bed Manager	*Suggest Admission staff enter patients on FIlemaker*		PATHWAY	
7		Referrals to General OPD - if seen by speciality doctor in A & E are registered as Consultant referrals and review - if a new referral to the speciality, the A & E Consultant sends referral to Consultant Secretary ???? OC referrals should be Ore'd by A & E staff and sent to R & B C	*Agree A & E ORE referrals and send to R&BC*		PROCESS	

Action Number	Source	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
8		Seen as " main reception desk" for whole hospital on occasions	*OSL to talk to AD*			
9		Difficulty obtaining information from patients eg drunk, abusive, obnoxious	*Situation escalated when appropriate – to be noted in protocol* -			
10		Typists have difficulties deciphering doctors hand writting	*Filemaker*		PROCESS	
11		READ coding done in CAH and not in DHH - Why !!!	*Discuss with information – re requirement*		PATHWAY	
2		Filing of x ray results and bloods – different procedure in DHH and CAH	*Agree within speciality* -		PROCESS	
13		Sort x ray reports and make decision whether normal or abnormal	*Clinical Decision only –* *Agree not A & C role* *Needs to be addressed*		PATHWAY	
14		Fracture and Review patients booking in at same			PROCESS	

Action Number	Source	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
		time and reception area as new patients				

Cardiac Investigations

Action Number	Source	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
1		Separate Folder for Pacings - general chart also pulled for appointment	*Letter filed in general casenote –* *OK*		PATHWAY	
2		Test Requests - left in different locations No central receiving point	*Need to identify central point* *(need to revise request form)*		PROCESS	
3		TOMCAT to use H & C Number in future	*(To use H & C Number after TOMCAT has been implemented in DHH)*			
4		Do not use TOMCAT in DHH	*(To be implemented in 6th months)*			

Action Number	Source	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
			Access to database for DHH Secretaries			
5		If Direct access needs OP appointment after investigations Direct Access referrals sent Directly to Cardiac Investigations - not triaged by Consultants Not registered on PAS	*Phyllis to speak to HOS re service – triage and recording*		PATHWAY/ PROCESS	

OBSTETRICS - DRAFT

Action Number	Source	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
1		Decisions being made at higher level / other departments – Admin/clerical staff not involved in decision making therefore inaccurate decisions made in relation to streamlining processes			PATHWAY	

Action Number	Source	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
		Example • NIMATS implementation • NIPACS – duplication of reports, results not received in a timely manner				
2		**EPPC:** Incomplete referrals from GP's GP's sending patients to EPPC without referral letter Large volume of walk-in patients at early stages of pregnancy as opposed to going to GP Details on assessment form in EPPC incomplete / inaccurate resulting in time spent chasing individual midwife to confirm details / instructions *Suggestion: Midwives provides verbal information to*			PATHWAY	

Action Number	Source	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
		Ward Clerk who completes form Example • LMP missing • Omit to indicate if interpreter required or which language • Patient's telephone number				
3		**BOOKINGS**: GP's sending antenatal referrals to Regional Booking Centre for all sites e.g. CAH, STH and ACH – time delay in re-directing 10-11 week NICE guideline target too early resulting in significant additional admin/clerical work • Unnecessary wastage of NIMATS charts due to higher volume of miscarriages • Time element involved in creating NIMATS			PATHWAY	

Action Number	Source	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
		number / withdrawing number, issuing appointment to patient, closing episodes, making up charts/labels etc • Having to make another appointment for 12 weeks gestation as Consultant unable to interpret scan accurately				
4		**WARD ATTENDERS**: Proforma required for gynae Ward Attenders who miscarry and should be sent to OPD No field on PAS to enter such information so that Ward Clerk can close down episode and record 'patient miscarried'			PROCESS	Raise with PAS
5		Admin / Clerical staff not involved in design of Antenatal chart resulting in the following:				

Action Number	Source	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
		Therefore did not meet its objective in reducing clerical work • Inadequate room for labels • Stickers on front • No facility for multiple births • No mount sheets for results				
6		All NIMATS numbers preceded with DHH – causes confusion outside the department			PATHWAY	
7		Should all foreign nationals automatically be allocated an interpreter for new/review appointments. Unnecessary expenditure, patients continually requesting specific interpreters (relatives). Phone service may be sufficient for reviews			PATHWAY & PROCESS	

Action Number	Source	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
8		**TRACKING OF MATERNITY CHARTS**: • Not tracked as Hand Held when appropriate • Significant waste of time when pulling clinics • Midwives not completing sheet at clinics to indicate Hand Held/retained • Midwives need to be reminded not to issues charts until 20 week appointment • Charts been given to patients pre-scanning appointment by Doctors/Midwives/Bank staff Dr McCormick's patients charts not retained when induction date allocated			PROCESS	
9		A number of episodes recorded on PAS as clinic attendances as opposed to			PATHWAY	

Action Number	Source	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
		Ward attenders (as per DHH). This can be a significant number in some cases				
10		Pulling of general charts for EPPC patients by Medical Records			PATHWAY	
11		Midwives to file results in antenatal charts when patient attends for review			PATHWAY	
12		Issues surrounding confidential information being filed in patient's chart i.e. Ward of Court, Social Services etc			PATHWAY & PROCESS	

RADIOLOGY PATHWAY

Action Number	Timescale	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
1		E-requests flagged wrongly. For example Routine instead of Red Flag. Incorrect department details. E.g. patient not in hospital, will require outpatient appointment.	Communication with GPS. Walk in seminar arranged in near future		PROCESS	
2		No contact details for patients. E.g. telephone and mobile numbers.	AS ABOVE Internal requests also problematic – Doctors don't have log in details – change over of docs - Raise through AD/AMD (is provision for emergency log in)		AS ABOVE	
3		Patients aren't aware of the urgency of the appointment.	AMDs to communicate with clinicians		PROCESS	

5		Two modalities on one request. Need to be separated for appointing.	Communicate to referring consultant - Need to separate electronic requests Raise with medical staff and systems manager		PROCESS	
8		Patients arrive in department before E-request has been sent.	Commuinicate to referring consultant - wait to end of clinic to do e request but patient has already arrived in x ray		PROCESS	
9		Duplicate requests/unnecessary requests. Not informed if patient no longer requires examination.	Communicate to referring consultant		PROCESS	

SCHEDULING TEAM PATHWAY

Action Number	Timescale	Issue	Recommended Action Actions Agreed by Working Group	Recommended Lead		UPDATE
1		Diabetic, Warfarin, Plavix, Iron, HRT and Pill etc, who do you ask for advice on medication	Patient should be advised re medication at pre op assessment DHH – Gynae patients - Pre OP deal with this Raise with AD – Surgical/Gynae/Medicine			
2		Being able to give information to patients regarding medication as each consultant / speciality has different protocol	See above			

3		Patients don't always have time to come off medication due to short notice of lists	Need SOP Need to indicate on PAS – to assist with scheduling Suggest include section in green Waiting List form – Need comment on PAS			
4		BMI levels for day surgery clarification required – pre –op changing pts over BMI of 40 to in-pts	Medical/Goverance issue At time of pre op - need more communication with Consultant Need anaesthetic assessment Need Guidance			
5		TMS not being up to date, lists not on in advance	Raise with OSL Need backup plan when Lorraine is absent.			
6		Updating/changes to patient comments, has to be updated by Systems Manager	Need to upgrade access to assist with scheduling			

7		Why do theatre lists have to be e-mailed when TMS is a live system	Refreshed access to TMS Facilitate ward staff to access TMS			
8		More care should be taken when adding procedures and correct sides (ie in ortho absence of side or correct side and abbreviations	Raise awareness with staff – no abbreviations			
9		Wrong procedures added to PAS, wrong sides, wrong consultant	Raise awareness with staff			
10		Pt's added twice to waiting list for same procedure/speciality	Raise awareness with staff - Check list Emergency patients – need to inform secretary if patient still on elective list.			
11		Planned pts being added to waiting lists/speciality incorrectly, therefore appearing on the PTL reports too soon	Raise Awareness with staff. Suggest secretary run WL routinely – part of SOP			

12		Anaesthetic cover being confirmed, at short notice resulting in delay and under utilisation. Pts not being seen in chronological order	Suggest formal close down for list			
13 **See 5**		Updates to Rota not being relayed, list cancellation at short notice, having to book/cancel lists at last minute	Better communication between HOS and scheduling team.			
14		Not enough lists for capacity of pts	Capacity Issue - HOS			
15 **See5**		Receipt of anaesthetic cover not in good time (eg DHH no anaesthetist on rota, case mix & complex	Need better system for indicating anaesthetist for DHH lists HOS C &CS			
16		Morning medical lists for diabetic patients – no list available	Raise with OSL/ HOS M&UC			
17		in-pt medical endoscopies who is responsible for scheduling	Raise with OSL/HOS M&UC			
18		Ogd's lack of space	Capacity Issue			

19		Back dating red flag, pts (back within 7 days)	Raise with OSL C&CS Suggestion deal with Red Flags			
20		Red Flags – who is responsible to put patients onto the waiting list	Secretarial responsibility			
21		Marie Wilson – takes only colonoscopies-causes issues with medical lists as consultants don't want too many OGD's	Discussions within medical team			
22		Red flag patients are not always available at short notice	As Above			
23		Red Flag pts don't always have time to come off medication and have to be moved, therefore breaching cancer targets	As Above			
24		Awaiting replies from e-mails can be too slow (ie queries for lists on way forward, eg GA/Local or meds	Issues re rota/ medication etc			
25		Secretaries giving leave etc to schedulers and it not being reflected on rota	HOS not sending information to HOS C & CS re consultant A/L			

26 **See 1 Main pathway**		Referral letters- nothing to do with scheduling office	**Direct Access referrals for specialities within scheduling team to be held by Scheduling Team**		
27		Not enough PAS access to all schedulers for all hospital sites	PAS Issue		
28		Procedure for in mates at her majesty's pleasure going to day procedure or as in pts (protocol should be developed as IR1 form was completed)	Need Protocol -		
29		Secretaries asking for pts to be seen out of chronological order	Instructions should come from Consultant re clinical decision		
30		Pt's being upgraded in urgency and therefore affecting waiting time	Advice from PAS to reflect appropriate wait		
31		Outcomes of lists not being recorded (ie DNA etc) as difficult to unpick what happened eg DHH DNA pt when had attended	Discuss with Wendy		

32		Inappropriate calls to scheduling team (ie pts looking for dates, medication queries)	Suggesting secretary deal with query – epi check etc Only transfer when can't deal with		
33		Target dates not being met			
34		Interpreters required to return, who is responsible to book return appointment	Suggest interpreter should be booked by ward to assist with discharge of patient - use telephone facility Sharon to discuss with Heather Troughton		
35		Who is responsible to book transportation for patients	Sharon to explore with Eileen Murray		
36		Who is responsible for warfarin pts over weekends when GP is closed.	Guidance from Medics		

Action Number	Timescale	Issue	Recommended Action	Recommended Lead		

Glenny, Sharon

From: Glenny, Sharon
Sent: 02 May 2023 16:27
To: Glenny, Sharon
Subject: FW: Triage of referrals
Attachments: Triage Process.docx

-----Original Message-----
From: Carroll, Anita <Personal Information redacted by the USI>
Sent: 17 February 2014 16:10
To: Carroll, Anita <Personal Information redacted by the USI>; Boyce, Tracey <Personal Information redacted by the USI>; Conway, Barry <Personal Information redacted by the USI>; Gibson, Simon <Personal Information redacted by the USI>; McVey, Anne <Personal Information redacted by the USI>; Carroll, Ronan <Personal Information redacted by the USI>; Trouton, Heather <Personal Information redacted by the USI>
Cc: Clayton, Wendy <Personal Information redacted by the USI>; Glenny, Sharon <Personal Information redacted by the USI>; McAreavey, Lisa <Personal Information redacted by the USI>; Richardson, Phyllis <Personal Information redacted by the USI>; Robinson, Katherine <Personal Information redacted by the USI>; Burns, Deborah <Personal Information redacted by the USI>; Stinson, Emma M <Personal Information redacted by the USI>; Lappin, Aideen <Personal Information redacted by the USI>; Hewitt, Irenee <Personal Information redacted by the USI>; Lawson, Pamela <Personal Information redacted by the USI>; Cunningham, Lucia <Personal Information redacted by the USI>; Cunningham, Andrea <Personal Information redacted by the USI>; McCaul, Helen <Personal Information redacted by the USI>; McGinn, Noreen <Personal Information redacted by the USI>; Rafferty, Lauri <Personal Information redacted by the USI>; OHanlon, Carmel <Personal Information redacted by the USI>; Watters, Kate <Personal Information redacted by the USI>; Cunningham, Lucia <Personal Information redacted by the USI>; Loughran, MarieT <Personal Information redacted by the USI>
Subject: Triage of referrals

Dear all

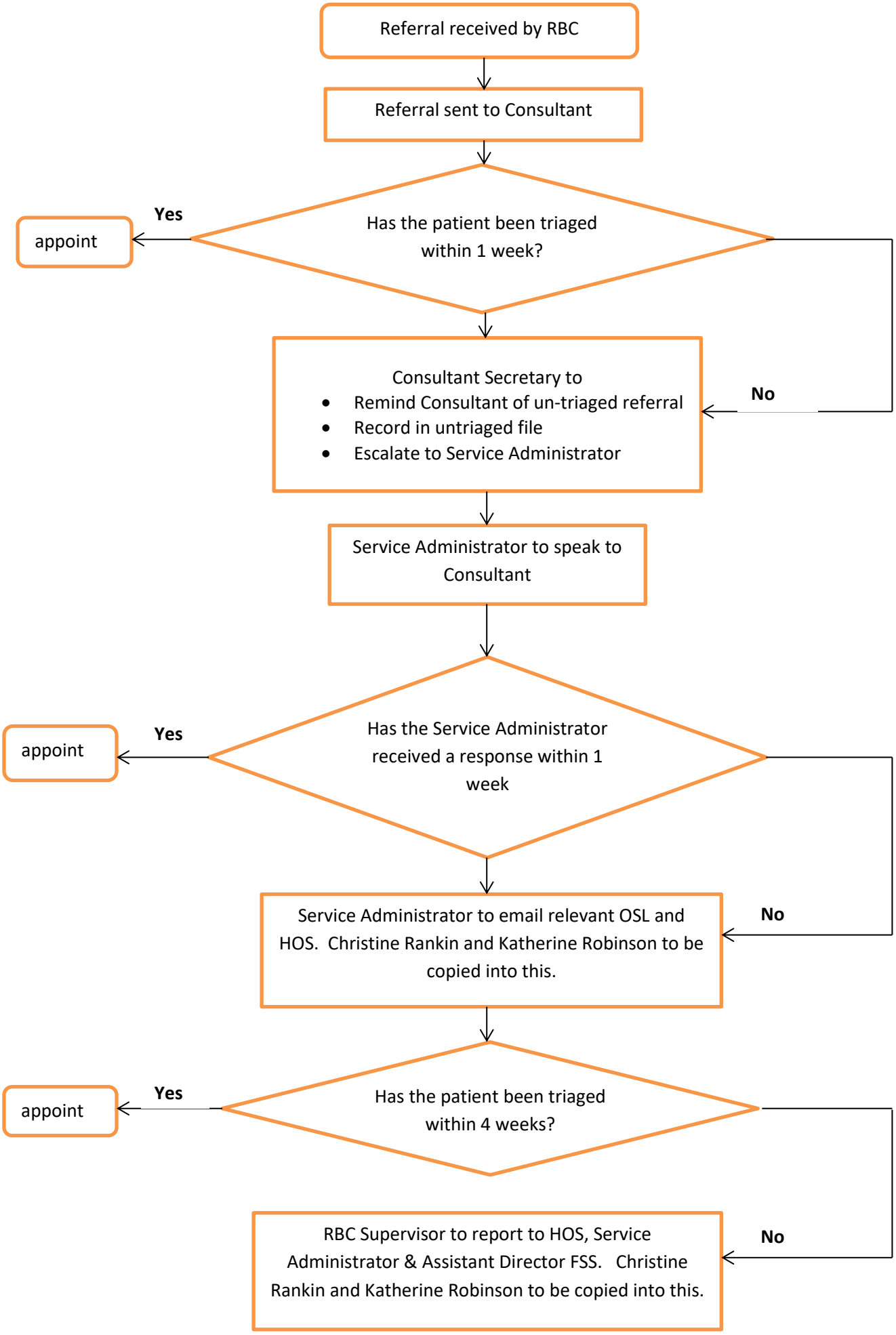
I attach the draft process that we will follow as an interim. I suggested to Heather that we should move to the position of accepting the GP categorisation on referrals if these are not triaged and returned in 1 week then we move to appoint, but I appreciate you would have to discuss with Clinicians. However any comments on process as outlined to be returned to me by Wednesday 19th February otherwise we will ensure this is adhered to by all secretaries and Service Administrators, OSLs and RBC Supervisors and Managers.

Anita

Mrs Anita Carroll
Assistant Director of Acute Services
Functional Support Services
5 Hospital Road
Newry
Co. Down
BT35 8DR

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

TRIAGE PROCESS



Glenny, Sharon

From: Glenny, Sharon
Sent: 27 April 2023 15:52
To: Glenny, Sharon
Subject: FW: DARO REPORT - UROLOGY ONLY - FOR ACTION
Attachments: URO - OPs DISCHARGED WITH REASON DARO (BASED ON APPOINTMENT DATE (ATTENDANCE) RUN 04.02.13.xls

Importance: High

-----Original Message-----
From: Conway, Maria <Personal Information redacted by the USI>
Sent: 05 February 2013 08:45
To: Dignam, Paulette <Personal Information redacted by the USI>; Elliott, Noleen <Personal Information redacted by the USI>; Hanvey, Leanne <Personal Information redacted by the USI>; McCorry, Monica <Personal Information redacted by the USI>; Troughton, Elizabeth <Personal Information redacted by the USI>
Cc: Glenny, Sharon <Personal Information redacted by the USI>
Subject: DARO REPORT - UROLOGY ONLY - FOR ACTION
Importance: High

Dear all

Please find attached the latest DARO report(Discharged Awaiting Results – Outpatients) for Urology only, which requires validation and action by Friday 15 February 2013.

If you have any queries, please contact me.

Kind regards,
Maria

Maria Conway (Mrs)
Service Administrator – ENT & Urology
Surgery & Elective Care
Acute Services
Lead Nurses' Office (SEC)
Admin Floor
Craigavon Area Hospital

Tel: Personal Information redacted by the USI
(Mornings only - Mon to Fri)

Tracking code: CSRBLO

Glenny, Sharon

From: Glenny, Sharon
Sent: 24 April 2023 13:22
To: Glenny, Sharon
Subject: FW: Preparing Urology referrals for triage

-----Original Message-----
From: Glenny, Sharon <[redacted]>
Sent: 03 October 2008 12:58
To: 'Gibson, Simon' <[redacted]>
Cc: O'Brien, Aidan <[redacted]>; Clayton, Wendy <[redacted]>;
'aidanpobrien[redacted]' <aidanpobrien[redacted]>
Subject: RE: Preparing Urology referrals for triage

Dear Simon

From my knowledge of how Aidan triages referral letters, he normally carried out a PAS check on attendances, labs systems for recent reports, and x-ray system for recent x-rays and future planned investigations.

This would require a member of staff preparing this information for him by accessing these systems:

1. screen dumps from PAS regarding attendances 2. searching Labs and printing recent or relevant test results 3. searching x-ray system for recent or related x-rays, and also checking if patients have been referred for future investigations.

In the past I had offered to do this myself for Aidan when I was project manager in ICATS, as this was quite time expensive for him to be doing. It does not require someone of that banding though, if they are experienced and know what they are looking for, although hard to quantify. I'm not sure that this would take a great deal of time to do per patient, maybe 5 minutes, however, it would depend on the volume of patient referrals which Aidan would be dealing with on his turn to be triaging.

Hope this is helpful.

Sharon

Sharon Glenny
Operational Support Lead
Acute Services Division
Direct Dial [redacted]

-----Original Message-----
From: Gibson, Simon [mailto:[redacted]]
Sent: 03 October 2008 09:43
To: Glenny, Sharon
Cc: OBrien, Aidan; aidanpobrien[redacted]; Clayton, Wendy
Subject: Preparing Urology referrals for triage

Dear Sharon

What would be the practical issues required to prepare referrals with lab results for Aidan, in a deal with Aidan to triage within 48 hours.

Kind regards

Simon

Simon Gibson

Assistant Director of Acute Services - Surgery & Elective Care

Southern Health & Social Care Trust

Personal Information redacted by the USI

Personal Information redacted by the USI <mailto: Personal Information redacted by the USI >

P Please consider the environment before printing this e-mail.

Glenny, Sharon

From: Glenny, Sharon
Sent: 02 May 2023 16:38
To: Glenny, Sharon
Subject: FW: Urology referrals

-----Original Message-----
From: Gibson, Simon <Personal Information redacted by the USI>
Sent: 08 October 2008 11:22
To: Glenny, Sharon <Personal Information redacted by the USI>
Subject: FW: Urology referrals

For information

Simon Gibson
Assistant Director of Acute Services - Surgery & Elective Care Southern Health & Social Care Trust
Personal Information redacted by the USI
Personal Information redacted by the USI

P Please consider the environment before printing this e-mail.

-----Original Message-----
From: Mackle, Eamon [mailto:Personal Information redacted by the USI]
Sent: 07 October 2008 20:20
To: Cunningham, Teresa; Gibson, Simon
Subject: Urology referrals

Simon

I met with Michael today (I see Teresa had spoken to him just before me).

He is not keen on taking on Aidan's triaging.

He and Mehmood will take on the backlog to clear it if necessary.

They will meet with Aidan on thursday and discuss it with him.

I said that if the letters are incomplete then they should return them.
I said we would not provide staff to pull all the data. He said the ICATS form has certain requirements re bloods etc thus my sta(ement re returnig letters.

I also said we would not delete other work for aidan as this is rewarding inefficency if both Michael and Mehmood can do it in their time.

I said I would prefer an in house decison/ solution

Eamon

Eamon Mackle
Associate Medical Director
Surgery / Elective Care
Southern Trust

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Glenny, Sharon

From: Glenny, Sharon
Sent: 27 April 2023 17:30
To: Glenny, Sharon
Subject: FW: Referral process
Attachments: ICATS flowchart.ppt; ERMS MDS ICATS UPDATE Sept 06.ppt

-----Original Message-----
From: Aldrina Magwood <Personal Information redacted by the USI>
Sent: 23 November 2006 10:23
To: Glenny, Sharon <Personal Information redacted by the USI>
Subject: RE: Referral process

Hi Sharon – hope the assignment went off ok.

The 72 hours does include weekends as I suppose effectively if a referral was received at 9am on fri it would have to be triaged by mon 9am – i.e. done on the Friday triage session if triage is being arranged in the morning. Alternatively if received at 11 am it would have to be triaged in the mon session etc. Ultimately it will is 72 hours that will be monitored against. But really is unlikely to be possible until ERMS is in place.

I take it your querying as stating 3 days does effectively build in a bit of slack. I would say in these early stages (and given the issues) achieving 3 days in itself will be quite an achievement, but we should just keep an awareness that the 72 hrs will be the target when ERMS is live.

I've attached few flowcharts – some more detailed than others, hope its helpful

Other items you asked about:-

The Trust is responsible for all contract issues with ICATS practitioners. The Service Model/ specification identifies the GP rate paid at 275 per session and it is based on this rate that the Trust funding has been agreed (as well as the rate advertised on job ads – that have gone out regionally – albeit not necessary in your case as GPSI already in post.
-GP rate letter only on hardcopy – Ruth sticking one in post to you.
-Ruth chasing copy of sample contract as we speak. Will forward asap.

Few other items of update from yesterdays regional meeting, which we can discuss in greater detail but just to let you know what's on the horizon:-

ERMS has gone out to tender again, contract going out on revised (pared down) spec. PA consulting have been appointed to take forward and are currently trying to organise within very tight timescales -, workshop/discussions with all stakeholders to arrive at an agreed revised specification for the system. I have forwarded your name (and Louise) as stakeholders for the system within the Trust. If you think anyone else needs involved please advise.

Training for the regional database that is being developed – a training workshop for implementation managers is being arranged (week commencing 4 December)

Weekly reporting of numbers of patients seen from the backlog will need to be sent regionally.

Monthly reporting on urology required (next report for 20 December) to include clinic provision, recruitment process, training , flows (Jenny and Kates activity sheets could be used for this) – basically the stuff you already reported to me for this weeks meeting. Again, I'm happy enough to do it as we did this month as long as I have info. – Not asking for formal report or anything

And last but certainly not least – following success of orthopaedic ICATS Conference which brought clinical teams from across England and Scotland to come and share their experiences of implementing ortho ICATS –like services – it has been agreed that the same sort of thing should be arranged for Urology on a regional basis and as SB have made such significant progress – the task has fallen to me to arrange and organise this one for hopefully sometime in Feb. We will want one presentation certainly from local team (Michael if he'll agree to it) – to share what you's have been doing so far. – Obviously I'll need your help on this one and any suggestions welcome but perhaps you could float the intention with the team and see if any suggestions.

That should do it for now I think. Any queries give me a shout.

A
Aldrina Magwood
SHSSB ICATS Manager

Tel: Personal Information redacted by the USI ext. Personal Information redacted by
DDI: Personal Information redacted by the USI

-----Original Message-----
From: Glenny, Sharon [mailto: Personal Information redacted by the USI]
Sent: 22 November 2006 14:06
To: Aldrina Magwood
Subject: Referral process

Aldrina

I am working on a flow for the referral process into urology. The "72 hours" from receipt to triage, can we use the terminology 3 working days, or is this 72 hours inclusive of weekends?

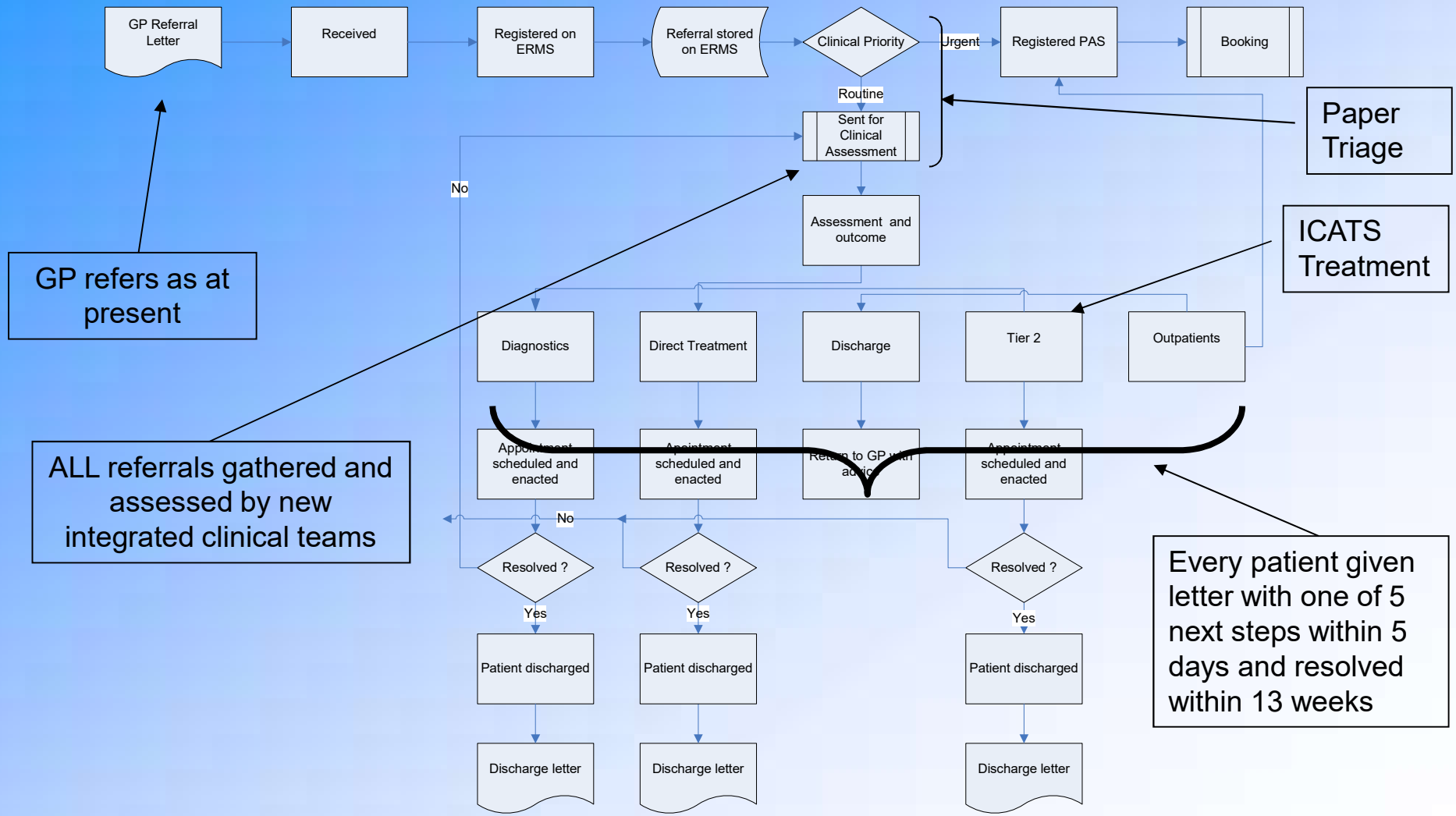
Just for information purposes for myself, do you have any slides or flows for a true ICATS model, eg, waiting times, etc?

Thanks

Sharon

Sharon Glenny
Project Manager
Urology ICATS
Direct Dial Personal Information redacted by the USI

New model supported by new IT systems



Received from Sharon Glenny on 12/05/2023. Annotated by the Urology Services Inquiry.

Integrated Clinical Assessment and Treatment Services (ICATS)

Update September 2006

Aldrina Magwood
SHSSB ICATS Manager

Modernising Elective Care

- No one waiting more than 12 months for in-patient or day case treatment by **March 2006**

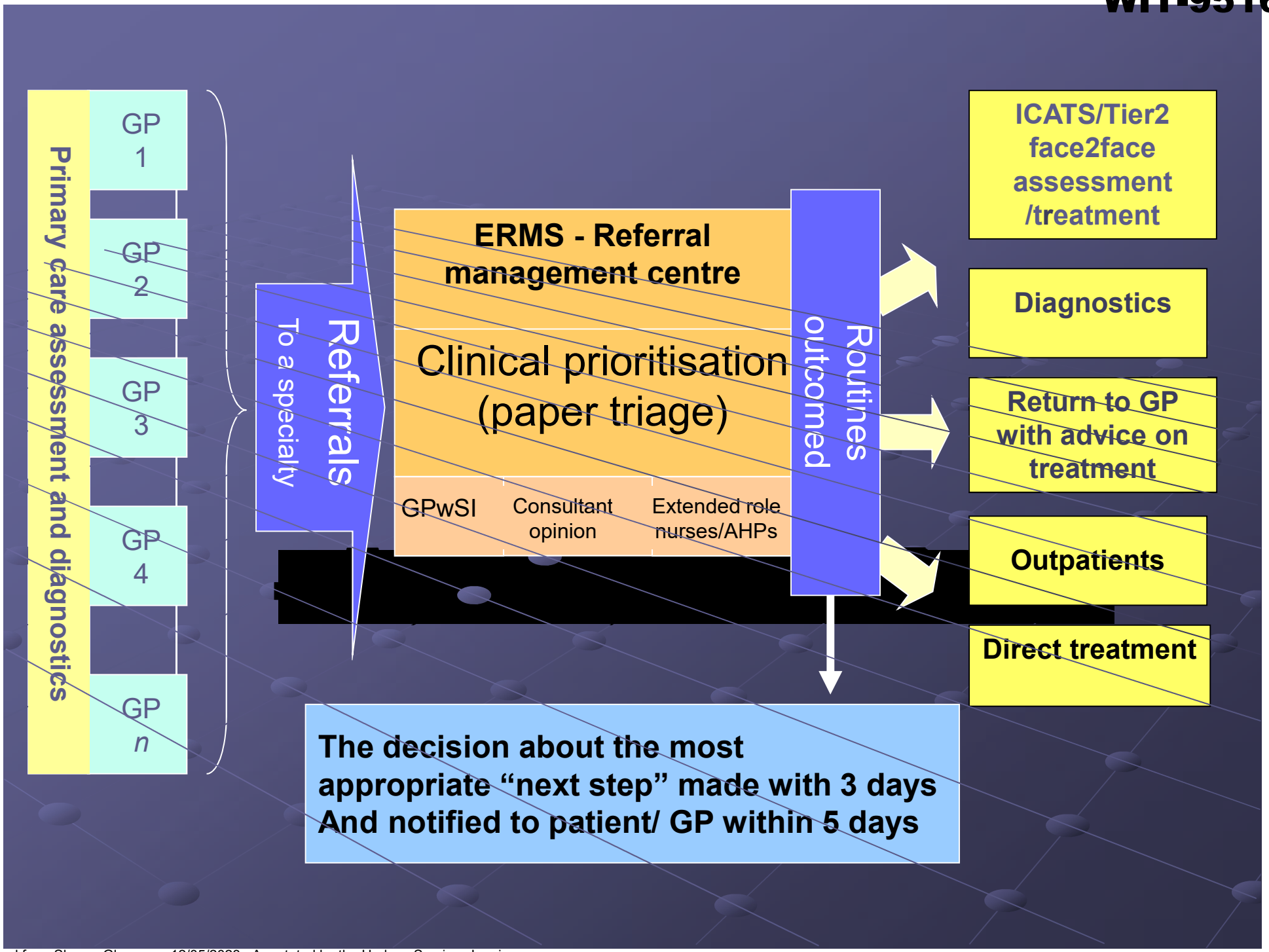
– *this target has been achieved*

- No one waiting more than 6 months for outpatient appointment, an in-patient or day case treatment by **March 2007**

- No one waiting more than 13 weeks from referral to a resolution of the referral e.g. decision to treat, by **March 2008**

Where are we going ?

208 weeks plus to 34 weeks in 104 weeks



What are we implementing?

By Winter 2006/07

Orthopaedics

A range of GPSI, Physiotherapy and Podiatry services to assess over 5500 referrals per year.

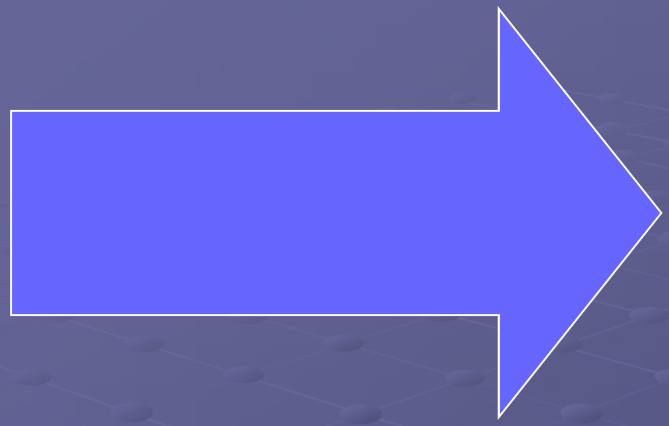
Urology

GPSI and Nurse Specialists will provide LUTS , prostate diagnostic and Urodynamic clinics for approximately 2500 referrals per year.

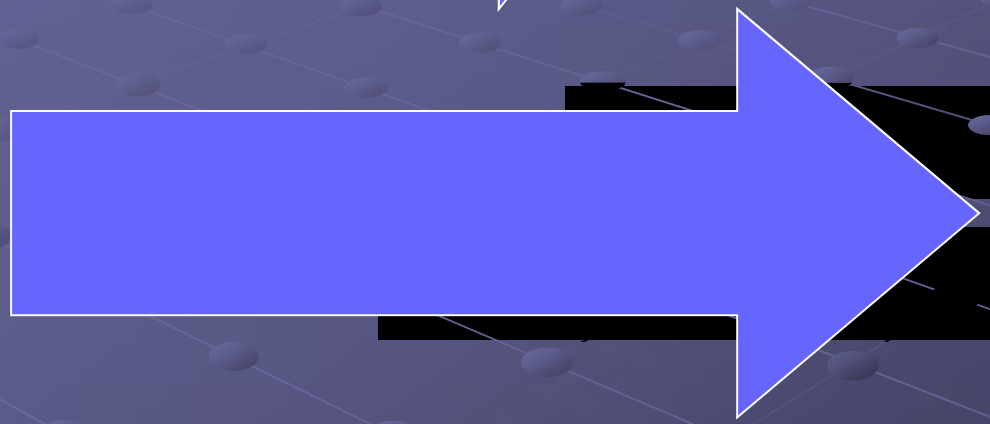
Ophthalmology

Initially building up triage and assessment services through Optometrists, Nurse Specialists and GPSI's of approximately 7000 referrals per year

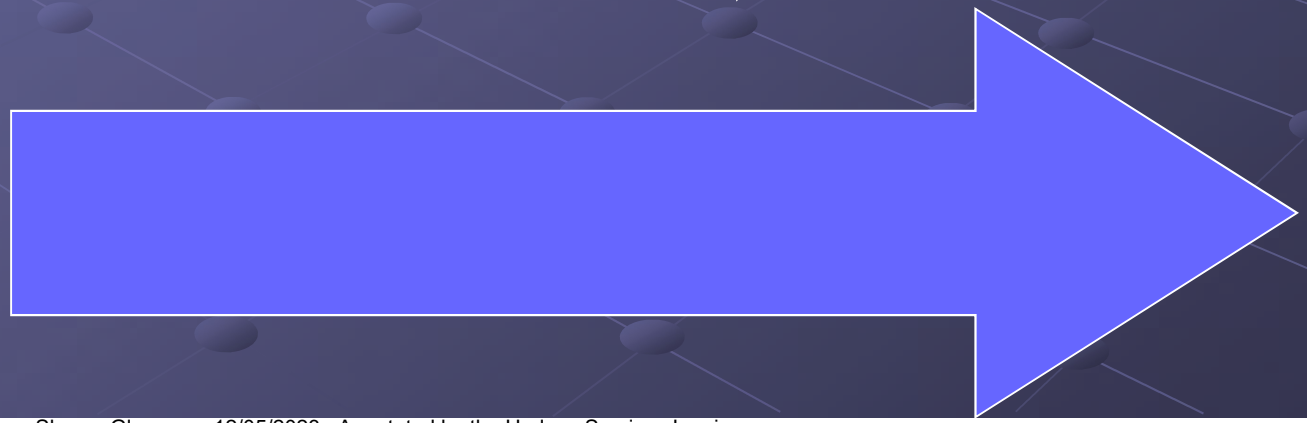
Next Phases



Implementation of Core Models Recruitment, Training and Premises and work on the O/P backlog



Complete ENT and Dermatology service designs by 30th October



Complete service designs for Cardiology, Pain Mgmt, General Surgery, rheumatology, by 30th Nov

What does it mean for you ?

- Refer patients into a specialty not a named consultant
- Send ALL referrals as you have in the past (in the first instance), difference is referrals will be looked at and triaged by the MD ICATS team
- A decision on the next step will be taken quickly (72hrs/3 days) and communicated to pt/GP within 5 days. GPs will have restricted access to ERMS to monitor status of patients referral - Call Centre to support
- Reduce the number of patients coming in to your surgery just to find out what is happening to their referral
- Career opportunities for those with specialist interest to develop and use their skills

What is required of you ?

- Good quality information on your referral letters – minimum data set not a ream of new referral protocols
- Referral letters to be forwarded to referrals office within one day
- H&C number (if available)

Contact Details

Aldrina Magwood
ICATS Manager
Personal Information redacted by the USI
email: Personal Information redacted by the USI

Glenny, Sharon

From: Glenny, Sharon <[redacted]>
Sent: 09 January 2007 18:55
To: Aldrina Magwood
Cc: Burns, Deborah; Davidson, Alexis; Haughey, Barry; Leeman, Lesley; Marley, Jerome; McCorry, Monica; McMahon, Jenny; O'Neill, Kate; Tedford, Shirley; Young, Mr; Leeman, Lesley
Subject: Update on Urology ICATS
Attachments: Implementation of the Urology ICAT Services 21.12.06 - progress update.doc

Aldrina

As promised, please find attached an update on the Urology ICATS project to date.

If you require any further information, please do not hesitate to contact me.

Regards

Sharon

Sharon Glenny
Project Manager
Urology ICATS
Direct Dial [redacted]

Implementation of Urology ICAT Services – Update on Progress

Service	Project Plan Status	Information	Update
LUTS	Fully Implemented		No further requirement
GPSI	Third session commenced beg Nov 2006	Third session initially used to shadow Mr Young.	Third session to be defined from January 2007. A meeting has been arranged with Mr Young, Dr Rogers, and Sharon Glenny for Friday 19 January 2006 to discuss definition of third session. GP job description currently with Medical Director for approval.
TRUS	Full TRUS sessions to be implemented by January 2007	This requires an additional session for Assessment, Biopsy, and Histology every other week. Increase in patient numbers from 4 to 6.	Implementation of the additional session is currently constrained due to current and impending vacancies within the radiology department in terms of consultant radiologist posts. The Trust is currently looking at ways to create capacity to implement the additional session as soon as possible. A further update on this situation will be made available in the next 2 weeks once initial options have been reviewed.
Urodynamics	Implementation Date January 2007	Equipment ordered. Delivery date: 15.12.06	The Nurse Practitioner posts associated with this service will be advertised in the Belfast Telegraph 09.01.07, with a view to interview on 09.02.07. In the interim this service will be implemented by existing Nurse Practitioners on 31 January 2007 from capacity resulting from other services not yet implemented. Formal training on Urodynamics equipment has been arranged as part of the introduction of the new service.

Implementation of Urology ICAT Services – Update on Progress

Stone Service	Implementation Date January 2007		A job description for the supporting F Grade post is currently being developed by the Trust.
Andrology	Implementation Date January 2007		It is the intention to initially commence this service for patients with erectile dysfunction with plans then to move to scrotal swellings. Discussions with the Nurse Practitioner for this service are currently ongoing to discuss the operational processes which must be put in place prior to implementation. The implementation date for this service is mid February.
Haematuria	Implementation Date February 2007	Equipment now defined and in process of procurement with anticipated arrival date of beg/mid February 2007. Issues regarding the process of decontamination of equipment have now been resolved.	Radiology capacity now defined. This service is on schedule to commence in February 2007.
Oncology	Implementation Date February 2007		This service is on schedule to commence in February 2007.
Recruitment		Nursing Medical	Nurse Practitioner Post to be advertised Belfast Telegraph on 9 January 2007, with a view to interview 9 February 2007 Grade F for stone service in development of job description All other nursing posts currently being filled on additional hours, back and backfill Dr Rogers now working 3 sessions with

Implementation of Urology ICAT Services – Update on Progress

		Clerical	effect from 3rd November 2006 Consultant Radiologist post – difficulties with recruitment in terms of current vacancies within department Grade 4 Admin Co-Ordinator post has been advertised with no uptake. Re-advertised internally with closing date Thursday 11 January 2007. Personal secretary post for ICAT services successfully recruited Receptionist post currently being covered by temporary staff with a view to recruiting permanently. Audiotypist post to be interviewed in next 3 weeks. Radiology clerical posts to be filled on a permanent basis from existing temporary staff.
Accommodation			Currently awaiting costs from suppliers for modular build. At present on schedule.
Referral Process			Introduced into Urology Specialty on 1 December 2006, with initial results showing approximately 50% of referrals reaching 3 day target. Considerable effort will be made to improve upon this for next month.

Glenny, Sharon

From: Glenny, Sharon
Sent: 27 April 2023 17:21
To: Glenny, Sharon
Subject: FW: Stats for February
Attachments: Referral Stats February Urology ICATS.xls

-----Original Message-----
From: Glenny, Sharon <[redacted]>
Sent: 23 April 2007 12:27
To: Aldrina Magwood <[redacted]>
Cc: Leeman, Lesley <[redacted]>; Burns, Deborah <[redacted]>
Subject: Stats for February

Aldrina

Please find attached some figures for February for Urology ICATS:

Referral Triage Outcomes
72 Hour Referral Triage Process
Clinic Attendances

Thanks

Sharon

Sharon Glenny
Project Manager
Urology ICATS
Direct Dial [redacted]

Total Number of Referrals Received Dec - Feb (2006-2007)

Number of Referrals Triaged

Month	No of Referrals Received	New Referrals Triaged	New Referrals not Triaged	% Triaged
December	128	128	0	100
January	167	104	63	62
February	158	138	20	87

Outstanding Referrals for Triage per Consultant

Month	% Not Triaged	Mr Young	Mr O'Brien	Mr Batstone
December	Nil	0	0	0
January	38	2	61	0
February	13	3	17	0

Outcomes for Triaged Referral Letters

	Cons	LUTS	TRUS	Haem	Uro	SS	And	Onc	GPSI	Diag	Ret	DA	Other
Number	42	19	22	8	2	0	0	0	5	26	1	7	5
Percentage	30%	14%	16%	6%	1%	0%	0%	0%	4%	19%	1%	5%	4%
SD Model	30%	13%	11%	18%			5%						
						*	#	^					

30% triaged to consultant service
60% triaged to ICAT service
10% triaged to other outcomes
The Service Design Model proposed that there would be 30% of referrals directly to the consultant service, 65% assesed and treated, as far as appropriate, by the ICATS team.

* No patients have been triaged to this service, as this is currently not being offered as yet.
# Unfortunately there has been no demand demonstrated for the andrology service in terms of erectile dysfunction. The urology project group are in discussion regarding a change in direction of this service, to potentially commence with patients being referral with scrotal swellings.
^ The pathway into the ICATS oncology review service has been defined by the urology project team to be generated from the consultant stream, therefore it is not anticipated that there will be any patients generated from referral triage process

72 Hour Triage Process

Days	3	4	5	6	7	8	9
Patient Numbers	73	20	9	2	2	0	32
Percentage	53%	14%	7%	1%	1%	0%	23%

Received from Sharon Glenny on 12/05/2023. Annotated by the Urology Services Inquiry.

Clinic Attendances

ICAT Service	New	Rv	Total
LUTS	28	12	40
Haematuria	6	0	6
|Urodynamics	6	0	6
Dr Rogers	17	38	55
TRUS Assessment	15	0	15
TRUS Biopsy	0	14	14
TRUS Histology	0	11	11
Total ICAT Attendances	**72**	**75**	**147**

Glenny, Sharon

From: Glenny, Sharon
Sent: 27 April 2023 17:23
To: Glenny, Sharon
Subject: FW: Urology Highlight Report - 29 March 2007
Attachments: Urology ICATS Highlight Report 29.03.07.doc; Prostate Biopsy Service - Day 4 revised.doc; Referral Stats February Urology ICATS.xls

-----Original Message-----
From: Glenny, Sharon <Personal Information redacted by the USI>
Sent: 30 March 2007 12:27
To: Burns, Deborah <Personal Information redacted by the USI>; Davidson, Alexis <Personal Information redacted by the USI>; Haughey, Barry <Personal Information redacted by the USI>; Leeman, Lesley <Personal Information redacted by the USI>; Marley, Jerome <Personal Information redacted by the USI>; McCorry, Monica <Personal Information redacted by the USI>; McMahon, Jenny <Personal Information redacted by the USI>; O'Neill, Kate <Personal Information redacted by the USI>; Tedford, Shirley <Personal Information redacted by the USI>; Young, Michael Mr <Personal Information redacted by the USI>
Cc: Batstone, Richard <Personal Information redacted by the USI>; Troughton, Elizabeth <Personal Information redacted by the USI>; McClelland, Michelle <Personal Information redacted by the USI>; Hanvey, Leanne <Personal Information redacted by the USI>; Campbell, Catherine <Personal Information redacted by the USI>; philiprogers <Personal Information redacted by the USI>; O'Donnell, Noleen <Personal Information redacted by the USI>
Subject: Urology Highlight Report - 29 March 2007

Hi All

Unfortunately the meeting yesterday had to be cancelled as a number of staff were unable to attend.

For various reasons, the last project meeting that took place was 22nd February 2007. I therefore felt it would be worthwhile to send round a highlight report to keep the team up to date with progress. I have met with members individually regarding the issues in the highlight report, however, there are a few items that need a consensus at our next project meeting, scheduled for Thursday 5th April. I would be grateful if the members of the project team could make every effort to attend.

I have attached the highlight report, as well as performance activity on the referral process and a draft paper on the day 4 TRUS service.

I have copied this email to other key staff outside of the core project team as a communication tool to keep everyone up to date with progress.

Any problems give me a call.

Thanks

Sharon

Sharon Glenny
Project Manager
Urology ICATS
Direct Dial Personal Information redacted by the USI

Urology ICATS – Highlight Report 29th March 2007

Accommodation	I had a discussion with Bill and Alan this week regarding progress with the modular build. Bill has informed me that there will be an onsite meeting tomorrow (Friday) with the foremen overseeing the sites works in terms of preparation of the site, forging the road and bringing utilities to the site. With regards to the modular build itself, an order has been placed and the Trust are now in contract with McEvoys as previously agreed. It is anticipated that the modular build should be ready within 10 weeks of order placement. I checked with Bill and Alan regarding progress with obs and gynae estates works. 2 West is almost complete, however, there may be some plans to do further minor estate works. If this is the case, then it is unlikely that gynae will be moving out of PEU this side of June. On this basis I have asked that the modular build is pushed on, as current accommodation arrangements in PEU are far from ideal.
Capital Budget • Equipment • Modular Build	Given that the 31st March 2007 is fast approaching, I was asked to provide an update on capital spend (£450k) to date. Any capital budget remaining at this date ran the potential of being returned to the Department of Health. £200k – According to my calculations the capital spend was sitting at £180k on Monday morning. Following discussions between Dr Hall, Mr Batstone, Mr Young and I over the last few weeks and the issues raised therein, I raised a requisition for 3 additional TRUS biopsy probes, approx £20k, given that there may be a requirement decontaminate this equipment in the future. £250k – Alan has reassured me that there will be a visit to view progress with the modular build this week, with a view to "buying" the structure as is at present. This will hopefully equate to the capital budget for this part of the project.
Referral Process Overview (attachment enclosed)	Please see the attachment giving an analysis of the urology referrals received in February. There is also a breakdown of the referrals received through the referral process since commencement in December 2006. Of note, there are no outstanding referral letters to be triaged from December, however, there is still a significant volume of referral letters to be triaged from January and February amounting to 83. It would be very

	important that these referrals are triaged, not just to meet the 3 day commitment that has been made to the SHSSB, but also to feed all the clinics across the urology specialty in which the patients are offered the best service for their condition. The report further breaks down the 83 figure by consultant. I would be very grateful for you co-operation in triaging the letters as soon as possible. 72 Hour Target – Only 53% of referral letters were triaged within the 3 day target, although the bulk, 74%, were triaged within 5 working days. Of concern is the large volume, 23%, which took 9+ days to be triaged. Regarding the administration surrounding the referral process, I have had an initial meeting with the urology secretarial and admin staff to process map the referral process and identify any gaps or areas for improvement. The meeting was very productive and a referral "flow" for a routine patient being referred into the urology service has since been drafted up. I have arranged to meet with the secretarial and admin staff next Tuesday, 3rd April, to agree the process from their point of view, before presenting this at the next urology project group meeting for discussion and potential agreement. I also intend to use the next session with the secretarial and admin staff to process map an urgent referral received into the urology service.
Andrology Service	Following a period of planning and implementation of the andrology service for ED patients on 13 March 2007, I am concerned regarding the lack of demand for this service. There have been no patients triaged to this service from announcement of implementation date, and a retrospective look over all new referrals pending first appointment has produced no referrals for the clinic. I discussed this briefly with Mr Young and Mr O'Brien on Friday 16th March and had hoped to discuss this as a team at today's project group meeting, but unfortunately the meeting had to be cancelled due to poor attendance. A consensus is required on the direction for this clinic and consideration given to offering the service to patients' referrals with scrotal swellings initially with role out to ED when demand is evident. I would welcome your advice, comments and direction with this and will add this to the agenda for the next project group meeting on Thursday, 5th April 2007.
TRUS Biopsy Service <u>TRUS Biopsy</u>	I met with Dr Hall on behalf of the project team on Friday 2nd March regarding expansion of the TRUS Biopsy Service to meet the requirements of the service design model. Following that meeting I facilitated a meeting with Dr Hall and Mr Batstone, given that a shortage of consultant radiologists was constraining the roll out. The meeting went

	very well and Dr Hall agreed to consultant urologist input to the service on the basis that the radiology department were not in a position to do so at present. There was also discussion surrounding different issues regarding a "gold" standard service – decontamination, sedation and equipment. Dr Hall welcomed Mr Batstone to attend the next TRUS biopsy session he had with a view to familiarisation of equipment, as well as viewing the current service delivery. In terms of the optimum number of biopsies and siting of biopsies, Dr Hall suggested that this should be discussed at one of the Thursday morning meetings to reach a consensus with a view to developing a protocol for all clinicians involved in a TRUS biopsy service to follow. Mr Batstone agreed to raise this.
<u>TRUS Assessment Session</u>	Kate and I have discussed rolling out the expansion of this service, given that there is a substantial waiting list to be seen for initial assessment. I have since discussed this with Alexis in terms of radiographer input and Alison Porter in terms of accommodation this week. Both Alexis and Alison can support this service on a Tuesday afternoon, however, the team need to assess the feasibility of a Registrar being available for this session. I would be grateful for feed back regarding this.
<u>Day 4</u> (paper attached)	I have drafted a short paper as discussed at our last project group meeting regarding an additional consultant led session dedicated to the further management of patients following TRUS biopsy, entering the consultant stream for the first time. I have attached this for your perusal and comment; I have added in comments from Kate and Jenny and Kate and I are meeting on Tuesday to look at the figures.
Outstanding Recruitment <u>Nursing Posts</u>	Recruitment to the H Grade post for Phase 2 urodynamics was unsuccessful. The F Grade post for stone service has not yet been advertised. The job description is still in draft format. I think it would be very important that these 2 posts are taken forward as soon as possible and therefore I hope to arrange a meeting with Noleen, Mr Young, Jerome, Kate and/or Jenny, and I with this in mind.
<u>Clerical Posts</u>	The grade 4 administrative co-ordinator for urology specialty, Catherine Campbell has taken up post with effect from 19th February 2007. Recruitment to the receptionist and audiotypist posts were unsuccessful, and therefore these are being re-advertised.

Urology Conference	Arrangements for the urology conference have been emailed round to all the team. The conference application form needs to be completed and forwarded as requested on email. Aldrina has informed me that she has a number of speakers confirmed for the conference from across the water, and feels that the conference should be very informative for our team. She has requested that all staff who have been asked to complete a personal profile return this as soon as possible, as this information will be included in the conference pack which is being circulated next week.

Prostate Biopsy Service

Introduction

This paper provides an analysis of the Prostate Diagnostic Service and the difficulties associated with patients returning to the Consultant service on day 4. It provides the rationale for an additional consultant led session per week dedicated to the further management of patients following TRUS biopsy and diagnosis of prostate cancer and entering the consultant stream for the first time.

Current Service

The original Urology ICAT Service Design Model assumed that each new referral to the Prostate Diagnostic Service would require 3 appointments:

Day 1 - Assessment Clinic
Day 2 – TRUS Biopsy
Day 3 – TRUS Biopsy Review/Histology Clinic

Currently Day 3 is attended by a Registrar and Nurse Practitioner at which time patients are informed of TRUS Biopsy results.

If a diagnosis of cancer is confirmed on histology, further radiological investigation is usually necessary; most commonly Bonescan & MRI scanning. Treatment plans and options are discussed briefly however definitive treatment planning is deferred until staging of disease is known. The patient is discharged from the ICAT clinic to attend the consultant clinic for further discussion when results of these investigations are available.

If histology results are negative or inconclusive, the patient will have appropriate treatment or further review at Consultant clinic for monitoring with the potential to repeat biopsy if necessary.

Attendance Rates

Conversion Rate to Consultant Clinic

Disadvantages with Current Service

Received from Sharon Glenny on 12/05/2023. Annotated by the Urology Services Inquiry.

There are 2 key issues with current arrangement for patients leaving the ICAT service at Day 3 and entering the consultant stream:

1. **Qualitative Aspect** – patients returning to the consultant stream at a crucial stage in the decision making process. The current environment of the ICAT Prostate diagnostic service is not mirrored in the consultant service. It would be ideal to offer patients a continuum for this appointment which offers the same surroundings, staff and facilities as with all other attendances to the prostate diagnostic service.
2. **Impact on Consultant Service** – Patients are currently being booked onto the consultant clinic for discussion and planned management of their condition. There is a time element attached to this as patients need time to appreciate what is being discussed and reflect on the options open to them, approximately 40 minutes per patient. This has had an impact on the consultant service, given that this equate to 2 new patients or 4 review patients for each histology patient being added to the clinic.

Proposal for Day 4

In order to provide a dedicated, quality service for TRUS patients on the day 4 visit back to the hospital, it is proposed that a session outside of the normal consultant service is the most appropriate option. It is anticipated that with the future increase in the prostate diagnostic service that there could be XXX patients attending per week, equating to one session per week.

Costing

Medical	
Nursing	
Clerical	
Goods and services	