



Urology Services Inquiry

Urology Services Inquiry | 1 Bradford Court | Belfast BT8 6RB
T: 02890 251005 | E: info@usi.org.uk | W: www.urologyservicesinquiry.org.uk

Dr Maria O'Kane
Accounting Officer
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

10 March 2022

Dear Madam,

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

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

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

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

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

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

This Notice is issued to you due to your held posts, within the Southern Health and Social Care Trust, relevant to the Inquiry's Terms of Reference. The Inquiry is of the

view that as you hold this role you will have an in-depth knowledge of matters that fall within our Terms of Reference. The Inquiry understands that you will have access to all of the relevant information required to provide the witness statement required now or at any stage throughout the duration of this Inquiry. Should you consider that not to be the case, please advise us of that as soon as possible.

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

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

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

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

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

Given the tight time-frame within which the Inquiry must operate, the Chair of the

Inquiry would be grateful if you would comply with the requirements of the Section 21 Notice as soon as possible and, in any event, by the date set out for compliance in the Notice itself.

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

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

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

Yours faithfully

Personal Information redacted by the USI

Anne Donnelly
Solicitor to the Urology Services Inquiry

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

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

Chair's Notice

[No 3 of 2022]

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

WARNING

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

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

TO: Dr Maria O’Kane
 Accounting Officer

 Southern Health and Social Care Trust
 Headquarters
 68 Lurgan Road
 Portadown
 BT63 5QQ

IMPORTANT INFORMATION FOR THE RECIPIENT

1. This Notice is issued by the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust on foot of the powers given to her by the Inquiries Act 2005.
2. The Notice requires you to do the acts set out in the body of the Notice.
3. You should read this Notice carefully and consult a solicitor as soon as possible about it.
4. You are entitled to ask the Chair to revoke or vary the Notice in accordance with the terms of section 21(4) of the Inquiries Act 2005.
5. If you disobey the requirements of the Notice it may have very serious consequences for you, including you being fined or imprisoned. For that reason you should treat this Notice with the utmost seriousness.

WITNESS STATEMENT TO BE PRODUCED

TAKE NOTICE that the Chair of the Independent Public Inquiry into Urology Services in the Southern Health and Social Care Trust requires you, pursuant to her powers under section 21(2)(a) of the Inquiries Act 2005 ('the Act'), to produce to the Inquiry a Witness Statement as set out in the Schedule to this Notice by noon on **25th March 2022**.

APPLICATION TO VARY OR REVOKE THE NOTICE

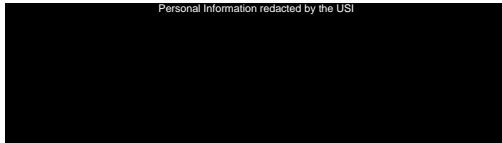
AND FURTHER TAKE NOTICE that you are entitled to make a claim to the Chair of the Inquiry, under section 21(4) of the Act, on the grounds that you are unable to comply with the Notice, or that it is not reasonable in all the circumstances to require you to comply with the Notice.

If you wish to make such a claim you should do so in writing to the Chair of the Inquiry at: **Urology Services Inquiry, 1 Bradford Court, Belfast, BT8 6RB** setting out in detail the basis of, and reasons for, your claim by noon on **18th March 2022**.

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

Dated this day 10th March 2022

Signed

Personal information redacted by the USI


Chair of Urology Services Inquiry

SCHEDULE
[No 3 of 2022]

Assurance Process

1. The Inquiry is aware that Dr Khan in the determination reached by him in the role of MHPS Case Manager (2018) referred to *"systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate"* and in doing so he recommended that the Trust carry out an independent review of relevant administrative processes.
2. The Inquiry has also received the Root Cause Analysis report on the review of serious adverse incidents concerning nine patients who were treated by or within Urology SHSCT Cancer Services. It is understood that this review was initiated by the Trust in 2020, and the report was submitted to HSCB on 1 March 2021. It is noted that the purpose of the review was, inter alia, *"to consider the quality of treatment and the care provided by Doctor 1 and to understand if actual or potential harm occurred."* It was said that, *"the review findings will be used to promote learning, to understand system wide strengths and weaknesses and to improve the quality and safety of care and treatment provided."*
3. The conclusion to the review encompassed the following findings:

"The systems of governance within the Urology SHSCT Cancer Services were ineffective and did not provide assurance regarding the care and experience of the nine patients in the review. Assurance audits were limited, did not represent whole patient journey and did not focus on areas of known concern. Assurances given to Peer Review were not based on systematic audit of care given by all."

While it is of little solace to the patients and families in this review, the Review team sought and received assurances that care provided to others adhered to recommendations on MDM and Regional / National Guidance."

4. Taking account of the findings referred to at (1) and (3) above, please address the following matters:

- a) Has the Trust accepted the findings set out at (1) and (3) above?
- b) What specific steps were taken by the Trust to address the systemic failures by managers referred to by Dr Khan? In answering this question you are required to identify each systemic failing and to state precisely how it has been addressed, when it was addressed, by whom it was addressed alongside their job description.
- c) What specific steps have been taken by the Trust to address the ineffective systems of governance within the Urology SHSCT Cancer Services referred to within the Root Cause Analysis report? In answering this question you are required to identify each aspect of the system of governance which was found to be ineffective and/or which failed to provide assurance, and to state precisely how it has been addressed, when it was addressed, by whom it was addressed alongside their job description.
- d) The MHPS investigation which led to Dr Khan's determination, and the Root Cause Analysis/SAI process concerning nine patients treated by or within Urology SHSCT Cancer Services, each identified shortcomings in the practices of Mr. Aidan O'Brien. Additionally, these processes pointed to systemic failures by managers and failures of governance. The Inquiry notes that each of these processes have focused on the patients which made up the case load of Mr. O'Brien. The Inquiry is unaware of any steps undertaken by the Trust to obtain and provide assurance that the shortcomings of Mr. O'Brien were not also to be

found in the practices of any other clinician, although it is noted that the RCA review team has referred to seeking and obtaining assurances. Accordingly, with reference to each clinician working within Urology Services generally, as well as Urology Cancer Services as at 1 July 2020, please address the following:

- I. What specific steps, if any, have been taken by the Trust to obtain assurance that each clinician concerned has adhered to all relevant Trust, regional and national standards (or guidance).

In answering this question you are required to specify for each named clinician within these clinical areas what processes, audits or other tools have been applied and what particular Trust, regional or national standard has been taken into account. You are also required to specify the areas of administrative and clinical practice which have been examined or audited (eg. triage, or practices in association with MDM) against the standard, and the period of time frame which has been considered. If steps have not yet been taken to obtain assurance of the kind referred to for any particular clinician, or at all, please make this clear.

- II. If steps have been taken to obtain assurance of the kind referred to, outline for each named clinician, the outcome of that process.

In answering this question you are required to specify for each named clinician whether the Trust has or has not been assured that the clinician concerned has adhered to all relevant Trust, regional and national standards, detailing the areas of administrative and clinical practice which have been examined, and the assurance outcome for each area. In the event that

assurance has not been obtained in any case, you are required to indicate what action the Trust has taken or proposes to take.

- III. If steps have been taken to obtain assurance of the kind referred to, please also outline whether the process applied has identified any systemic failures by managers and/or failures of governance and assurance systems, other than those which were known to the Trust as a result of the MHPS process and the Root Cause Analysis/SAI processes referred to above.

In answering this question you are required to describe in detail any systemic failure and/or failures of governance and assurance systems which have been identified as a result of conducting any assurance process, and to state what steps have been taken or will be taken to address these matters. You are also asked to provide a statement regarding the current status or quality of governance systems and assurance systems within Urology Services and Urology Cancer Services having regard to the failures and/or weaknesses identified in the processes referred to at (1)-(3) above.

- e) As outlined above, the report of the Root Cause Analysis / SAI review process indicated that the review findings will be used for three purposes: (i) to promote learning, (ii) to understand system wide strengths and weaknesses and (iii) to improve the quality and safety of care and treatment provided." By addressing each of these three matters in turn, provide a detailed account of the steps taken by the Trust, or to be taken by the Trust, having regard to the review findings.

In answering this question you are required to set out under each of the three headings a specific and detailed reply as appropriate. By way of example only, under (ii) you will set out the understanding of system wide strengths and weaknesses which has been obtained by the Trust on the basis of the findings of the review, who is responsible for

considering them, and if this has stimulated further actions you will want to assist the Inquiry to understand what those actions are, how they are being taken forward and by whom, and what stage has been reached.

In addressing the questions raised within this Notice, the Trust is also required to disclose any documentation relevant to its answers, and to refer to the specific sections of any document which support the answer being provided.

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.



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SAI action plan UROLOGY SERVICES INQUIRY

USI Ref: S21 3 of 2022

Date of Notice: 10 March 2022

Witness Statement of: Dr Ellen Maria O’Kane

I, Ellen Maria O’Kane, will say as follows:-

1. I am the Medical Director and Temporary Accounting Officer and Cover for the Chief Executive of the SHSCT (‘the Trust’). I make this statement, in response to Section 21 Notice No.3 of 2022 on behalf of the Trust in my capacity as acting Accounting Officer and Covering for the Trust Chief Executive.
2. With the permission of the Inquiry, I have relied upon the assistance of other Trust personnel in compiling documents and information in response to this Section 21 Notice. In particular, I have relied upon the following persons:

Question No	Name
4a	Not applicable
4b	Martina Corrigan, Assistant Director Public Inquiry and Trust Liaison Stephen Wallace, Assistant Director Systems Assurance
4c.	Sarah Ward, Head of Urology Clinical Assurance Ronan Carroll, Assistant Director Surgery and Elective Care
4d i	Not applicable
4d ii	Not applicable
4d iii	Barry Conway, Assistant Director Cancer and Clinical Services Mr Mark Haynes, Divisional Medical Director Urology Improvement Stephen Wallace, Assistant Director Systems Assurance Wendy Clayton, Head of Service, Urology and ENT Sarah Ward, Head of Urology Clinical Assurance Ronan Carroll, Assistant Director Surgery and Elective Care
4e.	Sarah Ward, Head of Urology Clinical Assurance Ronan Carroll, Assistant Director Surgery and Elective Care



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3. Below, I set out in bold text each question asked in Section 21 Notice No.3 of 2022 followed by my answer to it. Any documents being provided are in the form of Appendices to this statement.

1. The Inquiry is aware that Dr Khan in the determination reached by him in the role of MHPs Case Manager (2018) referred to “systemic failures by managers at all levels, both clinical and operational, within the Acute Services Directorate” and in doing so he recommended that the Trust carry out an independent review of relevant administrative processes.

2. The Inquiry has also received the Root Cause Analysis report on the review of serious adverse incidents concerning nine patients who were treated by or within Urology SHSCT Cancer Services. It is understood that this review was initiated by the Trust in 2020, and the report was submitted to HSCB on 1 March 2021. It is noted that the purpose of the review was, inter alia, “to consider the quality of treatment and the care provided by Doctor 1 and to understand if actual or potential harm occurred.” It was said that, “the review findings will be used to promote learning, to understand system wide strengths and weaknesses and to improve the quality and safety of care and treatment provided.”

3. The conclusion to the review encompassed the following findings:

“The systems of governance within the Urology SHSCT Cancer Services were ineffective and did not provide assurance regarding the care and experience of the nine patients in the review. Assurance audits were limited, did not represent whole patient journey and did not focus on areas of known concern. Assurances given to Peer Review were not based on systematic audit of care given by all.

While it is of little solace to the patients and families in this review, the Review team sought and received assurances that care provided to others adhered to recommendations on MDM and Regional / National Guidance.”

4. Taking account of the findings referred to at (1) and (3) above, please address the following matters:

a) Has the Trust accepted the findings set out at (1) and (3) above?

The Trust has accepted the findings as set out at (1) and (3) above.



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4. Taking account of the findings referred to at (1) and (3) above, please address the following matters:

b) What specific steps were taken by the Trust to address the systemic failures by managers referred to by Dr Khan? In answering this question you are required to identify each systemic failing and to state precisely how it has been addressed, when it was addressed, by whom it was addressed alongside their job description.

The specific steps have been taken by the Trust to address the ineffective systems of governance referred to by Dr Khan are set out in attachment MHPS excel spreadsheet using the prescribed headings above.

Relevant attachments:

Attachment – MHPS excel spreadsheet

Attachment - 20201215 – revised triage process

Attachment - Consultant to consultant referrals SOP

Attachment - 20210401 – Admin SOP Typing Clinics etc

Attachment - Memo to medical staff on patient letters

Attachment - Job Descriptions

The above are located in S21 No.3 of 2022 MHPS, 20201215 – revised triage process, Consultant to consultant referrals SOP, 20210401 – Admin SOP Typing Clinics etc, Memo to medical staff on patient letters, Job Descriptions

4. Taking account of the findings referred to at (1) and (3) above, please address the following matters:

c) What specific steps have been taken by the Trust to address the ineffective systems of governance within the Urology SHSCT Cancer Services referred to within the Root Cause Analysis report? In answering this question you are required to identify each aspect of the system of governance which was found to be ineffective and/or which failed to provide assurance, and to state precisely how it has been addressed, when it was addressed, by whom it was addressed alongside their job description.

The specific steps have been taken by the Trust to address the ineffective systems of governance within the Urology SHSCT Cancer Services referred to within the Root Cause Analysis report are set out in attachment 'SAI Recommendations' using the prescribed headings above. A supplementary overarching SAI action plan is also included which demonstrates wider actions relating to cancer services and the associated details.



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Relevant attachments:

Attachment - SAI Recommendations
 Attachment - Appendix 17a - Consultant ENT Surgeon
 Attachment - Appendix 17b - Consultant - OBS GYNAE
 Attachment - Appendix 17c - JD Consultant Respiratory
 Attachment - Appendix 17d - JD Consultant Breast
 Attachment - Appendix 17e - JD Consultant Gastro
 Attachment - Appendix 17f - Glossary of Terms
 Attachment - Appendix 17g - Data Map Process for Urology
 Attachment - Appendix 17h - Data Map Process for Urology
 Attachment - Appendix 17i - MDT NCAT Questionnaire
 Attachment - Appendix 17j - MDT Action Plan
 Attachment - Appendix 17k - Care Opinion Info
 Attachment - Appendix 17l - Brainstorming for Project
 Attachment - Appendix 17m - NiCan Guidance for Information Given to Patients
 Attachment - Appendix 17n - Whistleblowing Policy
 Attachment - Appendix 17o - Nursing and Midwifery Accountability
 Attachment - Appendix 17 p - DoH Code of Conduct
 Attachment - Appendix 17 q - Code of Conduct NMC
 Attachment - Appendix 17 r - Nursing Supervision Policy
 Attachment - Appendix 17s - GMC Code of Conduct
 Attachment - Appendix 17t - NiCan Urology Pathways
 Attachment - Appendix 17u - Terms of Reference for Service User Group
 Attachment - Appendix 17v - Terms of reference task and finish group

The above are located in S21 No.3 of 2022 SAI Recommendations - Appendix 17a - Consultant ENT Surgeon, Appendix 17b - Consultant - OBS GYNAE, Appendix 17c - JD Consultant Respiratory, Appendix 17d - JD Consultant Breast, Appendix 17e - JD Consultant Gastro, Appendix 17f - Glossary of Terms, Appendix 17g - Data Map Process for Urology, Appendix 17h - Data Map Process for Urology, Appendix 17i - MDT NCAT Questionnaire, Appendix 17j - MDT Action Plan, Appendix 17k - Care Opinion Info, Appendix 17l - Brainstorming for Project, Appendix 17m - NiCan Guidance for Information Given to Patients, Appendix 17n - Whistleblowing Policy, Appendix 17o - Nursing and Midwifery Accountability, Appendix 17 p - DoH Code of Conduct, Appendix 17 q - Code of Conduct NMC, Appendix 17 r - Nursing Supervision Policy, Appendix 17s - GMC Code of Conduct, Appendix 17t - NiCan Urology Pathways, Appendix 17u - Terms of Reference for Service User Group, Appendix 17v - Terms of reference task & finish group



Urology Services Inquiry

4. Taking account of the findings referred to at (1) and (3) above, please address the following matters:

d) The MHPS investigation which led to Dr Khan's determination, and the Root Cause Analysis/SAI process concerning nine patients treated by or within Urology SHSCT Cancer Services, each identified shortcomings in the practices of Mr. Aidan O'Brien. Additionally, these processes pointed to systemic failures by managers and failures of governance. The Inquiry notes that each of these processes have focused on the patients which made up the case load of Mr. O'Brien. The Inquiry is unaware of any steps undertaken by the Trust to obtain and provide assurance that the shortcomings of Mr. O'Brien were not also to be found in the practices of any other clinician, although it is noted that the RCA review team has referred to seeking and obtaining assurances. Accordingly, with reference to each clinician working within Urology Services generally, as well as Urology Cancer Services as at 1 July 2020, please address the following:

1. What specific steps, if any, have been taken by the Trust to obtain assurance that each clinician concerned has adhered to all relevant Trust, regional and national standards (or guidance).

In answering this question you are required to specify for each named clinician within these clinical areas what processes, audits or other tools have been applied and what particular Trust, regional or national standard has been taken into account. You are also required to specify the areas of administrative and clinical practice which have been examined or audited (e.g. triage, or practices in association with MDM) against the standard, and the period of time frame which has been considered. If steps have not yet been taken to obtain assurance of the kind referred to for any particular clinician, or at all, please make this clear.

A comprehensive audit of individual clinician practice within urology services has not yet been undertaken. Historically, audits involving an individual clinician(s) have only been undertaken where there have been specific concerns raised in relation to any element of an individual's practice.

As a result of a Trustwide external review of its Clinical and Social Care Governance functions and processes, a programme has commenced to develop a standalone clinical audit team to support operational teams with clinical assurance functions.

The Trust has committed to developing an audit programme of urology services to be enacted over the next number of months and we will report the results of audits carried out to the USI in due course.

4. Taking account of the findings referred to at (1) and (3) above, please address the following matters:



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d) The MHPS investigation which led to Dr Khan's determination, and the Root Cause Analysis/SAI process concerning nine patients treated by or within Urology SHSCT Cancer Services, each identified shortcomings in the practices of Mr. Aidan O'Brien. Additionally, these processes pointed to systemic failures by managers and failures of governance. The Inquiry notes that each of these processes have focused on the patients which made up the case load of Mr. O'Brien. The Inquiry is unaware of any steps undertaken by the Trust to obtain and provide assurance that the shortcomings of Mr. O'Brien were not also to be found in the practices of any other clinician, although it is noted that the RCA review team has referred to seeking and obtaining assurances. Accordingly, with reference to each clinician working within Urology Services generally, as well as Urology Cancer Services as at 1 July 2020, please address the following:

II. If steps have been taken to obtain assurance of the kind referred to, outline for each named clinician, the outcome of that process.

In answering this question you are required to specify for each named clinician whether the Trust has or has not been assured that the clinician concerned has adhered to all relevant Trust, regional and national standards, detailing the areas of administrative and clinical practice which have been examined, and the assurance outcome for each area. In the event that assurance has not been obtained in any case, you are required to indicate what action the Trust has taken or proposes to take.

As detailed in question 4di the Trust has not undertaken a comprehensive audit assurance programme for each individual clinician within urology services as there not been any clinical indication to do so. The Trust has committed to developing an audit programme of urology services to be enacted over the next number of months and we will report the results of audits carried out to the USI in due course.

4. Taking account of the findings referred to at (1) and (3) above, please address the following matters:

d) The MHPS investigation which led to Dr Khan's determination, and the Root Cause Analysis/SAI process concerning nine patients treated by or within Urology SHSCT Cancer Services, each identified shortcomings in the practices of Mr. Aidan O'Brien. Additionally, these processes pointed to systemic failures by managers and failures of governance. The Inquiry notes that each of these processes have focused on the patients which made up the case load of Mr. O'Brien. The Inquiry is unaware of any steps undertaken by the Trust to obtain and provide assurance that the shortcomings of Mr. O'Brien were not also to be found in the practices of any other clinician, although it is noted that the RCA review team has referred to seeking and obtaining assurances. Accordingly, with reference to each clinician working within Urology Services generally, as well as Urology Cancer Services as at 1 July 2020, please address the following:

III. If steps have been taken to obtain assurance of the kind referred to, please also outline whether the process applied has identified any systemic failures by



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managers and/or failures of governance and assurance systems, other than those which were known to the Trust as a result of the MHPS process and the Root Cause Analysis/SAI processes referred to above.

In answering this question you are required to describe in detail any systemic failure and/or failures of governance and assurance systems which have been identified as a result of conducting any assurance process, and to state what steps have been taken or will be taken to address these matters. You are also asked to provide a statement regarding the current status or quality of governance systems and assurance systems within Urology Services and Urology Cancer Services having regard to the failures and/or weaknesses identified in the processes referred to at (1)-(3) above.

As a result of the SAI findings and MHPS report, two additional assurance processes have highlighted areas for improvement within urology cancer services and acute medical services. These are each addressed in turn below:

Cancer Multidisciplinary Team Meetings

The Southern Trust is undertaking work to strengthen approaches to cancer multidisciplinary team (MDT) processes. This improvement work includes a review of how MDTs currently function and consider any potential additional assurance measures that may be required. The NCAT tool - Characteristics of an Effective Multidisciplinary Team (MDT), self-assessment and feedback questionnaire (Feb 2010) was adapted by the Trust and amended into a fillable audit proforma to assist with obtaining a baseline of the holistic MDT attributes and help form the basis for quality improvement. The MDT audit is designed to target and drive patient safety and quality improvement by identifying areas for strengthening systems and processes. Between June-August 2021, the x8 local MDTs completed the NCAT self-assessment tool to reflect the views of their own MDT, these were then circulated to the wider MDTs for review and comment. During September-October 2021, the Cancer Services Management Team met with all of the MDT Leads to review the baselines, identify common areas/themes, identify tumour-site specific areas and prioritise areas for improvement. This action plan is a product from those meetings to capture all of the issues identified and agree actions to address.

There are 5 categories in the NCAT baseline audit;

- The MDT
- Infrastructure for meetings
- Meeting organisation & logistics
- Patient centred clinical decision making
- Team governance

The baseline audit conducted across all cancer MDTs highlighted areas for improvement across a number of Southern Trust MDTs.

MDT action plan and MDT action plan summary



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The MDT service improvement action plan (based on all tumour site assessment responses of 'partial' or 'not at all') and a tumour site specific MDT action plan (2 tabs on the excel spreadsheet) - these are additional areas specific to the Cancer MDTs and over and above the areas in the generic action plan.

NCAT Characteristics Outcomes - Urology MDT

Implementation Status	Number of Elements
Fully implemented	51
Partially implemented	24
Not in place	16

A further meeting has been organised in the coming weeks to establish and address any outstanding issues.

The following documents are attached:

- Attachment - NCAT MDT characteristics report final
- Attachment - Cancer MDM baseline audit NCAT (adopted from the NCAT document)
- Attachment - The Urology Cancer MDM baseline audit
- Attachment - Overview of results from MDT Baseline assessments (May 2021)
- Attachment - MDT Action Plan (Jan 2022)
- Attachment - Summary MDT action plan update (March 22).

The above are located in S21 No.3 of 2022 NCAT MDT characteristics report final, Cancer MDM baseline audit NCAT (adopted from the NCAT document), The Urology Cancer MDM baseline audit, Overview of results from MDT Baseline assessments (May 2021), MDT Action Plan (Jan 2022), Summary MDT action plan update (March 22).

Private Practice

As a result of work undertaken to review practices of Mr O'Brien, gaps in the Trust's processes governing private practice were highlighted. In November 2020, at the request of the Urology Assurance Group, the Mr Shane Devlin, Chief Executive requested a review of Mr O'Brien's patients transferring into the Trust as HSC patients. In addition, the review considered any Trust involvement with the Craigavon Urological Research and Education Organisation. The review was conducted by Business Services Organisation (BSO) Internal Audit.

The audit focused primarily on Mr O'Brien's change of status private patients work during the period 1 January 2019 to 30 June 2020 in order to:

1. Establish the extent of Trust awareness of Mr O'Brien's work, through the job plan process and their private patient identification and management processes;



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2. Establish the extent to which Mr O'Brien's private work interacted with HSC services and facilities;
3. To identify all of Mr O'Brien's patients that changed status (private/NHS) and check there was evidence that relevant guidance / authorities had been adhered to. This will include providing assurance that:
 - The appropriate Change of Status paperwork has been completed and authorised and that this is supported by an assessment, by the consultant, of the patients clinical priority for treatment as a Health Service patient;
 - For all private work identified above, the patient joined the HSC waiting list at the same point as if their consultation had taken place as an NHS patient;
 - The Consultant fulfilled all obligations with regard to the recording and identifying private activity;
 - Where private work was conducted on HSC premises, ensure that patients had been invoiced for relevant costs.

Internal Audit also considered whether the Trust has any involvement with CURE - Craigavon Urological Research and Education, to understand if there was a flow of money into the Trust and to check as much as possible from a review of Trust records and engagement with Trust staff, whether any Directors / staff benefited from the operation of the company.

A final report on Private Practice was issued to the Trust on 31st August 2021.

The final report identified issues with Mr O'Brien's compliance with relevant guidance around private practice. Significant issues with the timing, completion and approval of change of status paperwork were identified when patients transferred from private to NHS care. Occasions were also found when patients that had been seen privately, were treated more quickly than the trust standard waiting times.

Significant issues were also found around the Trust's management and monitoring of compliance with private patient guidance, in particular the change of status process and their ability to monitor that patients transferring from private to NHS care are treated in an equitable manner. The findings in this report indicate issues around patients being able to pay to see a Consultant privately and then receiving preferential treatment in the NHS. The Trust was asked to consider whether these issues are isolated to this one Consultant or indicative of a wider cultural issue.

Internal Audit action plan

A series of actions have been taken to address deficits identified as a result of the internal audit findings which are detailed in the attached action plan.

The following documents are attached:



Urology Services Inquiry

- Attachment - Internal Audit Review of Mr A's Private Practice 2020/21
- Attachment - Internal Audit Action Plan Mr A's Private Practice 2020/21
- Attachment - Reference - 20211029 Private Patients Declaration Supplied with Section 21 2a/2021 Item 74
- Attachment - Reference - 20211029 Private Practice Structured Reflective Template Supplied with Section 21 2a/2021 Item 74
- Attachment - 20220112 Memo Medical Private Practice

These files are located at Section 21 No 3 of 2022 Internal Audit Action Plan Mr A's Private Practice 2020/21, - Internal Audit Review of Mr A's Private Practice 2020/21, 20211029 Private Patients Declaration Supplied with Section 21 2a/2021 Item 74, 20211029 Private Practice Structured Reflective Template Supplied with Section 21 2a/2021 Item 74, 20220112 Memo Medical Private Practice

You are also asked to provide a statement regarding the current status or quality of governance systems and assurance systems within Urology Services and Urology Cancer Services having regard to the failures and/or weaknesses identified in the processes referred to at (1)-(3) above.

Following consideration of the findings of both the SAI and MHPS reports the Trust has taken a number of actions to improve the governance processes around both urology and cancer services as noted in answers 4B, 4C and above in this answer (4D iii). Our systems and processes although still a work in progress have additional scrutiny that support earlier identification of any problems or issues that may occur in these services. The table below illustrates where specific improvements have been made with regards to improvements in governance in urology services and urology cancer services.

Urology Patient Safety Meetings	<p>Monthly patient safety meetings held in urology services have now increased their multi-disciplinary representation and now follow the regional set agenda format. A sample of minutes of a recent meeting is attached.</p> <p>Attachment - Minutes of Urology PSM February 2022</p> <p><i>This file can be located at Section 21 No 3 of 2022 - Minutes of Urology PSM February 2022</i></p>
Cancer Trackers	<p>Since May 2021 the Cancer Tracking team has increased from 8.6 by 5.5 for a total of 14.1 whole time equivalent posts in terms of funding. In absence of commissioned funding for these posts the Trust has funded these 'at risk' to allow the Cancer Tracking team to maintain service in line with increased demand.</p>
Clinical Nurse Specialists	<p>The Trust has invested to increase the number of clinical specialist nurses from 3 to 5 across cancer services to ensure</p>



Urology Services Inquiry

	additional capacity to support patients during their treatment journey.
DMD Urology Improvement	<p>To provide clinical leadership and oversight of urology service improvements the Trust has created a dedicated Medical Lead role of Divisional Medical Director for Urology Improvement.</p> <p>The Divisional Medical Director has a lead role in ensuring the division maintains high quality, safe and effective services and contributes to the division's strategic direction. To lead on all aspects of medical professional and clinical and social care governance including:</p> <ul style="list-style-type: none"> • Professional Medical Governance • Staffing and Staff Management • Professional Performance Management • Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Coronial Matters • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control) • Medications management • Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Medical Education in conjunction with DMD/ Dir Med Ed • Medical Workforce development • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement • Medical leadership in delivery of MCA and Safeguarding <p>Relevant attachment - DIVMD - Urology Improvement</p> <p><i>This file can be located at Section 21 No 3 of 2022 - DIVMD - Urology Improvement</i></p>
New Medical Leadership Roles within Urology	<p>New medical lead roles have been created for the following clinical areas:</p> <p>Lead roles in Urology including time allocations are as below:</p>



Urology Services Inquiry

	<ul style="list-style-type: none"> • Mr John O'Donoghue, Consultant Urologist Patient Safety Lead 0.485 Programmed Activities Per Week • Mr Anthony Glackin, Consultant Urologist Cancer MDT lead 1.0 Programmed Activities Per Week • Mr Matthew Tyson, Consultant Urologist S&G clinical lead 0.5 and Quality Improvement lead 0.5 Programmed Activities Per Week • Mr Michael Young, Consultant Urologist Rota clinical lead 0.5 Programmed Activities Per Week • Ms Laura McAuley, Speciality Doctor Education Lead 0.5 Programmed Activities Per Week • Mr Mark Haynes, Consultant Urologist NICAN CRG chair 0.5 Programmed Activities Per Week • Mr Michael Young, Consultant Urologist, Rota lead currently 0.5 Programmed Activities Per Week • Mr Anthony Glackin / Mr John O'Donoghue and Mr Haynes are NIMDTA educational and clinical supervisors (GMC recognised trainers) • Mr Tyson is Trust supervisor for Physician Associate and trust grade doctors
Benchmarking of Multidisciplinary meetings	As stated above, the NCAT audit has provided direction for improvement activity related to improving the function and outcomes from multidisciplinary meetings.

4. Taking account of the findings referred to at (1) and (3) above, please address the following matters:

e) As outlined above, the report of the Root Cause Analysis / SAI review process indicated that the review findings will be used for three purposes: (i) to promote learning, (ii) to understand system wide strengths and weaknesses and (iii) to improve the quality and safety of care and treatment provided." By addressing each of these three matters in turn, provide a detailed account of the steps taken by the Trust, or to be taken by the Trust, having regard to the review findings.

In answering this question you are required to set out under each of the three headings a specific and detailed reply as appropriate. By way of example only, under (ii) you will set out the understanding of system wide strengths and weaknesses which has been obtained by the Trust on the basis of the findings of the review, who is responsible for considering them, and if this has stimulated further actions you will want to assist the Inquiry to understand what those actions are, how they are being taken forward and by whom, and what stage has been reached.



Urology Services Inquiry

Relevant attachment - Understanding of system wide strengths and weaknesses which has been obtained by the Trust on the basis of the findings of the review.

This file can be located in Section 21 No 3 of 2022 - 20220401 v2 Spreadsheet of Positives and Negatives_

Statement of Truth

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

Signed:

Personal Information redacted by the USI

Date: 1 April 2022

Section 21 Number 3 of 2022

Attachment Index

Attachment Number	File Name
1	MHPS
2	20201215 – revised triage process
3	Consultant to consultant referrals SOP
4	20210401 – Admin SOP Typing Clinics etc
5	Memo to medical staff on patient letters
6	Job Descriptions
7	SAI Recommendations
8	Appendix 17a – Consultant ENT Surgeon
9	Appendix 17b – Consultant – OBS GYNAE
10	Appendix 17c – JD Consultant Respiratory
11	Appendix 17d – JD Consultant Breast
12	Appendix 17e – JD Consultant Gastro
13	Appendix 17f – Glossary of Terms
14	Appendix 17g – Data Map Process for Urology
15	Appendix 17h – Data Map Process for Urology
16	Appendix 17i – MDT NCAT Questionnaire
17	Appendix 17j – MDT Action Plan
18	Appendix 17k – Care Opinion Info
19	Appendix 17l – Brainstorming for Project
20	Appendix 17m – NiCan Guidance for Information Given to Patients
21	Appendix 17n – Whistleblowing Policy
22	Appendix 17o – Nursing and Midwifery Accountability
23	Appendix 17 p – DoH Code of Conduct
24	Appendix 17 q – Code of Conduct NMC
25	Appendix 17 r – Nursing Supervision Policy
26	Appendix 17s – GMC Code of Conduct
27	Appendix 17t – NiCan Urology Pathways
28	Appendix 17u – Terms of Reference for Service User Group
29	Appendix 17v – Terms of reference task and finish group
30	NCAT MDT characteristics report final
31	Cancer MDM baseline audit NCAT (adopted from the NCAT document),
32	The Urology Cancer MDM baseline audit
33	Overview of results from MDT Baseline assessments (May 2021)
34	MDT Action Plan (Jan 2022)
35	Summary MDT action plan update (March 22)
36	Internal Audit Action Plan of Mr A's Private Practice 2020/21
37	Internal Audit Review of Mr A's Private Practice 2020/21,
38	20211029 Private Patients Declaration Supplied with Section 21 2a/2021 Item 74
39	20211029 Private Practice Structured Reflective Template Supplied with Section 21 2a/2021 Item 74
40	20220112 Memo Medical Private Practice
41	Minutes of Urology PSM February 2022
42	DIVMD – Urology Improvement
43	20220401 v2 Spreadsheet of Positives and Negatives_

b) What specific steps were taken by the Trust to address the systemic failures by managers referred to by Dr Khan? In answering this question you are required to identify each systemic failing and to state precisely how it has been addressed, when it was addressed, by whom it was addressed alongside their job description.

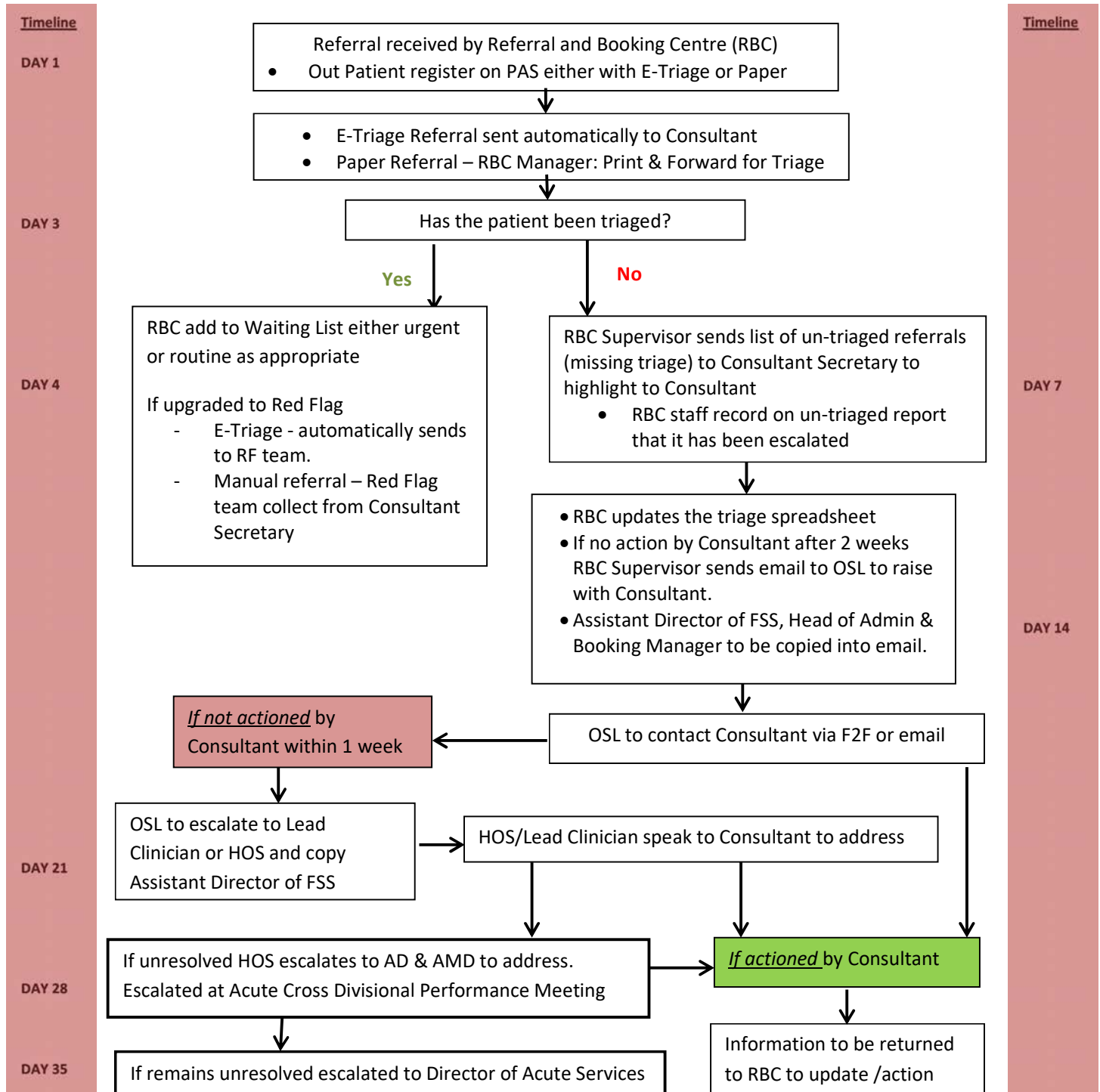
Failure Identified	Description of the issue	Gaps that led to the problem	Steps Taken to Address	Escalation for non-adherence	Date this was Addressed	Who Addressed this	Job Description(s)
Non-triage of GP and other Consultant Referrals	<p>Pre 2014</p> <p>Due to the ongoing delayed triage of referrals, the decision was taken by the Acute Director and Assistant Director of Functional and Support Services to add the untriaged GP referral to the outpatient waiting list as the clinical priority that the GP had assigned.</p>	<p>For routine and Urgent GP referrals, non-adherence and non-enforcement of the Integrated Elective Access Protocol (IEAP), resulted in referrals not being returned within the appropriate timeframe, which then resulted in a lost opportunity to either upgrade or downgrade urgent/routine referrals</p>	<p>The introduction of e-Triage on 27/3/17 enabled referrals to be monitored with respect to the triage process.</p> <p>A revised triage process (appendix 1) is based on the current IEAP was drafted/finalised and shared with all teams and this addresses the issues of timely and appropriate triaging</p> <p>Ongoing risks that still need addressed;</p> <p>Consultant-to-Consultant referrals (including outside of Trust) are not currently managed through e-Triage so there is still a risk that these could be delayed, and this is being addressed regionally as this is the same problem in all of the Trusts. While work is ongoing to resolve this, the Trust's current process is that all Consultant to Consultant referrals are added to e-Triage manually and a Standard Operation Procedure has been updated (appendix 2)</p>	<p>After 7 days</p> <p>Non- triage of urgent and routine referrals is escalated by the Referral & Booking Centre to the Operational Support Lead for the Clinical Area</p> <p>After 21 days</p> <p>OSL to escalate to Lead Clinician and HOS and copy Assistant Director of Functional & Support Services</p> <p>After 28 days</p> <p>HOS escalates to AD & AMD to address.</p> <p>After 35 days</p> <p>AD & AMD escalates to Director of Acute</p>	<p>27-Mar-17</p>	<p>This was developed regionally by Business Services Organisation and was rolled out to all Trust's with Urology Specialty being one of the first specialties to piloted this. This was addressed by the Information Technology Department with staff being seconded to work on this project with the individual specialties.</p> <p>ongoing monitoring is carried out by the Referral</p>	<p>Transformational Lead</p> <p>Referral and Booking Centre</p> <p>Operational Service Lead</p> <p>Lead Clinician</p> <p>Head of Service</p> <p>Assistant Director for Functional Support</p>
Non-dictation on patients who had attended outpatient clinics	<p>Some patients not having a letter dictated following an outpatient consultation resulting in no outcome recorded on PAS.</p>	<p>The current system used by the Trust to dictate clinic letters is the G2 system which replaced the hand-held dictaphones and whilst there is a report generated to provide how many letters have been dictated this is a stand-alone system which does not provide the patient demographics and the consultant still needs to provide this at the start of their letters, so there is currently no system or process that provides assurance that each outpatient consultation generates an outpatient outcome letter</p>	<p>All Medical staff must understand that a letter is required for every outpatient attendance.</p> <p>A limitation with the G2 system is that it simply records speech and generates a letter. However G2 is unable to correlate the letter dictated against the outpatient attendance.</p> <p>The Trust has been working on the G2/PAS interface. This major piece of work required integration with the help of BSO. It is now in 'live' mode and is being piloted by one consultant with positive feedback. This will provide the Trust with more assurance around the dictation of outpatient clinics.</p> <p>A policy and guidance document is being drafted and will be circulated to all Medical Staff to reiterate that a letter must be done for all outpatient attendance including for patients who do not attend.</p> <p>An updated typing Standard Operational policy is being drafted to highlight that when a letter is not dictated for a patient that the secretary raises with the consultant and line manager in the first instance. Secretaries need to do a check and balance after every clinic checking that every patient has a letter dictated. Secretaries to stipulate on their backlog reports if they know of any undictated clinics/letters</p> <p>Monthly typing reports are produced and shared throughout all divisions</p> <p>At Junior doctor changeover inductions, the importance of timely and accurate dictating of all outpatients they have reviewed must be highlighted to them.</p>	<p>When the secretary is typing the clinics she must escalate to the Consultant by e mail and cc their service administrator if there are any letters missing on Digital Dictation.</p> <p>If no response After 7 days</p> <p>This is escalated to the Service Administrator.</p> <p>After 14 days Service Administrator to escalate to Lead Clinician and HOS</p> <p>After 21 days</p> <p>HOS escalates to AD & AMD to address.</p> <p>After 28 days</p> <p>AD & AMD escalates to Director of Acute</p>	<p>Nov-21</p>	<p>Information technology Department</p> <p>Assistant Director of Functional Support Services</p> <p>Head of Referral and Booking Centre</p> <p>Service Administrators</p> <p>Medical Secretaries</p>	
Hospital notes being stored off Trust premises, namely the Consultant's home	<p>Patient's hospital records electronically casenote tracked to a consultant and a location.</p>	<p>When patients hospital records were required same not in the tracked location</p> <p>At a time health records did complete IR1 forms but were advised to stop by the Director at that time.</p>	<p>Current tracking system is a function on Patient Administrative System (PAS)</p> <p>Missing Charts are investigated and an IR1 form (datix) is completed if not found</p> <p>Any missing notes need to have an IR1 raised to highlight the problem. These should be reported to the respective areas.</p> <p>All staff managing patient notes are reminded of the need for accuracy on PAS when tracking notes and patient records should be returned to file as soon as possible and all consultants are reminded regularly that all charts are tracked in their name and that it is their responsibility to ensure the notes are kept in the location that the notes are tracked to.</p> <p>Business Case for IFit which is an electronic tracking system using barcode technology (as used in other Trusts in NI) is being considered for funding until the NI Electronic Patient Record replaces paper records under the Encompass Project</p> <p>This had been previously submitted and approved but no funding identified/available</p>	<p>Service Administrators to do spot-checks of offices and highlight any issues of charts being stored beyond a reasonable time period</p> <p>IR1's to be monitored by the Head of health records and to escalate to the AD FSS Division for repeat 'Borrower' missing notes and any concerns over a particular consultant should be escalated to Clinical Director/AMD and AD</p>	<p>Ongoing - pending funding allocation</p>	<p>Assistant Director of Functional Support Services</p> <p>Head of Records</p> <p>Service Administrators</p> <p>Medical Secretaries</p> <p>Head of Service</p>	
Private Patient's being scheduled sooner and outside of clinical priority than those from NHS patients	<p>Patients who had been initially reviewed privately were added to the waiting list in a non-chronological manner</p>	<p>No monitoring of patients seen privately where they are entered onto the waiting list</p>	<p>This is governed by the Private Patient policy</p> <p>This policy is currently being revised with a view to being reissued in September 2022</p> <p>Data Quality Release notice for recording of private patient activity on PAS has shared amongst clinical teams.</p> <p>An audit programme to assure private practice has been developed and will be deployed in June 2022</p>	<p>No compliances will be escalated to the Divisional Medical Director in the first instance. Pending were an issue of non-compliance is identified this will in turn be raised with the Medical Director who will consider the most appropriate action. Where cases that are found to be significantly outside of Private Patient policy the Trust and there are concerns regarding probity the Trust will consider application of MHPS framework</p>	<p>Ongoing - September 2022</p>	<p>Medical Director</p> <p>Deputy Medical Director - Appraisal and Revalidation</p> <p>Assistant Director - Medical Directors Office</p>	

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

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

PURPOSE OF TRIAGE

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



Note: This process will incur a minimum of 5 weeks in total if referral is un-triaged within the target times which means that if the referral is upgraded to Red Flag it is in excess of 14 day Red Flag turnaround.



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ADMINISTRATIVE & CLERICAL Standard Operating Procedure

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

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

Introduction

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

Implementation

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

Consultant to Consultant Referrals

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

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

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

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

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

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

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

ADMINISTRATIVE & CLERICAL STANDARD OPERATING PROCEDURE

Title	Checklist for processing typing of clinics, discharges and results letters <i>including final check & balance</i>	
S.O.P. Number	1	
Version Number	2	Supersedes: Typing SOP 3/10/11
Author	Katherine Robinson, Lucia Cunningham ,Joanne O'Brien and Susan Elliott	
Page Count	3	
Date of Implementation	1 st April 2022	
Date of Review	1 st April 2024	To be reviewed by: All Service Administrators
Approved by	Anita Carroll, Joanne McEvoy and Katherine Robinson	

Introduction

This SOP details the process for typing clinics, discharges and results including a final 'check and balance'.

Process – Clinic Attendances

- 1 Immediately on receipt of green 'adding to inpatient waiting list form' patients must be added to the inpatient waiting list on PAS by the secretary/audio-typist.
- 2 Type clinic letter and check any future appointments (6 weeks)/waiting list additions have been made on PAS by out-patient reception staff – if these have not been done it is the responsibility of the secretary/audio typist to do so.
- 3 Update any waiting list entry to the 'urgent review waiting list' when the consultant has indicated that the patient must be seen within a specific month ie Red Flag or patients on a specific medication
- 4 Discharge all patients who no longer require clinic review. Do not leave outpatient registrations open. If unsure of clinic outcome because dictation has not been clear, raise with consultant.
- 5 Discharge any patients who are awaiting results function set, OPI function, OD reason code DARO – the investigation should be entered in the reason text. The secretary/audio typist should also check that the investigation has actually been requested by the clinician, if not or no access to a system, raise with Service Administrator.
- 6 Patients who are admitted direct from clinic must be discharged on Function OD reason code ADM – details can be given of the ward etc in the reason text.
- 7 Patients with a date for a procedure from the clinic must be pre-admitted using function set ATD, function PAD. If a patient does not have a future appointment/waiting list entry they must also be discharged from the clinic, function set OPI, OD and use the appropriate code.
- 8 Patients who require a further date for a procedure should be added to the waiting list, function set WL and function WLA. Patients who do not have a future appointment/waiting list entry must also be discharged from the clinic using the OD function and reason code – details can be given of the procedure, ward, etc in the reason text.
- 9 Record DNA's, (Did not attend) as per Trust DNA policy
- 10 Ensure AAD's (attendances and disposals) are updated on PAS for each clinic (follow Attendance & Disposal SOP)
- 11 Ensure 'verification' status is completed on patient centre for EDT (Electronic Document Transfer)
- 12 Send any copy letters via post or email to other consultants, other hospitals etc. It is best practice to send to all by scanning/email as this provides an audit trail.
- 13 **Do a final 'check and balance' at the end of each clinic counting the number on the actual clinic list against the number of letters that are typed. Check there is a letter for every patient including DNAs and CNAs.**
- 14 **Bring to the attention of the clinician via email (copy in Service Administrator) any patients who have not had a letter dictated against them. Service Administrators will follow up on this monthly via a specific B/F procedure.**

- 15 Highlight on the backlog report any issues regarding non-dictation of clinics and no dictation on specific patients.
- 16 Track charts, update after each step of the process

Process – Discharges

- 1 Once discharges are typed or received via ECM from the ward clerks by email the secretary must check that all review appointments /waiting list additions have been made by the ward clerk. If these have not been completed it is the secretary/audio –typists responsibility to do so. Consistent failure to action follow up by the ward clerks should be brought to the attention of your Service Administrator for further escalation.
- 2 If any future investigations are required as an outpatient the secretary/audio-typist must ensure that these have been requested. Consistent failure to action by the medics should be brought to the attention of your Service Administrator.
- 3 Check that the patients are added to the waiting list for any future procedures that are planned. Function set, WL, function WLA.
- 4 Preadmit the patient if they have a date to come in for a future procedure, function set ADM, function PAD.
- 5 Send any relevant information to the other consultants, hospitals, (ward clerks responsibility) The ECM will automatically go to the GPs via EDT.
- 6 Track charts, update after each step of the process

Process – Results Letters

- 1 Type result letter, if a patient was discharged awaiting results and is now to be discharged, updated the patients records, function set OPI, function OD and choose the appropriate reason code, a reason text can be entered if felt necessary.
- 2 Check future appointments/waiting list entries have been made if required.
- 3 Ensure 'verification' is complete on Patient Centre for EDT/
- 4 Track charts – update after each step of the process
- 5 If a patient is being referred to another consultant follow SOP for 'Consultant to Consultant referrals'

Memorandum

To:	All Medical Staff (Consultant, SAS and Junior Doctors)
c.c.	Anita Carroll, AD Functional and Support Services; Katherine Robinson, Head of Secretarial and Booking Staff; Joanne McEvoy, Head of Health Records; Melanie McClements, Director of Acute Services (for dissemination)
From:	Maria O'Kane, Medical Director
Date:	1 st April 2022
Subject:	Acute Services Administration Processes

For all Medical Staff working within Acute Services

Dear Colleagues,

I would be grateful if you could assist with the following administrative processes, which also impact on patient safety. These administrative processes are already in place but if not always followed unfortunately could potentially lead to a significant risk of delay and ultimately harm to patients. If the administrative processes are adhered to they can also improve efficiency amongst administration and clerical staff and reduce risk to our patients.

Management of Administrative Staff

For purposes of clarity, management responsibility regarding administrative staff the following applies. Anita Carroll is the Assistant Director with responsibility for Health Records, Ward Clerks, Secretaries, Audio Typists, Booking Centre other administrative staff within Acute Services. Joanne McEvoy, Head of Health Records and Katherine Robinson, Head of Secretarial and Booking Staff are the Heads of Service for Administration in these areas and any issues regarding administration should be brought to their attention. They and the relevant Service Administrators will then work alongside the Head of Service for the Divisions to resolve identified issues.

Outpatients

- Can I ask that all medical staff remember to highlight Red Flag Cancer and high risk patients as appropriate on G2. This will ensure the clerical and administration staff can prioritise these communications.
- Junior doctors should select the appropriate supervisor (Consultant of clinic) on G2 for their clinic dictation. Unfortunately, frequently this is not completed and therefore dictation will not appear on the appropriate worklists for clerical staff. In some circumstances they may not be visible to the appropriate staff at all.
- Clinic outcome forms should be used to avoid unnecessary delays in the patient pathway, referrals and adding patients to waiting lists. The clinic outcome form records the outcome for each patient after their outpatient consultation, e.g. *review in 6/52, review in 3/12, add to WL, Discharge* . This is a vital communication tool for administration staff as they use the clinic outcome sheet to action any follow up immediately instead of waiting to listen to dictation, and so avoid delays in getting patients added to the Waiting list / referred on to another consultant.
- If a patient requires review within a specific timescale this should be highlighted by using the comment – *Must be seen (MBS 3 months)* or *Urgent 3 months* to ensure the patient is added to the correct review waiting list. When the booking centre is selecting patients for review for outpatient clinics it selects from the Must Be Seen and Urgent Waiting Lists first, and so ensures that these patients are seen within the required timeframe.
- Waiting list Proformas should be placed in a separate envelope and placed on top of the charts after each clinic. When the secretary receives the envelope they will add the patients to the waiting list immediately. If the proforma is placed inside the patients chart this will cause a delay in adding the patient to the waiting list as they will not be dealt with until the clinic is typed.
- All doctors must ensure a letter is dictated for every clinic appointment including patients who Did Not Attend (DNA) and Could Not Attend (CNA)

Inpatients**E Discharges**

- The information recorded on the e-discharge letter may seem unclear to others, e.g. *'review in due course'*, or *'refer to Dr Smyth'*. This is ambiguous— if a patient requires to be reviewed then a timeframe must be stated.
- If a patient has to be referred on to another consultant / specialty / hospital full details of the consultant, the specialty and the hospital site must be recorded on the discharge letter.
- If a discharge letter is changed the ward clerk must be informed – e.g. it may be changed to record that a review appointment is required. However if the ward clerk hasn't been told that changes have been made she / he will not know to book a follow up appointment.
- Delay in completing a discharge letter or not completing a discharge letter at all could lead to a patient's review/referral not being made.
- Doctors are reminded to authorise the discharge letter when they have finished it. If this does not happen the ward clerk cannot print the letter and therefore complete the follow up action and file the letter in the chart.

Misfiling

- Misfiling – some medical and nursing staff collect patient documentation and place this into a single chart – this may contain more than one person's information. If that patient is then transferred to another ward without the ward clerk having had the opportunity to check the loose filing the chart will contain incorrect information.
- Following an SAI where the Coroner was critical regarding a missing Kardex, ward clerks have commenced a new process where they are filing the patient information at discharge and they record any missing information. This has highlighted a problem with the Kardex. As a result Kardexs have recorded as missing. .

Results

- Results and X-rays on the ward must be signed by electronic means if possible
- Results in paper form should be viewed/actioned and not held back until a chart is available or previous clinic letter is typed. Doctors can action the results and advise for urgent typing straight away.

If you have any questions regarding these issues please contact Anita Carroll, Assistant Director Functional and Support Services. It is important that we all adhere to established administration processes to ensure that we provide safe, effective and efficient care for all patients.

Yours sincerely

Personal Information redacted by the USI

DR MARIA O'KANE
MEDICAL DIRECTOR



Southern Health
and Social Care Trust

Quality Care - for you, with you

Assistant Director – Medical Directorate



Working together



Excellence



Openness & Honesty



Compassion



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JOB DESCRIPTION

JOB TITLE	Assistant Director – Medical Directorate
BAND	8C
DIRECTORATE	Medical Directorate
INITIAL LOCATION	Daisy Hill Hospital
REPORTS TO	Medical Director
ACCOUNTABLE TO	Medical Director

JOB SUMMARY

The postholder will work closely with the Medical Director, Associate Medical Directors and other Trust Directors to facilitate the implementation of the strategic and operational objectives of the Trust, in line with corporate policies and strategies. In particular the postholder will have lead responsibility on the planning, implementation and progression of specific strategic objectives for which the Medical Director is accountable. The postholder will act on behalf for the Medical Director in all aspects of their role.

The role of this post is to deliver on the strategic and operational priorities of the Medical Directorate, with a focus on:

- Medical leadership
 - Medical revalidation
 - Medical appraisal
 - Medical Job planning
 - Medical leadership development
 - Delivering on the Medical Directors/AMDs identified priorities



- Medical education
 - Undergraduate training
 - Postgraduate training
- Patient safety and clinical & quality indicators
 - Mortality & Morbidity
 - Clinical audit
 - Clinical guidelines
- Research & Development
- Infection prevention and control
- Business continuity and emergency planning
- Financial management within the Medical Directorate
- Staff management within the Medical Directorate

This post also has lead responsibility within Acute Services for:

- Co-ordinating the Acute Services Directorates response to the CAH site-wide hospital redevelopment plans
- Ensuring up to date plans are in place within the Acute Services Directorate for responding to a Major Incident
- Organising and participating in the Acute Services Directorate on-call rota

KEY DUTIES / RESPONSIBILITIES

Medical leadership - Medical Education

1. Provide managerial support to the designated Responsible Officer for the Trust in the **revalidation** of the Trust Medical workforce.
2. Development, implementation and on-going management of an effective scheme of **medical appraisal** which will meet the requirements of revalidation as defined by the General Medical Council.
3. Participation and development of collaborative working channels with regional colleagues, the DHSSPS and the General Medical Council on the development of



frameworks to support the implementation of revalidation, including development of MSF, Patient and Client Feedback and on-line appraisal systems.

4. Lead role in the development of corporate responses to consultations linked to professional governance.
5. Lead role in the interpretation of professional regulatory advice in relation to appraisal, revalidation, Good Medical Practice, continuing professional development – and lead responsibility for the development and/or amendment of policies/guidelines to reflect changes.
6. Provide leadership and support for **medical job planning** within the Trust
7. Work with Medical HR on the development of reports and updates, on behalf of the Medical Director on **professional workforce issues** to Senior Management Team, Governance Committee and Trust Board.
8. Research and development of audit methodologies that provide assurance to the Responsible Officer on the quality of medical appraisal.
9. Attendance at regional and national conferences to ensure best practice within the field of clinical leadership is applied within the Southern Trust.
10. Where required, lead the development and refinement of in-house bespoke information systems to monitor appraisal processes, professional registration, continuing professional development, study leave and mandatory training of medical staff.
11. Operational responsibility for the **undergraduate medical education** functions in the Trust.
12. Delivery of the QUB Accountability Framework – including liaison with regional committees, implementation of quality assurance and governance arrangements for undergraduate education.
13. Explore and develop links with other undergraduate suppliers including RCSI where appropriate.
14. Development of appraisal/performance management/response to feedback mechanisms to ensure quality educational experience.
15. Operational responsibility for the Trust **postgraduate medical education** functions.
16. Ensure that processes exist for effective communication with all junior medical staff, irrespective of working patterns.



17. Work collaboratively with Operational and Medical HR to ensure the aims and targets of the New Deal for junior doctors are implemented and compliance with EWTD for junior doctors and career grade doctors is achieved and maintained.
18. Work collaboratively with Medical HR in the preparation of business cases for Junior doctor EWTD/New Deal compliance and manage the process of obtaining internal and external approvals in line with local and regional policy and standards.
19. Management of the relationship with NIMDTA in relation to Deanery Visits and the associated remedial actions.
20. Lead responsibility for the analysis of General Medical Council – Trainer and Trainee Surveys and development of supporting action plans.
21. Work collaboratively with NIMDTA and Medical HR to support the revalidation of junior medical staff.
22. Responsibility for the development of e-learning and on-site induction programme for junior medical staff.
23. Operational responsibility for the **continuing medical education of Consultant and SAS doctors**.
24. Develop a comprehensive programme of supervision for new start Consultants and SAS doctors.
25. Oversee the development of a leadership development programme for Consultants and SAS doctors.
26. Oversee the implementation of the Trust's Specialty doctor Framework.

Patient Safety and Clinical & Quality Indicators

1. Work with the Clinical Audit and Governance teams in the development of **in-house clinical indicators**, including research of best practice, development of methodologies, development, pilot and implementation.
2. Keep up to date with guidelines, best practice in relation to clinical indicators and patient safety and implement learning where appropriate.
3. Responsibility for the management of the implementation of **external clinical guidelines** and standards apportioned to the Medical Director, including their interpretation, development of implementation plans and on-going monitoring.



4. Implement and co-ordinate the Trust's M&M programme.
5. Liaise with regional bodies to develop further M&M reporting systems.
6. Support the Trust's whistleblowing Framework across medical staff groups in association with HR.

Research and Development

1. Operational management of **Research and Development** support staff.
2. Responsible for the implementation of a clear Research and Development strategy for the Trust.
3. Provide Trust representation at regional and national level on Research and development projects, such as ECME

Infection Prevention and Control

1. Managerial responsibility for the Trust **Infection Prevention and Control Team**.
2. Managerial support for the Infection Prevention and Control Governance structure.
3. Communication and collaborative working with internal and external agencies and stakeholders to ensure the achievement of performance and strategic objectives in relation to Healthcare Associated Infections.
4. Ensure regional policy and guidelines in relation to HCAI are effectively communicated, responded to and implemented.
5. Deputise for Medical Director at relevant internal and external committees/meetings in relation to HCAI.
6. Ensure effective mechanisms for performance management of HCAI infections against internal and external targets.
7. Responsibility for the achievement of Infection Control – Controls Assurance Standard.
8. Co-ordinate the Trust's response to achieving relevant PHA infection control targets.



9. Co-ordinate the work streams of the Antibiotic Stewardship champions.
10. Chair the Microbiology/infection Control Team meetings where appropriate.
11. Establish a leadership structure within the microbiology team, liaising with other Trusts and develop networking arrangements.

Business Continuity & Emergency Planning

1. Support the Directorate Management teams in their development of processes and systems to embed **business continuity management** within the organisation.
2. Ensure the Trust business continuity function satisfies the requirements in relation to accountability, governance and assurance requirements as outlined in the in the context of the NI Civil Contingencies Framework (2005).
3. Support the Directorate Management teams in their development of processes, plans and systems across the Trust for **emergency planning**, including the achievement of compliance with the Emergency Planning Controls Assurance Standards.
4. Co-ordinate Emergency Planning exercises across the Trust and ensure the successful testing of emergency plans at hospital and bronze levels on a regular basis.
5. Co-ordinate and support Trust-wide IFR and ECR requests.
6. Management of ECRs and drug requests for Southern Trust patients and undertaking the necessary liaison with commissioners.

Financial management

1. Responsibility for the **Directorate Budget** including the SUMDE Undergraduate Medical Education budget, ensuring the appropriate application of financial governance arrangements

Staff management



1. Responsibility for all **staff management** issues for staff within the Medical Directorate.
2. Review individually, at least annually the performance of immediately subordinate staff providing guidance on personal development requirements and initiate, where appropriate, further training.
3. Maintain staff relationships and morale among staff within the Medical Directorate.
4. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.
5. Participate in the selection and appointment of staff.
6. Develop and maintain effective communication networks and working relationships with key persons both within and outside the organisation.

Acute Services

1. Responsibility for co-ordinating the Acute Services Directorates response to the **CAH site-wide hospital redevelopment plans**, including ensuring that all Divisions, particularly operational teams, are engaged in the planning phases of this project.
2. Reviewing the **Acute Services Directorates response to a major incident**, and ensuring that plans are tested on a regular basis, and that are up-to-date and relevant to all threats which are emerging.
3. Participating in the **on-call rota** for AD/HOS within Acute Services, including organising and ensuring the distribution of the on-call rota

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

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



1. Establish and promote a supportive, fair and open culture that encourages and enables all parts of the team to have clearly aligned goals and objectives, to meet the required performance standards and to achieve continuous improvement in the services they deliver.
2. Ensure access to skills and personal development through appropriate training and support.
3. Promote a culture of openness and honesty to enable shared learning.
4. Encourage and empower others in their team to achieve their goals and reach their full potential through regular supportive conversation and shared decision making.
5. Adhere to and promote Trust policy and procedure in all staffing matters, participating as appropriate in a way which underpins Trust values.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. Adhere at all times to all Trust policies/codes of conduct, including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
 - standards of attendance, appearance and behaviour
4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
5. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.



6. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004, the General Data Protection Regulations (GDPR) and the Data Protection Act 2018. Employees are required to be conversant with the [org name] policy and procedures on records management and to seek advice if in doubt.
7. Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.
8. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

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

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

January 2020





Quality Care - for you, with you

PERSONNEL SPECIFICATION

JOB TITLE AND BAND

DEPARTMENT / DIRECTORATE

SALARY

HOURS

Ref No: <to be inserted by HR>

<Month & Year>

Notes to applicants:

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

ESSENTIAL CRITERIA

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

Factor	Criteria <i>Ideally no more than 6-8 criteria in this section</i>	Method of Assessment
Experience	<i>Manager should insert quantifiable and well defined criteria in relation to experience</i>	Shortlisting by Application Form
Qualifications/ Registration	<i>Include equivalencies where necessary</i>	Shortlisting by Application Form
Other	Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. <i>This criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of</i>	Shortlisting by Application Form



	<i>transport approved by the Trust which will permit them to carry out the duties of the post.</i>	
SECTION 2: The following are ESSENTIAL criteria which will be measured during the interview/ selection stage:		
Skills / Abilities	<i>Manager should insert relevant criteria Ideally no more than 6-8 criteria in this section</i>	Interview / Test
Knowledge		Interview / Test

DESIRABLE CRITERIA

SECTION 3: these will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these criteria. Failure to do so may result in you not being shortlisted

Factor	Criteria	Method of Assessment
Experience	<i>Manager should insert quantifiable and well defined criteria in relation to qualifications, experience > Ideally no more than 2-3 criteria in this section</i>	Shortlisting by Application Form
Qualifications	<i>Include equivalencies where necessary</i>	Shortlisting by Application Form

INCLUDE FOR SENIOR POSTS (Band 8a or above) IF RELEVANT

Candidates who are shortlisted for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. The competencies concerned are set out in the NHS Healthcare Leadership Model, details of which can be found at

<http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model>.

Particular attention will be given to the following dimensions:

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



If this is a Temporary Post add the following statement:

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

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

Successful applicants may be required to attend for a Health Assessment

THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER



**Working Together****What does this mean?**

We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.

What does this look like in practice? - Behaviours

- I work with others and value everyone's contribution
- I treat people with respect and dignity
- I work as part of a team looking for opportunities to support and help people in both my own and other teams
- I actively engage people on issues that affect them
- I look for feedback and examples of good practice, aiming to improve where possible

**Compassion**

We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.

- I am sensitive to the different needs and feelings of others and treat people with kindness
- I learn from others by listening carefully to them
- I look after my own health and well-being so that I can care for and support others

**Excellence**

We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high-quality, compassionate care and support.

- I put the people I care for and support at the centre of all I do to make a difference
- I take responsibility for my decisions and actions
- I commit to best practice and sharing learning, while continually learning and developing
- I try to improve by asking 'could we do this better?'

**Openness & Honesty**

We are open and honest with each other and act with integrity and candour.

- I am open and honest in order to develop trusting relationships
- I ask someone for help when needed
- I speak up if I have concerns
- I challenge inappropriate or unacceptable behaviour and practice

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



Follow us on:



Deputy Medical Director

Medical Appraisal and Revalidation (24 Months Initially)

Date of Advertisement:

Closing Date:



Invitation from the Medical Director

We are seeking to recruit a Deputy Medical Director with responsibility for **Medical Appraisal and Revalidation** to join our Medical Directorate team. The successful candidate will support the Trust Medical Director in providing strong professional leadership and direction, support high standards of medical practice and provide resolved advice for medical matters across the organisation, which has a reputation for excellent care, innovation and a focus on improving the experience and outcomes of all who use our services.

At a time of systemic change and challenge for health and social care within Northern Ireland, the Deputy Medical Director will take a leadership role in the provision of safe, high quality services, and support the delivery of the Trust's transformation agenda.

They will be results driven and have an exemplary track record as a clinical leader. If you have:

- the drive and ambition to keep the Southern Health & Social Care Trust at the forefront of development in health and social care;
- the passion and expertise to make a real contribution to our journey of continual improvement; and,
- a strong value base of service to our patients, clients and community,

then I look forward to receiving your completed application form.

DR MARIA O'KANE
MEDICAL DIRECTOR

JOB DESCRIPTION

JOB TITLE:	Deputy Medical Director Medical Appraisal and Revalidation (Up to 6 PAs)
BASE:	Base to be determined, however, post will have a Trustwide remit
DIRECTORATE:	Medical Directorate
RESPONSIBLE TO:	Medical Director
ACCOUNTABLE TO:	Medical Director

JOB SUMMARY

The Deputy Medical Director (Medical Appraisal and Revalidation) will focus with the Medical Director on providing strong leadership, systems and process to lead on professional standards and leadership development across the organisation, providing expert advice, develop, monitor and review Medical Appraisal and Revalidation systems and processes, and participate in training programmes as required. The appointee will be professionally accountable to the Medical Director for medical professional regulation within this role, and will deputise for the Medical Director as required in the key responsibilities as detailed below. Opportunities to continue to deliver direct clinical care for the Trust will be encouraged.

KEY RESPONSIBILITIES**Setting Direction**

- Provide professional leadership to medical staff, communicating the organisation's perspective to clinicians and building commitment among clinicians to achieve the Trust's objectives and overall aim of safe, high quality and responsive services in line with HSC values.
- Lead on the continued development, maintenance and strengthening of the Trust Medical Appraisal and Revalidation system.
- Lead on the development, maintenance and strengthening of a systems for Trust Medical Performance Support.
- Through the Medical Leadership team, Clinical Directors and Operational Directors, ensure that the Trust's Medical Appraisal and Revalidation system delivers measurable, targeted objectives.

Medical Appraisal and Revalidation

- Deputise Responsible Officer function for Medical Director for Medical Appraisal & Revalidation processes as required
- Through the Trust's Responsible Officer, Lead for Appraisal and Revalidation and Revalidation team ensure the implementation and maintenance of an appraisal, revalidation and performance review system, through setting of personal objectives for all medical staff (including locums) including the operation of relevant disciplinary procedures as and when appropriate.
- Manage the activity of medical appraisers to defined and quality assured standards.
- Promote excellence in medical appraisal to deliver robust revalidation recommendations and quality improvements in patient care through the professional development of doctors.
- Lead on the recruitment and selection of medical appraisers.
- Organise and/or delivering competency based new appraiser training.
- Lead and support the senior appraisers of the appraisal office.
- Support new appraisers through a probationary period, such as the first three appraisals, providing feedback on their performance.
- Monitor performance of existing appraisers, ensuring that appraisals are conducted in line with national, regional and local guidance, and that regular feedback is provided.
- Promote and support the continuing professional development (CPD) of medical appraisers.
- Promote the benchmarking of professional judgements between medical appraisers through the provision of resources and opportunities to learn with and from others.
- Support and facilitating local medical appraiser support group meetings, directly or indirectly.
- Answer queries from doctors and appraisers regarding the Medical Appraisal and Revalidation systems and processes
- Supporting the role of the responsible officer (RO) by ensuring that the outputs of appraisal provide the required information to enable robust revalidation recommendations to be made.
- Ensure that Medical Staff appraisals are carried out before the end of year deadline.
- Produce and promote appropriate evaluation, reports and summaries.
- Deal with significant events and complaints, with the medical appraisal manager.
- Keep abreast of local and national developments in appraisal and revalidation.
- Promote a quality assured appraisal and revalidation process to doctors and appraisers.
- Represent the appraisal team at local, regional and national initiatives

relating to the development and implementation of appraisal.

- Network with other clinical appraisal leads and their teams to maintain standards of delivery of medical appraisal across the HSC.
- Liaise with medical educators and their networks on issues relating to continuing professional development (CPD) for doctors being appraised.
- Ensure compliance with all confidentiality and governance requirements.
- Working at all times to promote equality and reduce inequalities, promote the health, safety and well-being of all staff.
- Engage with key stakeholders, including GMC and the Academy of Medical Royal Colleges.

Medical Performance Support

- On behalf of the Medical Director, lead on the development, implementation and evaluation of a robust framework to provide assurance regarding Medical Performance support, including the provision of performance management data, such as:
 - CLIP data
 - Clinical and Social Care Governance Indicators (e.g. SAI, Adverse Incident, Complaints, Clinical Audit)
 - Job planning
 - Education, Training and Development
- With Divisional Medical Directors and operational managers will support and coordinate the roll out of the medical performance support programme across all Trust operational directorates
- Develop processes to quality assure Medical Performance Support Processes
- Develop systems to record, track and report on Medical Performance Support progress Trustwide providing reports to the Medical Director, DMDs and Trust Board as appropriate
- Develop mechanisms to provide monitoring reports on Medical Performance Support activity and develop audit of clinical prioritisation.
- Lead on the development of support and escalation processes where areas of non-compliance with Trust policy and process are identified regarding Medical Performance Support

Private Practice and Paying Patients

- Provide assurance to the Medical Director that paying / private practice policy and relevant codes of practice are kept up to date with both statutory and regional requirements and adhered to across all service areas
- On behalf of the Medical Director, work with operational teams and clinical leaders to develop mechanism to provide assurance that paying / private practice within the Trust is standardised, appropriately audited and monitored on an ongoing basis.
- Ensure that all medical staff are aware of their duties and responsibilities within the health service of medical staff engaging in private practice and fee paying services both inside and outside the Trust.
- Ensure that all Trust staff, clinical and non-clinical, in relation to the treatment of paying patients and fee paying services within the Trust.
- Provide assurance to the Medical Director that HSC values are applied to paying / private practice ensuring fairness and equality for both NHS patients and fee paying / private patients at all times.
- Provide assurance that the arrangements pertaining to paying / private patients is adhered to regarding:
 - record keeping
 - charging practices
 - administrative practices relating to transfers of status / onward referrals
- Develop mechanisms to provide monitoring reports on private / paying patient activity and develop mechanisms for audit of clinical prioritisation.
- Lead on the development of support and escalation processes where areas of non-compliance with Trust policy and process are identified regarding private / paying patient practice.

Collaborative Working

- Work closely with Divisional Medical Directors, Associate Medical Directors and Medical Human Resources and Finance to provide information on medical appraisal and revalidation issues
- Work closely with Divisional Medical Directors, Associate Medical Directors, Clinical Directors, and Clinical and Social Care Governance teams to support quality improvement activities relating to medical appraisal and revalidation issues

- Liaise with clinical colleagues to ensure that activities the post holder is responsible for across the Trust are appropriately co-ordinated and integrated.
- Work closely with the Medical Human Resources team to deliver on all aspects of this role.

Service Development & Improvement

- Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.
4. Adhere at all times to all Trust policies/codes of conduct, including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
 - standards of attendance, appearance and behaviour
5. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
6. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
7. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-

based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004, the Data Protection Act 2018 and General Data Protection Regulations. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

8. Take responsibility for his/her own ongoing learning and development, including full participation in appraisal, in order to maximise his/her potential and continue to meet the demands of the post.
9. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner. Seek to engage and involve service users and members of the public in keeping with the Trust's Personal and Public Involvement Strategy and as appropriate to the job role.

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

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

SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE: Deputy Medical Director Appraisal and Revalidation

DIRECTORATE: Medical Directorate

HOURS: Up to 6PA's

Notes to applicants:

1. **Your application form:** You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should do this for both essential and desirable criteria requirements. All essential criteria requirements listed below must be met by the stated closing date, unless otherwise stated.
2. Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.

ESSENTIAL CRITERIA

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

Factor	Criteria
QUALIFICATIONS / EXPERIENCE	<ol style="list-style-type: none"> 1. Hold full registration with the General Medical Council (GMC London) with a license to practice¹. 2. Have a minimum of 2 years' experience in a senior medical management / clinical leadership role² in a major complex organisation³. 3. Demonstrate personal responsibility for achieving measurable improvements in outcomes for Health and Social Care Services for a minimum of 2 years. 4. Have worked with a diverse range of stakeholders to achieve successful outcomes for a minimum of 2 years. 5. Evidence of practical experience of medical professional governance. 6. Evidence of practical experience supporting Medical Appraisal and Revalidation processes

¹ If successful at interview, applicants will be required to provide proof of their GMC application. Applicants must be registered, with a licence to practice at the time of appointment.

² 'senior medical management' is defined as experience gained at Associate Medical Director, Clinical Director or Clinical Lead equivalent level in a major complex organisation.

³ 'major complex organisation' is defined as one with at least 200 staff or an annual budget of at least £50 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders

The following are essential criteria which will be measured during the interview stage.

KNOWLEDGE, TRAINING & SKILLS	<p>7. Have an ability to provide effective leadership at a strategic level to enable the ongoing development and improvement of services.</p> <p>8. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.</p> <p>9. Demonstrate highly effective communication skills to meet the needs of the post in full.</p>
Other	<p>1. Hold a full current driving licence valid for use in the UK and have access to a car on appointment⁴. In respect of this point the successful applicant may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere.</p>

Candidates shortlisted and invited for further stages of selection will be assessed using the nine dimensions of leadership behaviour as specified in the ***NHS Leadership Academy Healthcare Leadership Model***, and the ***HSC's Values***. Shortlisted candidates will need to demonstrate that they have the required knowledge, skills, competencies and values to be effective in this role.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

⁴*This criterion will be waived in the case of a suitable applicant who has a disability which prohibits from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.*

JOB DESCRIPTION

POST:	Divisional Medical Director – Cancer and Clinical Services (Fixed Term Post 3 Years)
DIRECTORATE:	Acute Services (Under Review)
RESPONSIBLE TO:	Director of Acute Care (Under Review)
ACCOUNTABLE TO:	Medical Director
COMMITMENT:	3 PAs
LOCATION:	Trustwide

Context:

The Divisional Medical Director (DivMD) will be a leader of the Divisional Management Team, member of the Directorate Senior Management Team and Medical Directors divisional representative. The DivMD will have a lead role in ensuring the division maintains high quality, safe and effective services and will also contribute to the division's strategic direction.

The DivMD will embody HSC values of Openness & Honesty, Excellence, Compassion and Working Together. The Trust is firmly committed to embedding the "right culture" where everyone's "internal culture" or values are realized through the provision of caring, compassionate, safe and continuously improving high quality health and social care.

For the Southern Trust, the "right" culture is underpinned by a collective and compassionate leadership approach, model and behaviours. This Collective Leadership approach will be supported with the implementation of a more collective leadership (CLT) model within the Service Directorates.

Job Purpose:

The DivMD has a lead responsibility within the Division for the delivery and assurance surrounding all aspects of Professional and Clinical and Social Care Governance.

In partnership with the Assistant Director and Professional Leads the DivMD will also be responsible for setting divisional direction; service delivery; development; research and innovation; collaborative working; communication; financial and resource management; people management and development; information management and governance and performance management.

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.

- To medically lead on all aspects of patient safety.
- To provide robust clinical leadership in reviewing and improving cancer and clinical services in the context of the Urology Public Inquiry.
- To lead on all aspects of medical professional and clinical and social care governance including:

<ul style="list-style-type: none"> • Professional Medical Governance <ul style="list-style-type: none"> –Staffing and Staff Management –Professional Performance Management –Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Coronial Matters • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control) • Medications management 	<ul style="list-style-type: none"> • Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Medical Education in conjunction with DMD/ Dir Med Ed • Medical Workforce development • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement • Medical leadership in delivery of MCA and Safeguarding
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Specific Divisional Responsibilities

- Provide oversight and development of a workforce strategy for the division that meets the needs of the changing health and social care landscape
- Promote, develop and strengthen effective multi-professional team working and assurance mechanisms to strengthen governance arrangements surrounding Cancer MDT processes
- Provide leadership and guidance regarding the development of Radiology, Pathology and Cancer services within the Trust

Leadership Responsibilities

- To provide assurance on the quality of the professional, clinical and patient safety / Multi-Disciplinary Team systems, processes and meetings within the division.
- To promote quality improvement and to grow and embed a culture of Collective Leadership within the Division.
- To manage the clinical quality of care within the Division, promoting a climate of continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.
- To promote and strengthen links with primary care services including communications and development of service pathway improvements.
- To develop and ensure guidelines and clinical pathways are maintained and embedded within clinical and social care governance structures and culture.
- To be a leader in the alignment and commitment of developing a culture that delivers caring, compassionate, safe and continuously improving high quality health and social care.
- To be a leader in developing an inspiring vision that is put into practice at every level within the division, identify clear, aligned objectives for all teams, departments and

staff, provide supportive enabling people management, develop high levels of staff engagement, support learning, innovation and quality improvement in the practice of all staff.

- To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full potential.
- To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:
 - (a) delivery of safe, high quality and effective person-centred care
 - (b) secures activity and performance
 - (c) maintains ongoing financial viability
 - (d) is aligned to corporate goals
- The Divisional Medical Director with the Assistant Director and professional leads will work in partnership to achieve the above objectives.
- To be a leader in the development of key performance indicators for the Division and to ensure that effective performance management arrangements are in place.
- To ensure robust financial management of all medical staff across the Division.
- To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
- To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.
- To model the HSC values.
- To act as an advocate for the Division.
- To represent the Division at the relevant senior Trust meetings.
- To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.
- To ensure that systems are in place so that all Health and Safety and other statutory requirements for patients, visitors, employees and contractors and the wider public are met.
- Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
- Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options.
- To provide quarterly updates on the progress of aspects of professional and social care governance.
- Perform any other duties that are consistent with the post.

Appraisal and Revalidation

To work with the Appraisal and Revalidation Team to ensure that all doctors are engaged in Appraisal and Revalidation in a timely fashion.

Through the Collective leadership team and medical management structures to ensure that areas of concern raised within the Appraisal and Revalidation process are addressed.

In conjunction with the Medical Director's Office to be involved in the oversight of Revalidation and Appraisal processes including undertaking at least 8 appraisals

annually, equating to 0.25SPA of DivMD allocation.

Job Planning

- Provide leadership and support for Job planning process within the Directorate for Consultants, Associate Specialists and Specialty Doctors.
- Co-ordinate the implementation of Job Planning within Job Planning guidelines.
- Monitor the completion of Job Plans within agreed timescales.
- Undertake Job Planning for Clinical Directors (and Lead Clinicians) and any other relevant medical staff.
- Advise and mediate in cases that cannot be resolved by Clinical Directors within existing job planning guidance.
- Ensure that Job Planning process and outcomes reflects the Directorate's service capacity needs and Service and Budget Agreement with our Commissioner.

Implementation of HR policies for medical staff

- Co-ordinate and monitor implementation of all relevant policies including:
Annual Leave
Study Leave
Performance
Sickness absence
Locum cover (long and short term)
- Liaise with Human Resources for appropriate advice and support.
- Liaise with the Director of Medical Education and Training and NIMDTA with regard to junior doctors in training for appropriate advice and support.

Budgetary management

- Monitor financial information on medical staffing to ensure staff costs are within budget including the Division's collective training and development budget for non-training medical staff.
- Receive reports from Finance and work with Finance staff support on management of the budget.
- Take account of medical staffing costs within the Job Planning context.

GENERAL REQUIREMENTS:

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.
4. Adhere at all times to all Trust policies including for example:
 - Smoke Free policy

- IT Security Policy and Code of Conduct
5. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
 6. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
 7. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.
 8. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.
 9. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

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

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

SOUTHERN HEALTH & SOCIAL CARE TRUST**PERSONNEL SPECIFICATION**

JOB TITLE Divisional Medical Director – Cancer and Clinical Services

DIRECTORATE Acute Services

Notes to applicants:

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

ESSENTIAL CRITERIA – these are criteria all applicants **MUST** be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

1. Applicants must be a permanent Consultant within the Southern Health and Social Care Trust.
2. Hold a medical qualification, GMC registration with Licence to Practice and specialist accreditation (CCT).
3. Experience of leadership within a team that led to successful service development and/or quality improvement.
4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

The following are essential criteria which will be measured during the interview stage.

5. Excellent communication skills, both orally and in writing.
6. Be prepared to undertake clinical management development.

IMPORTANT NOTES REGARDING SELECTION PROCESS / INTERVIEW PREPARATION:

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

Prior to interview all shortlisted applicants will be offered the opportunity to meet with Dr Maria O'Kane, Medical Director to allow further discussion of the role of Divisional Medical Director in the Trust. You can do this at any time during the application process or immediately following shortlisting. To arrange a suitable appointment please contact Emma Campbell on Personal Information redacted by the USI.

You should also note that shortlisted applicants will be assessed against the criteria stated in this specification as it links to the NHS Healthcare Leadership Model. Candidates who are shortlisted for interview are therefore advised to familiarise themselves with this model to ensure that at interview they can adequately demonstrate they have the required skills to be effective in this demanding leadership role. Further information may be obtained from <http://www.leadershipacademy.nhs.uk/healthcare-leadership-model/>

Please note that interviews for this post will be held weeks commencing 29th November or 6th December 2021 (subject to change).

The post will be for a period of 3 years and will be offered under a separate contract which will attract additional programmed activities of 3PA's and a fixed management allowance of £ Personal Information per annum. Successful applicants can opt to have the responsibility allowance superannuable or non-superannuable at the outset of the contract agreement – which will then apply for the duration of the contract.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

JOB DESCRIPTION

JOB TITLE	Head of Urology and ENT
BAND	8B
DIRECTORATE	Acute
INITIAL LOCATION	Craigavon Area Hospital
REPORTS TO	Assistant Director

JOB SUMMARY

- To be responsible for the operational management and strategic development of Urology and ENT services across the Southern Trust.
- To be responsible for leadership, service provision and service development of Urology and ENT services and ensuring high quality patient centred services.
- To be responsible for achieving service objectives through the implementation of national, regional and local strategies and access targets.
- To work in partnership with the Assistant Director, Associate Medical and Clinical Director to define a service strategy, which support the Trust's and Division's overall strategic direction and ensures the provision of a high quality responsive service to patients within resources.
- As a head of service, the jobholder will be a member of the division's senior management team and will therefore contribute to policy development in the division and the achievement of its overall objectives.

KEY DUTIES / RESPONSIBILITIES**1. Quality & Governance**

- 1.1 Promote a culture which focuses on the provision of high quality safe and effective care, promotes continuous improvement, empowers staff to maximise their potential.
- 1.2 Be committed to supporting honest, open communication and effective multi-disciplinary working.
- 1.3 Develop appropriate mechanism/forums for accessing the views of and

engaging with staff, service users and their carers and use this information to inform the development, planning and delivery of services.

- 1.4 Support the Assistant Director with the implementation of quality initiatives such as Investors in People and Charter Standards.

2. Leading & People Management

- 2.1 Lead, manage, motivate and develop staff so as to maintain the highest level of staff morale and to create a climate within the Division characterised by high standards and openness.
- 2.2 Ensure the contributions and perspectives of staff are heard, valued and considered when management decisions are taken within the division.
- 2.3 Ensure that the division has in place effective arrangements for staff appraisal, training and development, using the KSF framework.
- 2.4 Continually review the workforce to ensure that it reflects the division's service plans and priorities. The manager will implement skill mix review, role redesign and changes to working practices as required.
- 2.5 Ensure the division implements and adheres to Trust HR policies and procedures.
- 2.6 Work in partnership with Trade Unions and staff representatives in developing the workforce, managing employee relations and changing working practices.

3. Service Delivery

- 3.1 Manage and co-ordinate the delivery of services to achieve safe and effective outcomes for patients who come into contact with the Trust.
- 3.2 Support the Assistant Director in achieving key access and performance targets for each service through robust planning and service improvement.
- 3.3 Make sure that services are delivered to the standard and quality expected by the DHSSPS, Regional Authority and by the Trust Board.
- 3.4 Facilitate multi-disciplinary and inter-agency working to make sure that services are co-ordinated to best effect.
- 3.5 Identify and contribute to local and national development initiatives e.g. clinical networks and national programmes.
- 3.6 Make sure that all recommendations arising from RQIA inspections are implemented in a timely manner.

- 3.7 Act as a member of the division's senior management team and contribute to its policy development processes.
- 3.8 Make sure that services are maintained at safe and effective levels, that performance is monitored in accordance with the Trust's policies and procedures and that corrective action is taken, where necessary, to address deficiencies.
- 3.9 Make sure that serious adverse incidents, accidents, incidents and near misses are brought to the attention of the Assistant Director at the earliest opportunity and are appropriately managed.

4. Strategic Planning and Development

- 4.1 Assist with the development of the strategic plan for the delivery of operational services on behalf of the Assistant Director in line with regional strategies, Ministerial and HSSA priorities.
- 4.2 Work closely with the Assistant Director to secure the commitment and involvement of commissioners and relevant internal and external stakeholders in the implementation of strategic planning initiatives and targets.
- 4.3 Work with members of relevant teams on the innovative development of new and existing services.

5. Financial & Resource Management

- 5.1 Be responsible and accountable for a delegated budget ensuring the optimum use of resources through establishing and maintaining effective management/financial processes.
- 5.2 Identify, negotiate and implement cost improvement and revenue generation opportunities when they arise.
- 5.3 Participate in contract and service level negotiations with commissioners.
- 5.4 Ensure that working arrangements are in place to enable the division to comply with the Trust's complaints procedure. To investigate complaints as appropriate under the procedure and ensure action is taken to address issues of concern and prevent reoccurrence of similar events.
- 5.5 Update and monitor the operational policies of the Division and take account of risk management needs.
- 5.6 Ensure procedures are in place to report, investigate and monitor clinical incidents putting action in place to address areas of concern.

- 5.7 Ensure that environmental standards are appropriate for safe & clean care delivery.

6. Information Management

- 6.1 Ensure the effective implementation of all Trust information management policies and procedures within the Division.
- 6.2 Ensure systems and procedures for the management and storage of information meet internal and external reporting requirements.

7. Corporate & Divisional Responsibilities

- 7.1 Contribute to the Trust's corporate planning, policy and decision making processes including the implementation of the Trust Performance Management Framework, in line with annual schedule, by contributing to the development of a Divisional Plan for Services.
- 7.2 Attend meetings of the Trust Board, its' committees or SMT as required to provide appropriate, high quality, information to the Assistant Director/ Director, Chief Executive and Trust Board concerning those areas for which he/she is responsible.
- 7.3 Develop and maintain working relationships with senior managers and staff to ensure the achievement of the Trust's objectives and the effective functioning of the directorate's management team.
- 7.4 Support the Assistant Director in establishing and maintaining effective collaborative relationships and networks with external stakeholders in the public, private voluntary and community sectors.
- 7.5 Participate in and comply with requirements in the production of performance reports.
- 7.6 Contribute to the Trust's overall corporate governance processes to ensure the development of an integrated governance framework for the Trust that assures safe and effective care for patients and clients and complies with public sector values, and codes of conduct, operations and accountability.
- 7.7 Lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

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

2. Maintain staff relationships and morale amongst the staff reporting to him/her.
3. Review the organisation plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives, and recommend change where appropriate.
4. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.
5. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
6. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. Adhere at all times to all Trust policies/codes of conduct, including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
 - standards of attendance, appearance and behaviour
4. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.
5. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

6. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.
7. Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the Band may be assigned from time to time.

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

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

PERSONNEL SPECIFICATION

JOB TITLE	Head of Urology and ENT Band 8B
DIRECTORATE	Acute Services
SALARY	£44,258 - £54,714 per annum
HOURS	Full Time

Notes to applicants:

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

ESSENTIAL CRITERIA – these are criteria all applicants **MUST** be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

QUALIFICATIONS / EXPERIENCE / SKILLS

- Hold a relevant¹, University Degree or recognised Professional Qualification or equivalent qualification **AND** Two years experience in a Senior Role² **OR** Have at least 5 years experience in a Senior Role².
- Have a minimum of 1 years experience in a lead role delivering objectives which have led to a significant³ improvement in service.

¹ 'relevant' will be defined as a business or health related field

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

³ 'Significant' is defined as contributing directly to key Directorate objectives

3. Have a minimum of 1 years experience working with a diverse range of internal and external stakeholders in a role which has contributed to the successful implementation of a significant³ change initiative.
4. Have a minimum of 2 years experience in staff management.
5. Hold a full current driving license valid for use in the UK and have access to a car on appointment⁴.

The following are essential criteria which will be measured during the interview stage

6. Have an ability to effectively manage a delegated budget to maximise utilisation of available resources.
7. Have an ability to provide effective leadership.
8. Demonstrate evidence of highly effective planning and organisational skills.
9. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.

INTERVIEW ARRANGEMENTS – FOR NOTING BY ALL CANDIDATES

SHORTLISTING

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

The competencies concerned are given in the NHS Leadership Qualities Framework, details of which can be accessed at www.nhsleadershipacademy.nhs.uk. Particular attention will be given to the following:

- *Inspiring shared purpose*
- *Leading with care*
- *Evaluating information*

⁴ *This criterion will be waived in the case of a suitable applicant who has a disability which prohibits them from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.*

- *Connecting our service*
- *Sharing the vision*
- *Engaging the Team*
- *Holding to account*
- *Developing capability*
- *Influencing for results*

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

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



Southern Health
and Social Care Trust

Quality Care - for you, with you

MEDICAL DIRECTOR

Applicant Information Pack

A large, 3D geometric graphic composed of several overlapping, semi-transparent blue and grey rectangular blocks, creating a complex, crystalline structure. The blocks are arranged in a way that suggests depth and perspective, with some blocks appearing to be in front of others. The overall shape is somewhat irregular, resembling a stylized building or a modern architectural element.

June 2018

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Invitation from the Chief Executive

We are seeking to recruit a dynamic Medical Director to join our Executive team. The successful candidate will provide strong professional leadership and direction, support high standards of medical practice and provide resolved advice for medical matters across the organisation, which has a reputation for excellent care, innovation and a focus on improving the experience and outcomes of all who use our services.

This is an exciting time to join our Trust. This post is the first of five senior executive appointments to be made to the Trust following a number of recent retirements.

At a time of systemic change and challenge for health and social care within Northern Ireland, the Medical Director will take a leadership role in the provision of safe, high quality services, and support the delivery of the Trust's transformation agenda.

The role requires a visionary individual with strong interpersonal skills and an inclusive leadership style who will work collaboratively both internally across the organisation and with external partners to ensure that the services we provide to the community we serve are the best they can be. The successful applicant must be able to champion clinical leadership and engage a range of partners through their strong commitment to co-production and co-design to deliver truly integrated care and improved outcomes for our population.

They will be results driven and have an exemplary track record as a clinical leader. A proven ability to inspire, motivate and promote teamwork at all levels across the medical and non-medical workforce is essential as the postholder will be the organisational lead for clinical governance.

If you have:

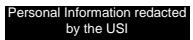
- the drive and ambition to keep the Southern Health & Social Care Trust at the forefront of development in health and social care;
- the passion and expertise to make a real contribution to our journey of continual improvement; and,

- a strong value base of service to our patients, clients and community,

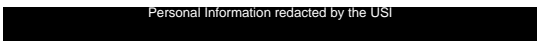
then I look forward to receiving your completed application form.

For an **informal discussion about this post**, please contact:

Dr Richard Wright

on 

or by e-mail to



SHANE DEVLIN
CHIEF EXECUTIVE

Profile of the Trust

The Southern Health & Social Care Trust provides integrated patient / client centred services to a population of c.370,000 people in the local areas of Armagh, Banbridge, Craigavon, Dungannon, South Tyrone, Newry and Mourne (see map outline below):



The Trust provides a wide range of hospital, community and primary care services. General acute in-patient hospital services are located at Craigavon Area Hospital and Daisy Hill Hospital and acute mental health and learning disability in-patient hospital services are located in the Bluestone Unit also on the Craigavon Area Hospital site. Working in collaboration with GPs and other agencies, Trust staff provide locally based health and social care services in Trust premises, in people's own homes and in the community. The Trust purchases some services, such as domiciliary, residential and nursing care and day care from private and voluntary organisations.

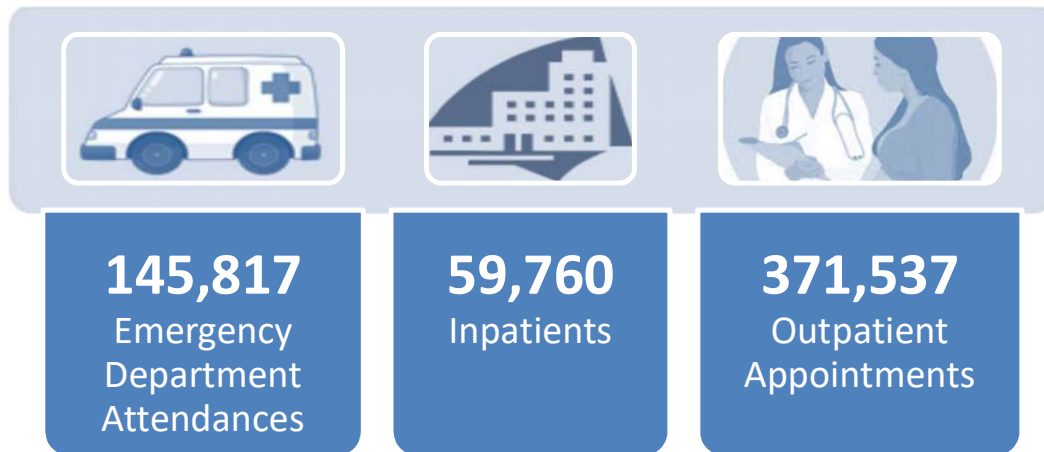
The Trust has an annual income of c.£678m and approximately 14,000 staff. Our geographical area covers in whole or in part, three of the new super-councils – Armagh, Banbridge and Craigavon; Newry, Mourne and Down; Mid-Ulster.

Key Facts

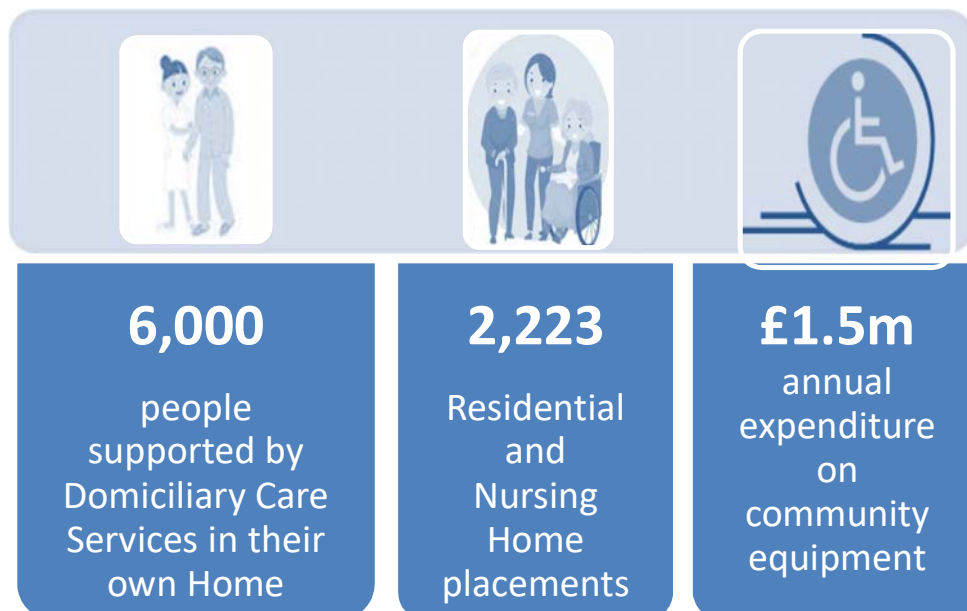
- Second largest resident population compared to other Trusts in Northern Ireland at 370,000 (20% of population).
- Over the 10 year period from 2014 to 2024 - Armagh City, Banbridge and Craigavon Council Area population is projected to grow by 10.4 per cent (i.e. 21,400 people). Newry and Mourne Council Area population is projected to grow by 7.4% (i.e. 13,100 people). Both growth rates are projected above the Northern Ireland average (5.3%).
- Over the past 10 years, there has been a 15% increase in the number of births in the Southern Area compared to a regional increase of 8% for the same period.
- 14% of the Southern Trust population is over 65 years. By 2039 this is projected to grow to 60% which is higher than the NI expected growth rate of 54%.
- 16% of the Southern Trust population falls within the NI's most deprived quintile.
- The Trust has the highest level of children with statements of educational need in NI.
- Central & Eastern European migration accounts for 4.2% of the Trust population, compared to the NI average of 2.2%.

We spend approximately £1.86m per day delivering care to local people

In 2017/18 the Southern Trust treated:



Each year across the Southern Trust area we support people to remain independent in their own homes within our community through:



Vision, Values & Priorities of the Trust

Trust Vision: 'Quality Care – for you, with you'

Our vision encompasses our core commitment to deliver safe, high quality care that is co-produced and co-designed in partnership with service users and staff who deliver our services. This vision is underpinned by the **Trust's Values** which shape what we do and how we do it.



Our **Corporate Objectives** reflect our priorities for the delivery of health and social care services to our local population. Achieving our objectives and delivering safe, quality care and services which are accessible and responsive to our patients and carers will remain our central focus:



Strategic Direction of the Trust

Our Corporate Plan “Improving Together” 2017/18 - 2020/21

“Improving Together” 2017/18 - 2020/21 is the prevailing strategic plan that sets out how we intend to deliver against regional and corporate priorities in our local area. This response is informed by the changing needs of local people, by new technologies and ways of delivering care and by the resources made available to the Trust by our local assembly. The strategic plan explains what we want to achieve, how we plan to achieve and how we will know if we have made a difference. It sets a roadmap of how we would like Trust services to look and what outcomes we expect four years from now. Read more [here](#)

For further information on the documents below visit:

<http://www.southerntrust.hscni.net/about/Publications.htm>

- Trust Delivery Plan
- Annual Report
- Annual Quality Report
- Board Assurance Framework

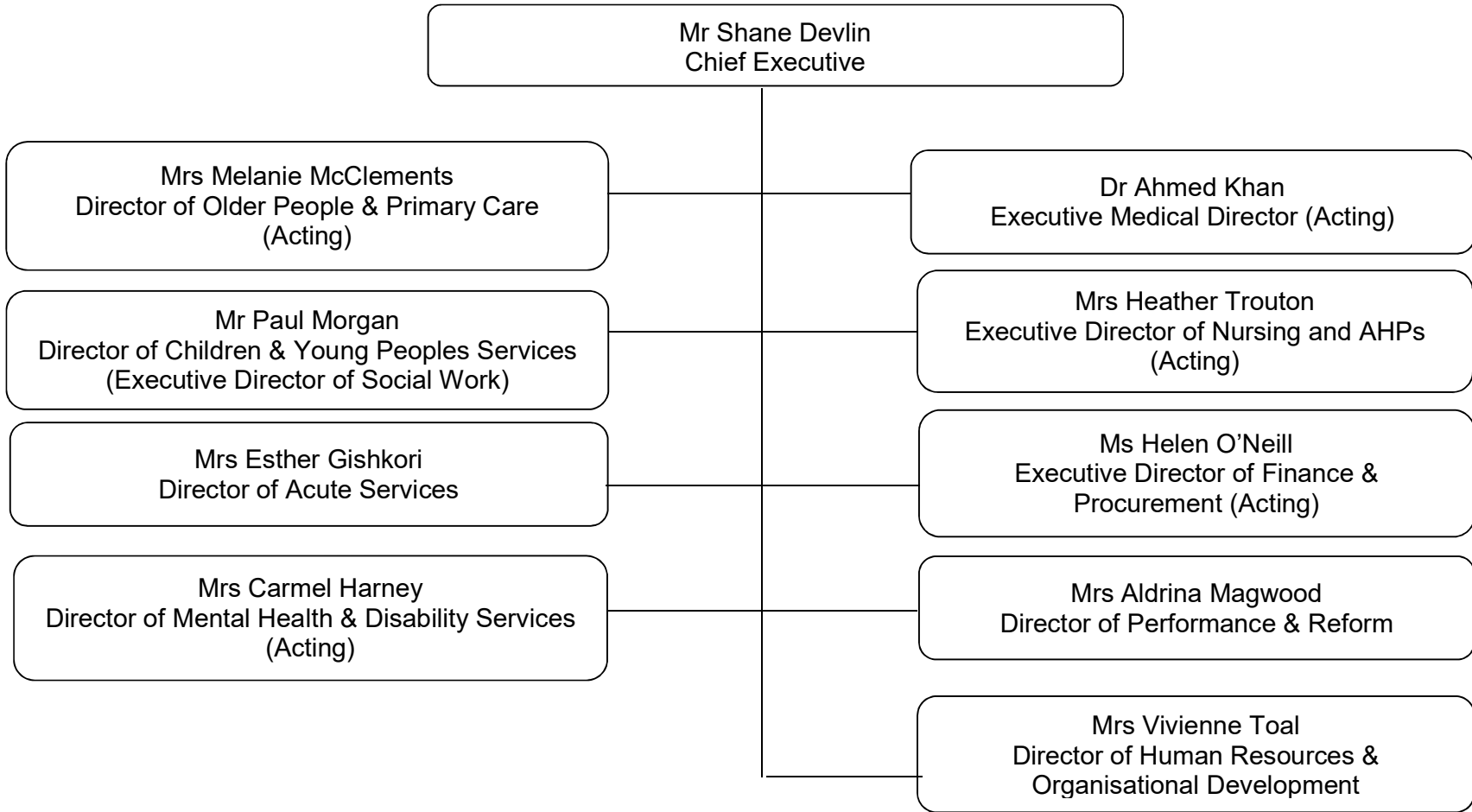
Southern Trust on Social Media

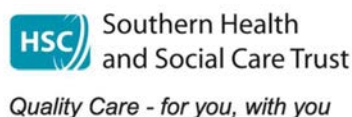
Click [here](#) to view the Southern Trust’s Facebook page.

Click [here](#) to view the Southern Trust’s Twitter account.

Click [here](#) to view the Southern Trust’s YouTube Channel.

SENIOR MANAGEMENT STRUCTURE





MEDICAL DIRECTOR

Ref No 73218002

This is an exciting time to join our Trust as we look to recruit a dynamic Medical Director to join our Executive team. This post is the first of five senior executive appointments to be made to the Trust following a number of recent retirements.

The Medical Director is an Executive Director and is responsible for providing assurance to Trust Board that effective systems and processes for good governance, including those arrangements to support good medical practice, are in place.

The successful applicant will provide strong professional leadership and direction, support high standards of medical practice and provide resolved advice for medical matters across Directorates. S/he will take a leadership role in the provision of safe, high quality services, and support the delivery of the Trust's transformation agenda.

They will be results driven and have an exemplary track record as a clinical leader. A proven ability to inspire, motivate and promote teamwork at all levels across the medical and non-medical workforce is essential as the postholder will be the organisational lead for clinical governance.

We seek a visionary individual with strong interpersonal skills and an inclusive leadership style who will work collaboratively both internally across the organisation and with external partners to ensure that the services we provide to the community we serve are the best they can be.

If you believe you have the drive and ambition to deliver in this critical role then we would very much welcome an application.

Informal enquiries can be made to the current postholder, Dr Richard Wright on

Personal Information redacted
by the USI

A full Job Description, Personnel Specification and associated information for this post is available online at www.HSCRecruit.com or by emailing recruitment.services@southerntrust.hscni.net. Please note that you must be an employee of an organisation within Health & Social Care in Northern Ireland to be eligible to apply for this post.

**The closing date for receipt of completed applications is
Thursday 28th June 2018 at 12.00pm**

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Job Description

JOB TITLE	Medical Director
LOCATION	Trust Headquarters, Craigavon Area Hospital
ACCOUNTABLE TO	Chief Executive

JOB SUMMARY

The Medical Director is an Executive Director and is responsible for providing assurance to Trust Board that effective systems and processes for good governance, including those arrangements to support good medical practice, are in place.

S/he will provide strong professional leadership and direction, support high standards of medical practice and provide resolved advice for medical matter across Directorates. S/he will take a leadership role in the provision of safe, high quality services, support the reform and modernisation programme and drive initiatives for continuous quality improvement. The postholder will have lead responsibility for clinical governance.

As Responsible Officer (RO), s/he has a statutory duty to make recommendations to the General Medical Council with regard to a doctor or dentist's fitness for revalidation, for those doctors and dentists who have a prescribed connection with the Southern HSC Trust.

As a member of the Trust Board and the Senior Management Team s/he will have both individual and corporate leadership responsibility for the governance of the Trust and compliance with legal requirements and contribute fully to the development, delivery and achievement of the Trust's corporate objectives.

KEY RESULT AREAS

PROFESSIONAL LEADERSHIP

1. Provide highly visible and inspiring clinical leadership for medical and dental staff throughout the Trust, championing a professional and open culture which empowers staff to consistently deliver high quality, safe and effective care, acting as a role model for the behaviours and high professional standards expected.

2. Develop and maintain effective relationships with GMC that supports the registration and regulation of the medical workforce.
3. Work closely with colleagues to enhance communication and working relationships between clinical leaders and senior managers and ensure that opportunities to improve services are harnessed.
4. As Responsible Officer, ensure the following are in place:
 - an appraisal policy that meets the requirements of revalidation
 - effective clinical governance systems that can provide doctors with the supporting information they need for appraisal and revalidation
 - a system which ensures all doctors are given the opportunity to take part in an annual appraisal and which tracks participation
 - regular briefing for Trust Board on progress
 - a process for recognising and responding to concerns about doctors in line with *'Maintaining High Professional Standards in the Modern HPSS'*.
5. Provide professional leadership and guidance to support Associate Medical Directors, Clinical Directors and Lead Clinicians throughout the Trust in relation to governance of the medical workforce, including clinical practice and service change.
6. Provide medical leadership to attract, educate, develop and retain a quality workforce from both local and international pools.
7. Ensure sound working relationships with the Director of Public Health, other Medical Directors and the Public Health Agency

CLINICAL GOVERNANCE

1. As a member of the Senior Management Team and Trust Board, assume corporate responsibility for ensuring an effective system of integrated governance within the Trust which delivers safe, high quality care, a safe working environment for staff and appropriate and efficient use of public funds.
2. Provide professional advice to the Senior Management Team as to the appropriate indicators of safety, quality and performance, to inform and commission the measurement of such indicators as part of Senior Management Team Governance, to regularly review

this information, and to provide assurance or expert input into necessary next steps to address any issues arising from same.

3. Work with other professional Directors to lead multidisciplinary teams to ensure there is a system for audit of clinical practice that assesses and reviews the quality of services provided and ensures that any learning is incorporated into professional practice and systems.
4. While the operational responsibility and accountability for patient safety rests with operational Directors, assume responsibility for:
 - a) Participation in regional co-ordination of patient safety initiatives, bringing intelligence and direction on these approaches into the organisation and providing strategic and professional advice on implementation.
 - b) Co-ordinating the implementation of agreed Patient Safety priority projects and monitoring systems, as endorsed by Senior Management Team, within the wider Clinical and Social Care Governance arrangements of the Trust.
 - c) Reviewing and monitoring the impact of Patient Safety Initiatives and providing regular Patient Safety reports to Senior Management Team, Governance Committee and Trust Board.
5. Ensure the development and maintenance of professional standards and education liaising with professional and education bodies as necessary
6. Provide advice on medical workforce policy including staffing levels, changes in working patterns and skill mix which will ensure the delivery of effective and efficient clinical services to patients and clients
7. Ensure that all doctors and dentists in the Trust work within agreed procedures, and, as appropriate the GMC's guidance "Good Medical Practice" and the GDC's "Standards for Dental Professionals"
8. Set up systems for meeting and liaising with Associate Medical Directors and Clinical Directors in the Trust to ensure appropriate arrangements are in place for securing patient and client safety.
9. Ensure effective systems of clinical risk management and adverse event reporting are in place demonstrating trend analysis and processes to share learning.

10. Support the development and implementation of the Trust's Audit Strategy.
11. Ensure compliance with relevant assurance standards.
12. Provide arrangements for the clinical scrutiny of claims and litigation.
13. Ensure that there are effective systems in place to support the Trust's research governance arrangements.
14. Act as the designated lead Director for strategic management of patient safety initiatives, and the link Director with the Patient Safety Forum and other regional fora.

QUALITY

1. Promote high standards of medical and dental practice and provide advice and support to ensure the development of a quality culture with a focus on continuous improvement.
2. Ensure robust systems and processes for monitoring and improving outcomes for people who use our services are in place to provide assurance that clinical care is safe and effective.
3. Ensure effective systems are in place to comply with regional requirements for morbidity and mortality review and ensure compliance with Coroner's court processes.
4. Support innovation and change to underpin the modernisation of services
5. Be responsible for the delivery of undergraduate and postgraduate medical education and training to the standards and requirements set out in the service level agreements with Queen's University Belfast (QUB) and NIMDTA.
6. Act as the Trust Data Guardian, providing an advocacy role for data protection on behalf of patients, their families and carers.
7. Ensure systems and processes are in place to support responses to complaints, provide trend analysis and systems to share learning.
8. Work in partnership with the members of the Trust Senior Management Team to ensure the integration of learning from complaints, incidents and claims into the service delivery model within the Trust, via the Lessons Learned Committee.

9. Keep up to date with policies and guidelines on good practice from the Royal Colleges, GMC, universities, etc, and identify opportunities to enhance the quality of services provided by the Trust.

MEDICAL EDUCATION & TRAINING

1. Ensure the quality of medical education and training within the Trust, working closely with education and training bodies and ensure the Trust has a highly skilled career grade medical workforce. This will include accountability for the quality of undergraduate training including delivery of QUB Accountability Framework and utilisation of SUMDE budget, and the provision of Annual Report to Trust Board.
2. Lead on the post graduate training of junior doctors in training within the Trust, including managing the relationship between NIMDTA and the Trust, and ensuring the Trust and NIMDTA work in partnership to maintain a high standard of education and related patient safety.
3. Lead on the work related to the “Sub Deanery” for Queens University (QUB) Medical School within the Trust, including managing the relationship between QUB and the Trust, and ensuring the Trust and QUB work in partnership to maintain a high standard of education and supervision of the Medical students placed. This work includes an Annual report and financial report on the funding provided to the Trust by QUB in respect of the work of the sub-deanery.
4. Management of the Associate Medical Director (AMD) for postgraduate Medical Education, induction and training for Junior Doctors, QA / evaluation of training and supporting operational Directors to address issues arising from Deanery and PMETB evaluation and inspections.
5. Ensure that all doctors and dentists in the Trust work within agreed procedures, and, as appropriate the GMC’s guidance ‘Duties of a Doctor’, ‘Good Medical Practice’ and related documents, and succeeding and replacement documents or the GDC’s lifelong learning requirements.
6. Ensure the implementation of an effective process of professional self-regulation for doctors employed by the Trust.

RESEARCH & DEVELOPMENT

1. The postholder will be responsible for the strategic and operational management of Research and Development within the Trust, including the line management of the Associate Medical Director for Research and Development and associated support staff. This role includes responsibility for CAS for Research and provision of Research and Development Annual Report to Trust Board.
2. Responsible for the Trust's Research Committee to agree a programme of research and development and ensure the extant legal and regularity permissions are obtained.

SERVICE DELIVERY

1. Strategic management and co-ordination of effective Emergency Planning within the Trust and the provision of annual reports to Trust Board.
2. Ensure a Major Incident Policy is in place for the Trust, and suitable support is in place for the testing, recording and subsequent modification of the policy and attached plans are reviewed constantly and reported on at agreed intervals.
3. Management of ECRs and Drug Requests for Southern Trust patients, and responsible for medical evaluation, decision-making and liaison with Commissioner in relation to same.
4. Responsible to Trust Board for the discharge of medical statutory functions.
5. Lead Director for the Trust's litigation arrangements.

FINANCIAL AND RESOURCE MANAGEMENT

1. Be accountable for the management of the Directorate's budget (pay and non pay) and the meeting of all financial targets by each division and service.
2. Advise and assist the Trust Board and Chief Executive in determining its expenditure on clinical services.
3. Participate in contract and service level negotiations with Commissioners.

4. Advise and assist in the development of capital investment strategies across the Trust, ensuring these reflect and contribute to meeting targets set by the DoH/HSCB and the Trust's Corporate Plan.

LEADERSHIP & PEOPLE MANAGEMENT

1. Ensure effective engagement with doctors and dentists and their representatives including co-chairing the Trust's Local Negotiating Committee (LNC)
2. Ensure the aims and targets of the New Deal for junior doctors are implemented and compliance with EWTD for junior doctors and career grade doctors is achieved and maintained.
3. Support managers both in establishing and reviewing performance targets with individual consultants, recognising workloads and other pressures on medical staff and ensuring adequate mechanisms are in place for the support of medical staff
4. Responsible, in association with the Director of Human Resources & Organisational Development, for the management of disciplinary matters and complaints relating to medical staff
5. Provide exemplary and visible leadership and promote a strong positive model of valuing staff, effective communication and engagement so as to enable staff to perform to the best of their abilities to deliver high quality care and support and be involved in the transformation agenda.
6. Ensure that management structures and practices in the Directorate are fit for purpose and support a culture of effective team working, collective leadership, continuous improvement and innovation, always striving to remain focused on person-centred care for citizens of the Trust.
7. Ensure the effective implementation of all Trust people management policies in the Directorate and the achievement of all relevant targets such as relating to corporate mandatory training, personal development plans, the management of sickness and absenteeism, turnover etc.
8. Ensure the effective management of staff health and safety and support in the Directorate.

9. Review individually, at least annually, the performance of immediately subordinate staff, provides guidance on personal development requirements and advises on and initiates, where appropriate, further training.
10. Maintain staff relationships and morale amongst the staff reporting to him/her.
11. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.
12. Participate, as required, in the selection and appointment of staff in accordance with procedures laid down by the Trust.
13. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

CORPORATE & COLLECTIVE LEADERSHIP

1. Demonstrate exemplary standards of corporate leadership and share a collective responsibility for all Trust corporate decisions, initiatives and the effective implementation and communication of same.
2. Actively promote a culture of collective leadership within the Trust, and across organisational boundaries, in line with the four key components of the *HSC Collective Leadership Strategy*.
3. Share a collective responsibility for the Trust's financial performance and the achievement of all quality, safety and other legislative requirements.
4. Share a collective responsibility for the Trust's overall corporate governance processes to include the implementation of an integrated governance framework that assures safe and effective care for patients and clients and complies with public sector values and codes of conduct, operations and accountability.
5. Lead by example, to ensure the Trust demonstrates respect through its culture and actions, for all aspects of diversity in the population it serves and the staff who provides the services.

6. Share a collective responsibility for the Trust's corporate planning, policy and decision making processes as a member of the Directorate's senior management team and ensure the Trust's objectives and decisions are effectively communicated.
7. Continually strive to develop self and improve capability in the leadership of the Trust and its staff.
8. Lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HSC Staff.
9. Participate in the Director on-call rota.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. Adhere at all times to all Trust policies/codes of conduct, including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
 - standards of attendance, appearance and behaviour
4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
5. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
6. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004 and the General Data Protection Regulations (GDPR). Employees are

required to be conversant with the Trust's policy and procedures on records management and to seek advice if in doubt.

7. Take responsibility for his/her own ongoing learning and development, including full participation in Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.
8. Represent the Trust's commitment to providing the highest possible standard of the patient/client experience and services delivered by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

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

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

May 2018

PERSONNEL SPECIFICATION

JOB TITLE Medical Director

Eligibility	Be an employee of an organisation within Health & Social Care within Northern Ireland ¹
Qualifications/ Experience	<ol style="list-style-type: none"> 1. Registration with the GMC, have a licence to practice and be on the GMC Specialist Register. 2. A minimum of three years' experience in a senior medical management² role in a major complex organisation³ AND clear significant⁴ personal evidence of:- <ul style="list-style-type: none"> • managing major service improvement and transformation; • high level leadership and people management skills; • effective medical professional governance and risk management; • building strategic relationships with external agencies / partners
Other	<ol style="list-style-type: none"> 3. Hold a full current driving licence valid for use in the UK and have access to a car on appointment⁵. In respect of this point the successful applicant may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere.

¹ **'Organisation within Health & Social Care NI'** is defined as any one of the following: HSC Trusts; Health & Social Care Board; Business Services Organisation;; Public Health Agency; Patient Client Council; Regulation & Quality Improvement Authority; NI Practice & Education Council; NI Medical & Dental Training Agency; NI Guardian Ad Litem Agency; NI Blood Transfusion Service, and; NI Social Care Council

²**'senior medical management'** is defined as experience gained at Director, Assistant / Associate / Deputy Medical Director or equivalent in a major complex organisation

³**'major complex organisation'** is defined as one with at least 200 staff or an annual budget of at least £50 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders

⁴**'significant'** is defined as contributing directly to Key Corporate Objectives of the organisation concerned.

⁵This criterion will be waived in the case of a suitable applicant who has a disability which prohibits from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.

Candidates shortlisted and invited for further stages of selection will be assessed using the nine dimensions of leadership behaviour as specified in the **NHS Leadership Academy Healthcare Leadership Model**. Shortlisted candidates will need to demonstrate that they have the required knowledge, skills, competencies and values to be effective in this role.

Notes to applicants:

- 1. We will not accept CVs, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms;*
- 2. You must clearly demonstrate on your application form how you meet each of the required criteria – failure to do so will result in you not being shortlisted.*
- 3. Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer will be withdrawn*

As part of the Recruitment & Selection process it will be necessary for the Trust to carry out an Enhanced Disclosure Check through Access NI before any appointment to this post can be confirmed.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

All staff are required to comply with the Trust's Smoke Free Policy

TERMS & CONDITIONS OF SERVICE

Hours - This post is ideally a full-time commitment, however applications will be considered from suitable qualified applicants who wish to continue with a small clinical commitment.

Remuneration – to be agreed on appointment. The salary will be in line with the HSC Hospital Consultant Medical and Dental Terms and Conditions of Service. The post will also attract a pensionable management allowance.

Annual Leave and Statutory / Public holidays - as per HSC Hospital Consultant Medical and Dental terms and conditions of service.

HSC Pension Scheme / HPSS Superannuation Scheme

One of the leading pension schemes available, Trust staff are automatically enrolled in the Health & Social Care Pension Scheme upon taking up employment within the HSCNI. Further information may be obtained from the HSC Pension Service Website at www.hscpensions.hscni.net. Applicants who are already members of the HPSS Superannuation Scheme may continue with their current arrangements

Current contributions are as follows:

Employer contribution rate:	16.3%
Employee contribution rate:	13.5%

Human Resources Policies

The Trust offers a wide range of Human Resource Policies to underpin the value that is placed on its staff such as:

- A range of Work Life Balance/Flexible Working Policies;
- Special Leave;
- Child Care Voucher Scheme;
- Cycle to Work Scheme;
- Access to savings on Social and Leisure Activities;

The HSC Code of Conduct is available on request.

Committed to Equality of Opportunity

The Trust recognises and values the diversity of its workforce and the population it serves. The Trust is committed to a working environment free from intimidation of any kind. Through a systematic and objective recruitment & selection process the Trust is committed to ensuring that appointment decisions are taken solely on the basis of merit.

COMPLETING YOUR APPLICATION FORM

The application form is designed to ensure that applicants provide the necessary information to determine how they meet the essential criteria. We strongly encourage all applicants to complete their application online at www.HSCrecruit.com. For those who wish to complete an offline application, please note that in order to ensure Equality of Opportunity for all applicants:

- The space available on the application form is the same for all applicants and must not be altered;
- We will not accept CVs, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms;
- Applicants must complete the application form in either typescript font size 12, or legible block capitals using black ink;
- Applicants must not reformat electronic application forms;
- Information in support of your application will not be accepted after the closing date and time for receipt of applications;
- Applications will not be examined by the selection panel until after the closing deadline;

Completing the Criminal Convictions / Offences Section

The application form requires you to confirm your understanding that the Trust's positions fall under the Rehabilitation of Offenders Exceptions (NI) Order 1979 as amended. Within the Health Service, criminal convictions are never regarded as spent and therefore if you are offered a post with the Trust you must tell us about all previous or pending convictions or offences (including motoring convictions), even if they happened a long time ago (other than protected convictions).

The Trust is committed to the equality of opportunity for all applicants, including those with criminal convictions. We will undertake to ensure an open, measured and recorded discussion on the subject of any offences or other matters that might be considered relevant for the position concerned e.g. the individual is applying for a driving job but has a conviction history of driving offences. This will be conducted following the selection process if this applies to the successful candidate. Whilst the disclosure of information will not automatically prevent an individual from obtaining employment, it is essential that all convictions (other than protected convictions) are disclosed to allow the Trust to adequately consider their relevance to the post in question. The Trust considers failure by applicants to declare complete and accurate information about convictions to be a serious breach of trust.

Access NI Disclosure – the Trust operates in line with the Access NI Code of Practice. Further details can be obtained from www.accessni.gov.uk

It should be noted that some posts will fall within the definition of 'Regulated Activity'. Further information on Regulated Activity can be obtained on request. Any post falling within the definition of Regulated Activity will be subject to an Access NI Enhanced Disclosure check with Barred list check.

Completing the Medical History Section

The application form requires you to confirm your understanding that you must be in a fit state of health to render regular and reliable service in the post you are applying for. If successful, you will be asked to tell us about any periods of sickness you have had in the last 3 years, whether you have been in employment or not. Your sickness absence record will be verified through the reference checking process; therefore it is important that you give full and accurate information when requested.

Meeting the Criteria set out in the Personnel Specification

- Always refer to the Job Description and Personnel Specification when completing your application form.
- Clearly demonstrate on your application form how you meet the essential shortlisting criteria as detailed in the Personnel Specification. Failure to do so will result in you not being shortlisted for interview. Please remember that selection panels cannot make assumptions on whether or not you meet the essential shortlisting criteria.

Completing the Reference Section

We will want to seek references which cover the previous 3 years to the date of application in relation to your employment / training / education.

Completing Your Current / Previous Employment Details

- Ensure that full details are provided.
- Be specific about all the dates that you provide, in the format DD.MM.YYYY.
- Explain any gaps between periods of employment and include reasons for leaving each post.
- Provide a list of key duties that you have been responsible for in current post / previous posts.

Disability requirements

We ask on the application form if you require any reasonable adjustments, due to disability, to enable you to attend the interview or undertake the duties of the post. Details of any disability are only used for this purpose and do not form any part of the selection process. If you require any reasonable adjustments to be made during the Recruitment Process please contact Lynn Magee, Resourcing Manager by email to Personal Information redacted by the USI or by phone to Personal Information redacted by the USI who will be happy to discuss your requirements

Completing the Personal Declaration

It is important to remember that when signing the personal declaration section or submitting your form via email you are stating that the information is true, complete and accurate, and confirming your understanding that giving wrong information or leaving information out could lead to the withdrawal of an offer of employment, or dismissal if you take up a post.

Data Protection

The information you provide the Trust will be processed in accordance with the Data Protection Act 2018.

Completing the Equal Opportunity Monitoring Form

Please note that this information is regarded as part of your application and you are strongly encouraged to complete this section. This information is treated in the strictest confidence and is for monitoring /statistical purposes only. Selection panels do not have any access to this information at any stage of the recruitment process.

Advising us if you are not available to attend for assessment / interview

If you have any planned holidays, it is useful to tell us about this by detailing it on your application form. However please note that the selection panel are under no obligation to take these into account when arranging assessment / interview dates.

Submitting your completed form

Forms must be received by the stated closing date and time, as **late applications will not be accepted.**

Please remember that the Trust's standard Application Form is the only acceptable method of application to the Trust.

Closing Date for Receipt of Completed Applications

The closing date for receipt of completed applications is **Thursday 28th June 2018 at 12.00 noon.**

Applications can be submitted via www.HSCRecruit.com or in hard copy format to:

Mr Iain Gough
HR Resourcing Team
Hill Building
St Luke's Hospital site
Loughgall Road
Armagh
BT61 7NQ

Please note the Trust will not accept any late, incomplete or reformatted application forms received after the closing date and time.

Applicants using Royal Mail should note that 1st class mail does not guarantee next day delivery. It is the responsibility of the applicant to ensure that sufficient postage has been paid to return the form to the address above by the stated closing date and time. Existing Health & Social Care staff should not rely on the internal postal system.

Selection Process

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and skills are relevant to this post and the extent to which they satisfy each criterion specified. This includes demonstrating how they meet the definitions of 'major complex organisation', and 'senior management' as defined within the Personnel Specification. **Please note this should be detailed under each appropriate criterion heading on your application form.** Only those applicants who clearly demonstrate on their application form how they meet the essential criteria, and if applied, the desirable criteria, will be shortlisted. Failure to demonstrate clearly how you meet each element of the essential / desirable criteria will result in you not being shortlisted for the further stages in the assessment process.

Candidates who are shortlisted following a review of their application form will then be invited to the further stages in the assessment process. The Trust reserves the right to incorporate additional shortlisting stages dependent on the number of applications received.

Throughout the assessment process applicants will need to demonstrate that they have the required competencies to be effective in this demanding leadership role. It is therefore intended that applicants who meet the essential criteria will be assessed against the criteria stated in this specification, linked to the Dimensions set out in the [NHS Healthcare Leadership Model](#).

In accordance with best practice all appointments within the Trust are made under the 'merit principle' where the best person for any given post is selected in fair and open competition.

Candidates may be contacted by telephone following each stage of the assessment process to confirm onward arrangements. This method, if used, is to ensure those being invited to the next stage have as much time available for preparation as possible. Candidates are therefore asked to ensure that mobile telephone numbers are provided where possible and that in any event the contact telephone numbers stated provide for ease of contact. All such communication will be followed up in writing.

Please note that the Trust is under no obligation to take account of your planned holiday arrangements.

Useful Links / Further Information

Further details on the HSCNI may be obtained from;

Southern Trust Website - <http://www.southerntrust.hscni.net/> or you can follow us on facebook or Twitter

Click [here](#) to view the Southern Trust's Facebook page.

Click [here](#) to view the Southern Trust's Twitter account.

Click [here](#) to view the Southern Trust's YouTube Channel.

Department of Health www.doh.gov.uk

Further Enquiries / Information

Applicants requiring any further information on the application process, shortlisting or interview arrangements should contact Lynn Magee, Resourcing Manager on Personal Information redacted by the USI or by email to Personal Information redacted by the USI

Operational Support Lead - Acute Services (4 posts)

Ref: 88207120



Southern Health
and Social Care Trust

Closing Date: 20 June 2007 12:00

Location: Craigavon Area Hospital / Daisy Hill
Hospital

Contract: Permanent

Salary: Band 7 (£26,269 - £36,416)

Hours: Full-time / Job Share

Interview Dates: Expected late June / early July

Job Description:

SOUTHERN HEALTH & SOCIAL CARE TRUST

JOB DESCRIPTION

- JOB TITLE:** Operational Support Lead
- BAND:** Band 7
- REPORTS TO:** Assistant Director of a division within Acute Services
- JOB PURPOSE:** To work as a key member within a division of the Trust's Acute Services Directorate, responsible for managing the day-to-day operational functions associated with patient access and flow in line with the reform and modernisation agenda, quality of patient care and resources available.
- To assist the Assistant Director within the division in the delivery of the operational functions associated with the development of a booked elective pathway and maintenance of patient access via management of the Primary Target Lists (PTL) and waiting list management processes. Where applicable, to assist the Assistant Director within the division in the delivery of the operational functions associated with the maintenance of patient access to Medicine and Unscheduled Care services in line with DHSSPS standards of care.
- To assume day to day line management responsibility for the administrative and clerical staff within the division (Personal Secretaries, Audio Typists, Ward Clerks), ensuring efficient and flexible administrative support to clinical teams.

MAIN DUTIES:

OPERATIONAL MANAGEMENT – PATIENT ACCESS AND FLOW:

1. Engage with senior medical, nursing, administrative and allied health professional teams to ensure that the main focus continues to be on the management of specialty specific PTLs to meet maximum patient access targets for inpatient and daycase patients and where applicable to meet access targets for unscheduled care.
2. Work with clinical directorate teams to develop realistic capacity plans to facilitate

planning for the achievement of PTL schedules and to ensure identified capacity is fully utilised across the division. Similarly for the planning of unscheduled care capacity requirements.

3. Support and facilitate elective and non-elective clinical teams in sustaining patient flow, for example assisting in capacity assessment, job planning and service development issues particularly in relation to issues affecting capacity and service provision.
4. Assess the waiting list and unscheduled access target positions for risk, identify and communicate issues affecting access and work with clinical and functional directorate teams to ensure plans are in place to deal with bottle-necks and pressures, escalating as appropriate.
5. Support staff from all key disciplines to ensure a whole system approach to improve and sustain waiting list and unscheduled care management and the development of elective and non elective access pathways.
6. Ensure the Trust is compliant with regional access policy issues for elective and non elective patients and that all supporting processes are in place, documented and implemented.
7. Manage development projects as directed by the Assistant Director for the division to further improve patient access and operational performance across the hospital system.
8. Be the main point of contact for day-to-day operational performance issues for the division.
9. Develop excellent working relations with key stakeholders to encourage collaborative working.
10. Provide updates on performance at Trust and regional meetings as required.

INFORMATION AND ANALYSIS:

1. Work with the Trust's Information Department to co-ordinate the collection and analysis of data to facilitate the monitoring of elective and non elective access and flows across the hospital system.
2. To analyse complex performance information to identify areas for improvement and to work collaboratively to develop plans to deliver improvement.
3. To monitor ongoing projects to assess outcomes, benchmarked against expected outcomes.

GENERAL MANAGEMENT:

1. Assume day to day line management responsibility for the administrative and clerical staff within the division.
2. Participate in the Trust's Staff Development and Performance Review Scheme. Review individually on a regular basis the performance of staff. Provide guidance on personal development requirements, advise on and initiate, where appropriate, further training.
3. Maintain good staff relationships and morale amongst staff reporting to him/her.
4. Where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.

5. Participate as required in selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
6. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.
7. Promote the Trust's policy on equality of opportunity through his/her own actions and ensure that this policy is adhered to by staff for which he/she has responsibility.

GENERAL RESPONSIBILITIES

Employees of the Trust will be required to promote and support the mission and vision of the service for which they are responsible and:

- At all times provide a caring service and to treat those with whom they come in contact in a courteous and respectful manner.
- Demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- Comply with the Trust's No Smoking Policy.
- Carry out their duties and responsibilities in compliance with health and safety policy and statutory regulations.
- Adhere to equal opportunities policy throughout the course of their employment.
- Ensure the ongoing confidence of the public in service provision.
- Comply with the HPSS Code of Conduct.

This job description is subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the postholder works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Assistant Director of the division.

Personnel Specification:

Personnel Specification

Knowledge, skills and experience required:

Applicants must provide evidence by the closing date for application that they are a permanent employee of the Southern Health and Social Care Trust and have:

- university degree or relevant professional qualification and worked for at least 1 year in a middle management role* within an acute hospital clinical support service

OR

- have worked for at least 3 years in a middle management role* within an acute hospital clinical support service.

AND

- experience of playing a lead role / managing projects within a multi-disciplinary environment within tight timescales.
- experience of playing a lead role in the successful implementation of change initiatives.
- a proven track record of people management and organisational skills.

- a full current driving licence with access to a car or access to a form of transport to meet the mobility needs of the post.

SHORTLISTING

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

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

- Self Belief
- Self Management
- Drive for results
- Leading change through people
- Effective and strategic influencing

The following additional clarification is provided:

**"middle management role" is defined as experience gained *for example* at Admin & Clerical Grade 5 and above or Nursing & Midwifery Grade F and above or equivalent. The role must have included staff management responsibility.

June 2007

Other Information:

Downloads: [SHSCT rpa](#)

Instructions: [Instructions for Completing Application Form](#)



**THIS POST IS FOR EMPLOYEES OF THE SOUTHERN TRUST
ONLY**

JOB DESCRIPTION

JOB TITLE	Personal Secretary
BAND	4
DEPARTMENT/ LOCATION	Craigavon Area Hospital
DIRECTORATE	Acute Services
REPORTS TO	Line Manager
ACCOUNTABLE TO	Operational Support Lead

JOB SUMMARY

The post-holder will provide secretarial support to a consultant or consultants, and their team, supporting the day-to-day clinical activities associated with out-patients, elective and emergency care within the Acute Services Directorate.

KEY DUTIES / RESPONSIBILITIES

1. Prioritise and manage workload on a daily basis, escalating areas of concern to the Directorate/Service Administrator as appropriate. Exercise judgement and use own initiative to provide non-clinical advice, information and guidance directly to patients, relatives and carers, requiring an intermediate level of medical terminology and procedures.
2. Management of waiting lists which includes providing timely

reports for consultants, eg, ensuring all patients receive treatment within Integrated Elective Access Policy targets and other Regional and internal milestones.

3. Responsible for compiling admission and theatre lists following guidance given by the consultant(s), which includes allocating/replacing patients for theatre slots and ensuring theatre sessions are used to full capacity.
4. Ensure patients are given correct guidance in relation to medication prior to surgery, eg Warfarin, Aspirin, contraceptive pill as per clinical standards agreed by the Trust and advice from Consultant(s)
5. Take initial receipt of all incoming correspondence – telephone, written and enquiries. Using initiative, prioritise urgency of response required and bring to the attention of consultant where necessary.
6. Prioritise and manage effectively results from x-ray and laboratory systems, ensuring all examinations and investigations have been received and brought to the attention of medical staff without delay.
7. Liaise with consultants, GPs and other hospital and external bodies to arrange out-patient appointments, urgent and routine, or the transferral of in-patient care.
8. Supervise and support new secretaries and audio-typists and actively participate in the induction and training of new staff within the directorate.
9. Application of diagnostic coding for out-patient episodes and procedure codes for waiting lists.
10. Arrange NHS meetings for consultants when required. Booking travel, hotel, courses and assisting consultant in continuing professional development activities such as research, audit, etc.
11. Operate all IT tools available to provide the most efficient use of time and most effective use of service, eg, Microsoft Outlook,

Patient Centre, PAS, Radiology, Laboratory Systems, Theatre Management System, ensuring the data contained on the system is accurate and up-to-date.

12. Monitor the typing workload within the office and allocate to audio-typists where appropriate and monitor quality of performance, escalating areas of concern to the Directorate/Service Administrator.
13. Maintain and provide accurate and timely statistics relating to consultant activity.
14. Manage the consultants dairy/schedule informing appropriate staff of changes to work schedule which affects theatre and out-patient scheduling. Co-ordinate the consultant(s) personal dairy for internal and external meetings.
15. Any other duties as may be assigned from time to time by Line Manager.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. Adhere at all times to all Trust policies/codes of conduct, including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
 - standards of attendance, appearance and behaviour

4. Comply fully with the Trust's policy and procedures regarding records management, as well as the Data Protection Act, accepting legal responsibility for all manual or electronic records held, created or used as part of his/her duties, and ensuring that confidentiality is maintained at all times.
5. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.
6. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.
7. Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

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

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

CRAIGAVON AREA HOSPITAL GROUP TRUST**JOB DESCRIPTION**

JOB TITLE: Acting Directorate Administrator Grade 5

LOCATION: Surgical Directorate

REPORTS TO: Clinical Services Manager

RESPONSIBLE TO: Clinical Director

JOB PURPOSE: To ensure the day to day administrative co-ordination of the Directorate through the provision of high quality, cost effective support to Clinical staff. The post holder will play an active role in the running of the Directorate by assisting the Clinical Services Manager with the full range of non-clinical duties and deputising in this respect in his/her absence.

MAIN RESPONSIBILITIES:**1. Clinical Information**

- 1.1 Monitor Directorate performance in respect of activity and waiting lists to ensure the Directorate is fully aware of its actual and projected performance against key performance targets and contractual obligations.
- 1.2 Assist clinical and non-clinical staff within the Directorate to plan and schedule routine work to ensure the achievement of key performance targets, specifically in relation to maximum waiting times.
- 1.3 Assist clinical and non-clinical staff within the Directorate to produce recovery and contingency plans to achieve performance targets where performance deviates from the plan.
- 1.4 Ensure the accurate, timely and complete recording of information within the Directorate on the Patient Administration System (PAS) and other clinical information systems.
- 1.5 Review the effectiveness of patient data collection and implement any necessary improvements.
- 1.6 Provide statistics and information as required to the Directorate using appropriate information systems and computer applications.
- 1.7 Work closely with the Operations, Contract and Information Team regarding information and performance issues & queries.
- 1.8 Provide information on performance against the Patients' Charter standards and co-ordinate charter monitoring surveys in appropriate areas.
- 1.9 Assist in the development and implementation of new systems, both computerised and manual, within the Directorate.
- 1.10 Liaise with Clinical Coders and Directorate staff to facilitate the clinical coding function.

2. Staff Management

Responsible for the management of the administrative and secretarial function within the Directorate (including the Accident & Emergency Department) including all administrative and clerical staff ensuring cost effectiveness and efficiency.

- 2.2 Review and continuously monitor workload distribution and allocate secretarial and administrative staff accordingly ensuring the effective provision of cover during staff absences.
- 2.3 Develop and implement staff appraisal.
- 2.4 Develop and maintain accurate staff records.
- 2.5 Allocate leave and monitor sickness and absenteeism.
- 2.6 Participate in the recruitment and selection of staff in accordance with the Trust's policies.
- 2.7 Participate in disciplinary matters in liaison with the Clinical Services Manager.
- 2.8 Identify staff training needs and ensure that these needs are met.
- 2.9 Monitor the secretarial and administrative budget, in liaison with the Clinical Services Manager.

3. General Duties

- 3.1 Provide and co-ordinate the full range of administrative support to the Clinical Directorate and its functions.
- 3.2 Work closely with the Directorate staff, Planning, Operations and Financial teams on behalf of the Directorate to assist the preparation of business cases and service development proposals as appropriate.
- 3.3 Participate in and or manage a range of non-clinical projects on behalf of the Directorate as appropriate.
- 3.4 Undertake research and prepare reports for the Clinical Services Manager and Clinical Director as directed.
- 3.5 Implement new processes and systems to support clinical and non-clinic processes within the Directorate, including preparation of protocol and provision of training as directed.
- 3.6 Work on behalf of the Directorate with the Theatre and Outpatient Managers, clinical and non-clinical staff to ensure full utilisation and backfill of surgical outpatient and theatre sessions.
- 3.7 Maintain the Clinical Services Manager's diary and deal with queries / take messages as appropriate when s/he is unavailable.

- 3.8 Assist in the preparation of the Directorate's annual business plan and submissions for the Trust's Annual Report and performance plans.

Assist in the formulation and monitoring of Directorate objectives.

- 3.10 Assist in the preparation and monitoring of Directorate budgets.
- 3.11 Assist in the setting and monitoring of quality standards within the Directorate.
- 3.12 Channel and record non-stock requisitions within the Directorate.
- 3.13 Assist the Clinical Director and Clinical Services Manager in the investigation and response to complaints.
- 3.14 Assist the Directorate to identify capital and revenue requirements and prepare submissions for new and replacement equipment.
- 3.15 Ensure minor non-capital and maintenance programmes within the Directorate are planned and completed effectively.
- 3.16 Ensure that all clinical records and information used within the Directorate are managed and stored in an appropriate manner and with due regard to confidentiality and Data Protection legislation.

GENERAL REQUIREMENTS

- Carry out his/her duties with full regard to the Trust's Equal Opportunities Policy.
- Co-operate fully with the implementation of the Trust's Health and Safety arrangements and report any accidents/incidents, defects with work equipment or inadequate safety arrangements.
- Accept legal responsibility for all records held, created or used as part of his/her duties (including manual or electronic records).
- Comply with the Trust's Smoke Free policy.
- Treat those whom he/she comes into contact with in the course of work, in a courteous manner.
- Accept that this job description will be subject to review in the light of changing circumstances and should be regarded as providing guidance within which the individual works rather than something which is rigid and inflexible.

September 2006

EMPLOYEE PROFILE

POST: Acting Directorate Administrator Grade 5

DEPARTMENT/SPECIALTY: Surgical Directorate

FACTORS	ESSENTIAL	DESIRABLE
Skills/Abilities	<p>Excellent communication skills - verbal and written</p> <p>Excellent administrative and organisational skills</p> <p>Good analytical and numerical ability.</p> <p>Good team working ability.</p> <p>Thoroughness and attention to detail at work.</p> <p>Ability to lead and take responsibility for the performance of a large team of administrative staff.</p>	
Qualifications/Experience/Training etc.	<p>Minimum of two years' recent clerical/administrative experience in a clinical setting.</p> <p>Evidence of recent personal development relevant to the post e.g. development programme, recognised qualification etc.</p> <p>Experience of using computerised database, spreadsheet and wordprocessing packages.</p>	<p>Third level qualification or equivalent.</p> <p>Staff Management experience.</p> <p>Experience in report writing.</p> <p>Experience of collecting and analysing data and presenting as meaningful information</p>
Knowledge	<p>Knowledge of acute hospital processes and associated information requirements.</p> <p>An understanding of the role of this post.</p>	
Other Requirements/Work Related Circumstances	Flexible with regard to working arrangements.	

September 2006

c) What specific steps have been taken by the Trust to address the ineffective systems of governance within the Urology SHSCT Cancer Services referred to within the Root Cause Analysis report? In answering this question you are required to identify each aspect of the system of governance which was found to be ineffective and/or which failed to provide assurance, and to state precisely how it has been addressed, when it was addressed, by whom it was addressed alongside their job description.

Recommendation	Steps Taken to Address	Date this was Addressed	Who Addressed this	Job Description(s)
1. The Southern Health and Social Care Trust must provide high quality urological cancer care for all patients.	A. Data Mapping Process exercise completed by QI team from point of GP presentation and referral to Urology Services to discharge from service.	Data Mapping Process commenced 7.12.21. Since then the data map has been confirmed with regards to stages of process (27.1.22). As of 3.3.22 meeting held to review the opportunities for data collection as baseline and mapping of the process alongside the patient experience survey being produced.	Internal QI team supports implementation. Outcomes from Data Map will need to be obtained to determine who needs to hold ownership of implementing actions. Please see appendices 17g and 17h	
	B. Baseline Assessment of Urology MDT using NCAT baseline tool & action plan developed to address areas identified. (descriptor of MDT)	Baseline assessments completed January 2021, Action plan developed in November 2021 & anticipated completion by June 2022	MDT Leads Please see appendices 17i & 17j	Seen Appendices 17a-17e
	C. Feedback from Patients from a variety of sources including:		For all of the below the MDT Chairs have forums to disseminate the feedback from these sources including the Monthly Patient Safety Meeting for Urology	
	-Complaints	Review Feb 22 of complaints raised by staff with regards to patient treatment. Only 1 identified from another directorate.	Complaints Department As new Datix arise and depending on the nature of complaint this can be the responsibility of a person/teams or multiple persons/teams to action.	

Recommendation	Steps Taken to Address	Date this was Addressed	Who Addressed this	Job Description(s)
	-Datix	Currently the National Incident Reporting system (DATIX) does not allow for categorising “concern”. Of the report run from Jan 2019 to Dec 2021 themes that could include a concern were: -Diagnosis-Wrong (8 reports) -Failure to Note Relevant Info In A Patients Record (61 reports) -Failure to Discontinue Treatment (10 reports) -Failure/ Delay to Order Correct Tests/ Images (125 reports) -Inadequate Investigation/ Inadequate Assessment (7 reports) - Treatment/ Procedure Not Clinically Indicated (13 reports) -Treatment/ Procedure Inappropriate/ Wrong (38 reports)	Governance Department Datix reports are submitted to the coded team. Depending on the nature of the incident it can be a person or persons that investigate and implement actions.	
	-Care Opinion	Jan 2022- initiation meeting with team. Details of requirements discussed and agreed. Next review due	Care Opinion Team. Outcome yet to be provided therefore ownership of actions required to be determined Please see Appednix 17j	
	-10,000 Voices	Not yet agreed until Care Opinion responses reviewed and if need for		

Recommendation	Steps Taken to Address	Date this was Addressed	Who Addressed this	Job Description(s)
	-Patient Surveys	Feb 22 commenced Project with service users focused on patient information.	Currently Sarah Ward, Head of Service for Clinical Assurance for Public Inquiry is leading this with our 2 service users. Following the outcomes of the survey the ownership of actions required may sit with person(s)/Team(s) or cross over specialities Please see Appendix 17l	
2. All patients receiving care from the SHSCT Urology Cancer Services should be appropriately supported and informed about their cancer care. This should meet the standards set out in Regional and National Guidance and meet the expectation of Cancer Peer Review.	A. Information Pathway. Review of: - information given to patients - Timing of Information given - Recording of Information given - Audit of Information Given - Past patient feedback on Information. Including sources, access, content etc	Commenced November 2021 & Ongoing	Currently Clinicians and Nurse Specialists delivering information regarding the patients care Please see Appendix 17m	
	B. All staff with patient facing contact are required to have advanced communication skills training and are up to date with requirements	Commenced November 2021 & most recent discussions to continue to secure training package in Feb 22	SAI Recommendation Group	Seen Appendices 17a-17e
	C. Allocation of Key Worker to newly diagnosed Urology Patient at MDT Meeting	November 2021 and work continues to Date	Requirement to be allocated at MDT	Seen Appendices 17a-17e
	D. Regional KPIS for CNS with particular reference to information and support for newly diagnosed Urology Patients.	Commenced November 2021 & CNS Workshop held 21.3.21. UPDATES PENDING	Governance	

Recommendation	Steps Taken to Address	Date this was Addressed	Who Addressed this	Job Description(s)
	E.Right Number of CNS with the Right Skills to support patients.	Commenced November 2021 & Ongoing. Awaiting DOH response on demand/capacity modelling for Cancer Strategy planning	Region initially and the Trusts	
3. The SHSCT must promote and encourage a culture that allows all staff to raise concerns openly	<p>A.Trust and Regional Guidelines and Policies</p> <ul style="list-style-type: none"> -Whistle Blowing Policy - DOH Your Right to Raise a Concern Guide -Nursing and Midwifery Accountability and Assurance Framework - GMC Code of Conduct - Working Well Together Policy - Supervision Policy 	<p>Feb / March 2022</p> <p>1. Complete at this stage</p>	<p>Trust & Individuals</p> <p>Please see Appendices 17n, 17o, 17p, 17q, 17r, 17s</p>	
4. The Trust must ensure that patients are discussed appropriately at MDM and by the appropriate professionals.	A. Urology MDT is formatted in accordance with the NCAT Framework.	Commenced November 2021 & Ongoing (see number 1)	<p>MDT Leads</p> <p>Please see appendices 17i & 17j</p>	
	B. Urology MDT Chair & essential professionals eg CNS will have Job Planned sessions for the MDT role. This is reflected also in their Job Description	Complete.	MDT Leads and CNS	
5. The Southern Health and Social Care Trust must ensure that MDM meetings are resourced to provide appropriate tracking of patients and to confirm agreed recommendations / actions are completed	A. Compliance with regional tracking requirements. Currently 31 & 62 day tracking is the only requirement. Regional Cancer Information System only supports patient tracking up to the first definitive treatment.	<p>Feb / March 22</p> <p>1. Requirement fully met to date</p> <p>2. Awaiting regional updates and actions</p> <p>-Owned by Region and internally OSL's, Cancer Service Improvement Lead</p>	Region initially and the Trusts	

Recommendation	Steps Taken to Address	Date this was Addressed	Who Addressed this	Job Description(s)
6. The Southern Health and Social Care Trust must ensure that there is an appropriate Governance Structure supporting cancer care based on patient need, patient experience and patient outcomes.	A. This supports recommendations 1-5 and the development of structures based on the outcomes awaited from these elements.	Commenced November 2021 & Ongoing	SAI Recommendation Group	
7. The role of the Chair of the MDT should be described in a Job Description, funded appropriately and have an enhanced role in Multidisciplinary Care Governance.	A new role description has been created for MDT chairs which increases their role in MDT governance. Administrative support has been secured in the form of a MDT administrator post. This staff member commenced in March 2022.	Commenced February 2022	DivMD Cancer and Clinical Services	
8. All patients should receive cancer care based on accepted best care Guidelines (NICAN Regional Guidance, NICE Guidance, Improving Outcome Guidance).	A. Initial referral to secondary care is completed in accordance to the NICE guideline 12. The diagnosis and treatment plan for patients is delivered in accordance with regionally agreed NiCan Guidance for each tumour site. MDT Administrator & Project Officer to audit monthly 1 Urology MDT to ensure actions agreed are implemented. Clinical Audit Team will be expanded to allow further audit of the MDT's.	Commenced November 2021 & Ongoing	Trust and MDT's Please see appendix 17t	

Recommendation	Steps Taken to Address	Date this was Addressed	Who Addressed this	Job Description(s)
9. The roles of the Clinical Lead Cancer Services and Associate Medical Director Cancer Services should be reviewed. The SHSCT must consider how these roles can redress Governance and Quality Assurance deficits identified within the report.	The job description for the Associate Medical Director has been reviewed and updated to the new Trust role of Divisional Medical Director. This post was advertised and successfully recruited to towards the end of 2021. The role of Clinical Director has also been reviewed and updated to the new templated Clinical Director format and is currently advertisement and will be interviewed for in the coming weeks	Commenced November 2021, expected completion April 2022	Medical Director	
10. The families working as "Experts by Experience" have agreed to support implementation of the recommendations by receiving updates on assurances at 3, 6 and 12 monthly intervals.	Service User Involvement group established. See Terms of Reference. Currently involved in patient experience project specific to Urology Cancer care.	Commenced November 2021 & Ongoing	Task & Finish Group Service User Group Please see appendix 17u and 17v	
11. The Southern Health and Social Care Trust should consider if assurance mechanisms detailed above, should be applied to patients or a subset of patients retrospectively.	A. To be discussed with the Medical Director and DMD'S as to whether there is sufficient information/ evidence to mandate a retrospective audit of all/ some tumour sites	Planned commenced August 2022	Trust	



SOUTHERN TRUST JOB DESCRIPTION **CONSULTANT ENT SURGEON**



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



Approval:



Approved by RCS 2 February 2016

JOB TITLE: Consultant ENT Surgeon

DEPARTMENT: ENT

BASE/LOCATION: All posts are appointed to the Southern Health and Social Care Trust. The base hospital for this post is **CRAIGAVON AREA HOSPITAL** however the post holder may be required to work on any site within the Southern Health and Social Care Trust.

REPORTS TO: Clinical Director – Surgery & Elective Care

RESPONSIBLE TO: Mr E Mackle – Associate Medical Director – Surgery & Elective Care

ACCOUNTABLE TO: Mrs E Gishkori – Director of Acute Services

SUMMARY OF POST:

- This is a replacement post and will join a team of 7 Consultant ENT Surgeons.
- This post will participate in a 1:7 Category A on-call rota. Current pay supplement: 5%
- This post will attract a salary of **£75,249 - £101,451 per annum**.
- This is a full-time position, however anyone interested in working part-time / job share is also welcome to apply.
- These posts has an attractive annual leave entitlement of a minimum of 27 days per annum and up to a maximum of 32 days per annum depending on previous experience
- The posts also has an attractive study leave entitlement of up to 30 days paid leave with expenses in any period of three years.
- A relocation package may also be available if required.
- The Southern Trust has established a dedicated revalidation support group which ensures all doctors have an annual appraisal with a trainer appraiser and supports all doctors through the revalidation process. The Trust has also appointed a Consultant and SAS Lead for appraisal and revalidation.
- The Trust offers a medical mentoring scheme which can be viewed on the Southern Docs website <http://www.southerndocs.hscni.net/wp-content/uploads/2016/01/Medical-Mentoring-Guidance-Nov2015.pdf>.

- The Trust supports the requirements for continuing professional development (CPD) as laid down by the GMC and is committed to providing time and financial support for these activities.
- The post will attract all the terms and conditions and employment benefits associated with an NHS post e.g. NHS indemnity; access to NHS pension scheme and many additional benefits such as child care vouchers etc.

THE SOUTHERN TRUST:

The Southern Trust is one of the largest employers in Northern Ireland and Craigavon Area and Daisy Hill hospitals form the Southern Trust Acute Hospital Network - serving a population of over 360,000. Each year in our hospital network there are approximately 63,000 inpatient admissions; 25,000 day cases; 300,000 outpatient appointments; 116,000 Emergency Department attendances; and over 6,000 births. Statistics updated in 2015

The Southern Trust's acute hospital network was reaffirmed in 2015 as one of the UK's Top Hospitals for the fourth consecutive year. The national CHKS Top 40 Hospitals programme recognises acute sector organisations for their achievements in healthcare quality, improvement and performance. The Top Hospitals award is based on the evaluation of over 20 key performance indicators covering safety, clinical effectiveness, health outcomes, efficiency, patient experience and quality of care. As well as being placed in the Top 40 Hospitals, the Southern Trust was shortlisted for the first time ever for the CHKS National Data Quality Improvement Award. Our vision is to 'to deliver safe, high quality health and social care services, respecting the dignity and individuality of all who use them'.

WHY SHOULD YOU WORK FOR US?

The Southern Trust was the first Trust in Northern Ireland to invest and implement in a fully electronic job planning system which is available for all permanent consultant and SAS doctors. This makes it much easier for doctors to maintain an up to date job plan to ensure they are paid correctly and to support the revalidation and appraisal process. Doctors in longer term temporary posts may also be able to use this system. As well as Corporate and Departmental Induction each new permanent medical employee will have an opportunity to have an informal meeting with the Medical Director at the end of month three / four of commencement with the Trust during which time they can explore the option of job shadowing a non-clinical manager within their speciality for a morning / afternoon. This will be facilitated via the relevant Associate Medical Director. There is also a fully embedded revalidation and appraisal process which supports all doctors with all of their appraisal and revalidation requirements. Opportunities also exist for doctors to avail of the Trust medical mentoring scheme.

The Southern Trust is keen to become an employer of choice for SAS doctors who choose to spend their career with us. The Trust has been proactive in encouraging the role of SAS doctors within the Trust and has a number of trained SAS Medical Appraisers and Mentors. Regular lunchtime SAS Link-Up sessions are held across the Trust which provide an opportunity for the SAS group of doctors to establish relationships and network with each other. A regional SAS Conference is also hosted by the Trust each year and a number of initiatives are being developed to support and retain our doctors within their chosen specialties. Our doctors play a vital role in the care and treatment of our patients and in return you can expect a positive experience that will support your development as a key member of the Southern Trust. But don't just take our word for it – listen to the comments of a few of our European doctors who have chosen to relocate from their home country and make a career with

the Southern Trust:

<https://vimeo.com/155571807>

<https://vimeo.com/155571800>

<https://vimeo.com/155571809>

Access code: ateam

SOUTHERN TRUST – IN THE SPOTLIGHT

The Southern Trust is one of the largest employers in Northern Ireland. Follow us on Twitter to hear all the latest news <https://mobile.twitter.com/southernhsct> or visit our YouTube channel for more news: https://www.youtube.com/channel/UC0YNNjgHJwX4WKregeR_IDQ/videos.

Some of our key achievements in 2015/16:

A day in the life of Southern Trust

<https://www.youtube.com/watch?v=eDkEYDEq298>

Consultant Geriatrician recognised at prestigious Institute of Health Care Management Awards

<http://www.southerntrust.hscni.net/3286.htm>

First UK Hospital to Trial Groundbreaking Physio for Critically ill Patients

<http://www.southerntrust.hscni.net/about/3270.htm>

First Trust in NI to trial new baby heart screening test:

<http://www.southerntrust.hscni.net/about/3210.htm>

UK Wide Recognition for Daisy Hill Anaesthetist:

<http://www.southerntrust.hscni.net/about/3192.htm>

Junior doctors rank Southern Trust among top 10 UK providers to work for:

<http://www.southerntrust.hscni.net/about/3121.htm>

Southern Trust Anaesthetists Ranked Top in Northern Ireland

<http://www.southerntrust.hscni.net/about/3027.htm>

DUTIES OF THE POST:

The post holder will:

- Share with his/her colleagues in the management of ENT patients.
- Provide outpatient services as per Job Plan.
- Participate with other consultant colleagues in strategic planning and delivery of high quality patient care on an area-wide and cross-border basis.
- Be required to share in the 1:7 on call rota with the existing Consultants.
- Be required to provide cover for Consultant colleagues during periods of approved study/annual/sick leave where appropriate.
- Share in undertaking the administrative duties associated with the department.
- Be required to participate in Medical Audit.
- Undertake the teaching of undergraduates and postgraduates as an essential part of the programme.
- Clinical and professional responsibility for patients
- Keep patients (and their carers if appropriate) informed about their condition.

- To involve patients (and their carers if appropriate) in decision making about their treatment.
- To maintain professional standards and obligations as set out by the General Medical Council and comply in particular with the GMC's guidance on Good Medical Practice as amended or substituted from time to time.
- Carry out any work related to and reasonably incidental to the duties set out in your job plan or rota including keeping of records and the provision of reports, the proper delegation of tasks and maintaining skills and knowledge.

PROPOSED JOB PLAN / ROTA PATTERN

A provisional job plan is outlined below which illustrates the content, but not necessarily the distribution of the individual fixed sessions. It is indicative only and may be subject to change following discussion with your clinical manager to deliver against service delivery.

	TIME	WORK ACTIVITY	LOCATION	HOURS				Total	Prem
				DCC	SPA	APA	EPA		
Mon	08.30 – 09.00	Travel to Armagh	Armagh	0.5				5	
	09.00 – 13.00	Outpatient Clinic		4.0					
	13.00 – 13.30	Travel		0.5					
		OFF							
Tues	07.45 – 08.30	Travel to Daisy Hill Hospital	DHH	0.75				10	
	08.30 – 09.00	Pre-op ward round		0.5					
	09.00 – 13.00	Theatres		4.0					
	13.30 – 17.00	Outpatients	DHH	3.5					
	17.00 – 17.30	Post-op ward round		0.5					
	17.30 – 18.15	Travel to CAH		0.75					
Wed	08.30 – 09.00	Pre-op ward round	CAH	0.5				9	
	09.00 – 17.00	Theatres		8.0					
	17.00 – 17.30	Post-op ward round	CAH	0.5					
Thur	09.00 – 13.00	Outpatient Clinic	CAH	4.0				8	
	13.30 – 14.30	Teach Students	CAH	1.0					
	14.30 – 17.30	SPA			3.0				
Fri	09.00 – 13.00	Admin	CAH	4.0				7	
	13.30 – 16.30	SPA	CAH		3.0				
TOTAL HOURS				33.0	6.0			39.0	
TOTAL PROGRAMMED ACTIVITIES				8.25	1.5			9.75	

Programmed Activities	Number of PA's/ Sessions
Direct Clinical Care	8.25
Supporting Professional Activities	1.5
Premium time	
On call	0.5
Total PA's	10.25

Emergency Work	
On-call Rota Frequency:	1 in 7
Agreed Category: (consultants only)	Category A
On-call % Supplement	5%

TERMS AND CONDITIONS:

This post will be contracted in accordance with:

Consultant Terms and Conditions which can be viewed at:

<https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/revised-consultants-terms.pdf>

Your salary scale will be in accordance with the NHS Remuneration for your grade, which can be viewed at: <https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/hsc-tc8-1-2015.pdf>

(updated February 2015)

If you would like any additional information about this post, for example details of the specialty or existing staff, please contact the Medical Staffing Office on

Personal Information redacted by the USI

GENERAL REQUIREMENTS:

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. Adhere at all times to all Trust policies/codes of conduct, including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
 - standards of attendance, appearance and behaviour
4. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.
5. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.
6. It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service

SOUTHERN HEALTH & SOCIAL CARE TRUST**PERSONNEL SPECIFICATION**

JOB TITLE: Consultant ENT Surgeon – Craigavon Area Hospital

DIRECTORATE: Acute Services

HOURS: Full-time **March 2016**

SALARY: £75,249 - £101,451 per annum

Notes to applicants:

1. **Your application form:** You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should do this for both essential and desirable criteria requirements. All essential criteria requirements listed below must be met by the stated closing date, unless otherwise stated.
2. **CVs:** If you decide to submit a CV, you should note that CV's will only be accepted in support of a properly completed application form. For shortlisting purposes the panel will only be assessing your application form, therefore do not rely on your CV to evidence shortlisting criteria. You **MUST** demonstrate all necessary shortlisting criteria on the Trust's standard application form or you will not be shortlisted.
3. Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.
4. This criterion will be waived in the case of a suitable applicant who has a disability which prohibits them from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.

Do not rely on your CV to evidence shortlisting criteria. You **MUST demonstrate all necessary shortlisting criteria on the Trust's standard application form or you may not be shortlisted.**

ESSENTIAL CRITERIA – these are criteria all applicants **MUST** be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

1. Full registration with the General Medical Council (London) with Licence to Practice;
2. Hold FRCS or an equivalent qualification;
3. Entry on the GMC (London) Specialist Register via:
 - CCT in the specialty (proposed CCT date must be within 6 months of interview)
 - CESR or
 - European Community Rights

4. Have a sub-specialist interest to compliment the current post holders.
5. Hold a full current driving license valid for use in the UK and have access to a car on appointment.¹

The following are essential criteria which will be measured during the interview stage.

6. Knowledge of evidence based approach to clinical care.
7. Understanding of the implication of clinical governance.
8. Have an interest in teaching and research.
9. Ability to lead and engender high standards of care.
10. Ability to develop strategies to meet changing demands.
11. Willingness to work flexibly as part of a team.
12. Good communication and interpersonal skills.
13. Ability to work well within a multidisciplinary team.
14. Ability to effectively train and supervise medical undergraduates and postgraduates.

DESIRABLE CRITERIA – these will only be used where it is necessary to introduce additional job related criteria to ensure files are manageable. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being short listed

1. Have some formal training in teaching methods.
2. Have management experience.
3. Have experience in research.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

¹ *This criterion will be waived in the case of a suitable applicant who has a disability which prohibits them from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.*



www.planetware.com



<http://www.mourne-mountains.com/mourmes/>



<http://www.armagh.co.uk>

SOUTHERN TRUST JOB DESCRIPTION CONSULTANT OBSTETRICIAN & GYNAECOLOGIST



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



APPROVED BY RCOG – 27.03.17

JOB TITLE: **CONSULTANT**

DEPARTMENT: Obstetrics & Gynaecology

BASE/LOCATION: All posts are appointed to the Southern Health and Social Care Trust. The base hospital for this post is **Craigavon Area Hospital** however the post holder may be required to work on any site within the Southern Health and Social Care Trust.

RESPONSIBLE TO: Dr G McCracken – Clinical Director – Obstetrics & Gynaecology – Craigavon Area Hospital

ACCOUNTABLE TO: Mrs E Gishkori - Director of Acute Service

SUMMARY OF POST:

- This is a permanent replacement post and will be based in Craigavon Area Hospital.
- This post will participate in a 1:10 rota and provide cross cover for each other at times of unavailability.
- This post will attract a salary of £76,001 - £102,466 per annum full time (pro rata for part-time).
- This is a full-time position, however anyone interested in working part-time / job share is also welcome to apply.
- Annual leave will be 32 days per annum initially rising to 34 days after 7 years' seniority, plus 10 statutory and public holidays.
- The post also has an attractive study leave entitlement of up to 30 days paid leave with expenses in any period of three years.
- A relocation package may also be available if appropriate.
- The Southern Trust has established a dedicated revalidation support team which ensures all doctors have an annual appraisal with a trained appraiser and supports all doctors through the revalidation process. The Trust has also appointed corporate, Consultant and SAS Leads for appraisal and revalidation.

- The Trust offers a medical mentoring scheme which can be viewed on the Southern Docs website [CLICK HERE](#) Personal Information redacted by the USI
- The Trust supports the requirements for continuing professional development (CPD) as laid down by the GMC and is committed to providing time and financial support for these activities.
- The post will attract all the terms and conditions and employment benefits associated with an NHS post e.g. NHS indemnity; access to NHS pension scheme and many additional benefits such as child care vouchers etc.

THE SOUTHERN TRUST:

The Southern Trust is one of the largest employers in Northern Ireland and Craigavon Area and Daisy Hill hospitals form the Southern Trust Acute Hospital Network - serving a population of over 360,000. Each year in our hospital network there are approximately 63,000 inpatient admissions; 25,000 day cases; 300,000 outpatient appointments; 116,000 Emergency Department attendances; and over 6,000 births. *Statistics updated 2015*

The Southern Trust's acute hospital network was reaffirmed in 2016 as one of the UK's Top Hospitals for the fifth consecutive year. The national CHKS Top 40 Hospitals programme recognises acute sector organisations for their achievements in healthcare quality, improvement and performance. The Top Hospitals award is based on the evaluation of over 20 key performance indicators covering safety, clinical effectiveness, health outcomes, efficiency, patient experience and quality of care. As well as being placed in the Top 40 Hospitals, the Southern Trust was shortlisted for the first time ever for the CHKS National Data Quality Improvement Award. Our vision is 'to deliver safe, high quality health and social care services, respecting the dignity and individuality of all who use them.

WHY SHOULD YOU WORK FOR US?

The Southern Trust was the first Trust in Northern Ireland to invest and implement in a fully electronic job planning system which is available for all permanent consultant and SAS doctors. This makes it much easier for doctors to maintain an up to date job plan to ensure they are paid correctly and to support the revalidation and appraisal process. Doctors in longer term temporary posts may also be able to use this system. As well as Corporate and Departmental Induction each new permanent medical employee will have an opportunity to have an informal meeting with the Medical Director at the end of month three / four of commencement with the Trust during which time they can explore the option of job shadowing a non-clinical manager within their speciality for a morning / afternoon. This will be facilitated via the relevant Associate Medical Director. There is also a fully embedded revalidation and appraisal process which supports all doctors with all of their appraisal and revalidation requirements. Opportunities also exist for doctors to avail of the Trust medical mentoring scheme.

The Southern Trust is keen to become an employer of choice for SAS doctors who choose to spend their career with us. The Trust has been proactive in encouraging the role of SAS doctors within the Trust and has a number of trained SAS Medical Appraisers and Mentors. Regular lunchtime SAS Link-Up sessions are held across the Trust which provides an opportunity for the SAS group of doctors to establish relationships and network with each other. A regional SAS Conference is also hosted by the Trust each year and a number of initiatives are being developed to support and retain our doctors within their chosen specialties. Our doctors play a vital role in the care and treatment of our patients and in return you can expect a positive experience that will support your development as a key member of the

Southern Trust. But don't just take our word for it – listen to the comments of a few of our European doctors who have chosen to relocate from their home country and make a career with the Southern Trust:

<https://vimeo.com/155571807>

<https://vimeo.com/155571803>

<https://vimeo.com/155571800>

<https://vimeo.com/155571809>

Access code: ateam

WORK OF THE DEPARTMENT

The successful candidate will join 10 other Consultants (2 part-time) to provide a full range of inpatient and outpatient Obstetrical and Gynaecological services.

The Obstetricians will operate a 1:10 rota and provide cross cover for each other at times of unavailability. The Consultants are supported by 3.2WTE Specialty Doctors, 7 Specialist Registrars and 8 junior doctors at ST1-2 or FY2 level.

Obstetrics:

There are currently 30 obstetric beds with approximately 4,000 patients delivered annually. Their type of care is agreed individually with most selecting shared care and others hospital care only, midwifery led care or domino confinement. There are 6 delivery rooms, 4 induction of labour rooms, 2 theatres and a 3 bedded recovery/ high dependency area. At all times there is a team, led by a Consultant, responsible exclusively for dealing with the Labour Ward and emergencies. There is a 24-hour epidural service. A Midwifery Led Unit has been developed within the Maternity Directorate and is now fully operational. A 'Consultant of the Week' system exists to provide 60 hours per week prospective labour ward cover.

Neonatology:

There is an excess of high-risk pregnancies managed within the hospital as the maternity unit acts as a secondary referral unit for other hospitals within the Southern Health and Social Care Trust area. This is largely because of the Special Care Baby Unit which, with 15 cots, is adjacent to the Labour Ward and is manned by a full team of Paediatricians.

Gynaecology:

The Gynaecology ward has 10 beds. During the Financial Year 2006/07 there were 1,883 inpatients and 846 day cases cared for. Each Consultant has access to operating lists in the theatre suite and in a day surgery unit.

Outpatients:

Outpatient clinics in both obstetrics and gynaecology are held in Craigavon Area Hospital, South Tyrone Hospital and Armagh Community Hospital. There are also Infertility Clinics and assisted reproduction sessions carried out in Craigavon Area Hospital.

Interests:

Special interests of the present Consultants include Colposcopy, Gynae Cancer, Subfertility, Ultrasonography and Perinatal Medicine.

There is an Area Infertility Clinic providing counselling, investigations, ovulation induction and assisted conception.

At present there are colposcopy clinics in Craigavon and South Tyrone Hospitals. All Gynae cancers are discussed at the MDM Meeting in Belfast on Wednesday morning and some selected cases are operated on at Craigavon Area Hospital by one of the Consultants. Vulval and cervical cancer cases are dealt with exclusively by the Regional Cancer Centre.

SOUTHERN TRUST – IN THE SPOTLIGHT

The Southern Trust is one of the largest employers in Northern Ireland. Follow us on Twitter to hear all the latest news <https://mobile.twitter.com/southernhsct>.

Some of our key achievements in 2015/16:

Consultant Geriatrician recognised at prestigious Institute of Health Care Management Awards
<http://www.southerntrust.hscni.net/3286.htm>

First UK Hospital to Trial Groundbreaking Physio for Critically ill Patients
<http://www.southerntrust.hscni.net/about/3270.htm>

First Trust in NI to trial new baby heart screening test:
<http://www.southerntrust.hscni.net/about/3210.htm>

UK Wide Recognition for Daisy Hill Anaesthetist:
<http://www.southerntrust.hscni.net/about/3192.htm>

Junior doctors rank Southern Trust among top 10 UK providers to work for:
<http://www.southerntrust.hscni.net/about/3121.htm>

Southern Trust Anaesthetists Ranked Top in Northern Ireland
<http://www.southerntrust.hscni.net/about/3027.htm>

DUTIES OF THE POST:

The appointee will:

- Share responsibility for inpatient, outpatient and day care services within the Directorate of Obstetrics & Gynaecology, as described above;
- Work within the Directorate as a member of the team thus ensuring continuity of approach and care;
- Participate in the “On-Call” rota with the other Consultants;
- Be responsible to the Clinical Director of the Obstetrics and Gynaecology Directorate for the maintenance of personal professional standards;
- Be expected to participate in the teaching and assessment of undergraduate medical students and postgraduate medical staff;
- Participate in medical and clinical audit and, where suitable, apply the results to improve the service;
- Continue to develop his/her knowledge, skills and expertise through Continuing Medical Education to which the Trust is committed and which is facilitated through its Study Leave Funding. If the post holder holds MRCOG, s/he will be expected to enrol in the Continuing Medical Education Programme of the RCOG;

- Undertake administrative duties associated with patient care in order that arrangements are in place to meet specified quality standards;
- Undertake, when required, administrative duties within the Clinical Directorate;
- Share a personal secretary with another Consultant within the specialty;
- The hospital presently offers a family planning service including appropriate gynaecological procedures. The appointee will be expected to carry out these procedures during fixed clinical sessions included in the enclosed job plan, unless they have a moral objection. Fees for family planning procedures are presently only payable when the procedures are carried out in non-contracted time.
- Clinical and professional responsibility for patients.
- Keep patients (and their carers if appropriate) informed about their condition.
- To involve patients (and their carers if appropriate) in decision making about their treatment.
- To maintain professional standards and obligations as set out by the General Medical Council and comply in particular with the GMC's guidance on Good Medical Practice as amended or substituted from time to time.
- Carry out any work related to and reasonably incidental to the duties set out in your job plan or rota including keeping of records and the provision of reports, the proper delegation of tasks and maintaining skills and knowledge.

PROPOSED JOB PLAN / ROTA PATTERN

A provisional job plan is outlined below which illustrates the content, but not necessarily the distribution of the individual fixed sessions. It is indicative only and may be subject to change following discussion with your clinical manager to deliver against service delivery.

Timetable

Hot Activities

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Consultant of the week 08:30 - 21:00 Week 1 (10 week cycle)	Consultant of the week 08:30 - 21:00 Week 1 (10 week cycle)	Consultant of the week 08:30 - 21:00 Week 1 (10 week cycle)	Consultant of the week 08:30 - 21:00 Week 1 (10 week cycle)	Consultant of the week 08:30 - 18:30 Week 1 (10 week cycle)		

Week 1

There are no activities this week

Week 2

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Antenatal clinic 08:30 - 12:30 Gynaecology clinic 13:00 - 17:00	Continuous professional development. 09:00 - 13:00 Patient related admin (reports, results etc) 13:00 - 17:00 Continuous professional development.	Pre-Op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 13:00 Post-op ward round 13:00 - 13:30 Day Obstetric unit 13:30 - 17:30	Continuous professional development. 08:30 - 12:30 Day surgery 12:30 - 18:00	Gynaecology clinic 09:00 - 13:00		

	17:00 - 17:45					
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Week 3

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Antenatal clinic 08:30 - 12:30 Gynaecology clinic 13:00 - 17:00	Patient related admin (reports, results etc) 13:00 - 17:00 Continuous professional development. 17:00 - 17:45	Pre-Op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 13:00 Post-op ward round 13:00 - 13:30	Continuous professional development. 08:30 - 12:30 Day surgery 12:30 - 18:00			

Week 4

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Antenatal clinic 08:30 - 12:30 Gynaecology clinic 13:00 - 17:00	Continuous professional development. 09:00 - 13:00 Patient related admin (reports, results etc) 13:00 - 17:00 Continuous professional development. 17:00 - 17:45	Pre-Op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 13:00 Post-op ward round 13:00 - 13:30 Day Obstetric unit 13:30 - 17:30	Continuous professional development. 08:30 - 12:30 Day surgery 12:30 - 18:00	Gynaecology clinic 09:00 - 13:00		

Week 5

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Antenatal clinic 08:30 - 12:30 Gynaecology clinic 13:00 - 17:00	Patient related admin (reports, results etc) 13:00 - 17:00 Continuous professional development. 17:00 - 17:45	Pre-Op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 13:00 Post-op ward round 13:00 - 13:30	Continuous professional development. 08:30 - 12:30 Day surgery 12:30 - 18:00			

Week 6

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Antenatal clinic 08:30 - 12:30 Gynaecology clinic 13:00 - 17:00	Continuous professional development. 09:00 - 13:00 Patient related admin (reports, results etc) 13:00 - 17:00 Continuous professional development. 17:00 - 17:45	Pre-Op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 13:00 Post-op ward round 13:00 - 13:30 Day Obstetric unit 13:30 - 17:30	Continuous professional development. 08:30 - 12:30 Day surgery 12:30 - 18:00	Gynaecology clinic 09:00 - 13:00		

Week 7

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Antenatal clinic 08:30 - 12:30 Gynaecology clinic 13:00 - 17:00	Patient related admin (reports, results etc) 13:00 - 17:00 Continuous professional development. 17:00 - 17:45	Pre-Op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 13:00 Post-op ward round 13:00 - 13:30	Continuous professional development. 08:30 - 12:30 Day surgery 12:30 - 18:00			

Week 8

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Antenatal clinic 08:30 - 12:30	Continuous professional	Pre-Op ward round 08:30 - 09:00	Continuous professional	Gynaecology clinic 09:00 - 13:00		

Gynaecology clinic 13:00 - 17:00	development. 09:00 - 13:00	Planned in-patient operating sessions 09:00 - 13:00 Post-op ward round 13:00 - 13:30 Day Obstetric unit 13:30 - 17:30	development. 08:30 - 12:30 Day surgery 12:30 - 18:00			
	Patient related admin (reports, results etc) 13:00 - 17:00 Continuous professional development. 17:00 - 17:45					




Week 9








Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Antenatal clinic 08:30 - 12:30 Gynaecology clinic 13:00 - 17:00	Patient related admin (reports, results etc) 13:00 - 17:00 Continuous professional development. 17:00 - 17:45	Pre-Op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 13:00 Post-op ward round 13:00 - 13:30	Continuous professional development. 08:30 - 12:30 Day surgery 12:30 - 18:00			

Week 10

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Antenatal clinic 08:30 - 12:30 Gynaecology clinic 13:00 - 17:00	Continuous professional development. 09:00 - 13:00 Patient related admin (reports, results etc) 13:00 - 17:00 Continuous professional development. 17:00 - 17:45	Pre-Op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 13:00 Post-op ward round 13:00 - 13:30 Day Obstetric unit 13:30 - 17:30	Continuous professional development. 08:30 - 12:30 Day surgery 12:30 - 18:00	Gynaecology clinic 09:00 - 13:00		

Activities

-  Hot Activity
-  Unaffected by hot activity
-  Shrunk by hot activity

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
								Total:	9.409	37:16
	Mon	08:30 - 12:30	wks 2-10	Antenatal clinic 30 minutes travel from Craigavon Area Hospital.	Southern Health and Social Care Tru..	South Tyrone Hospital	DCC	36.8	0.876	3:30
	Mon	08:30 - 21:00	wk 1 10 wk cycle	Consultant of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	5.2	0.408	1:33
	Mon	13:00 - 17:00	wks 2-10	Gynaecology clinic 30 minutes travel to Craigavon Area Hospital.	Southern Health and Social Care Tru..	South Tyrone Hospital	DCC	36.8	0.876	3:30
	Tue	08:30 - 21:00	wk 1 10 wk cycle	Consultant of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	5.2	0.408	1:33
	Tue	09:00 - 13:00	wks 2, 4, 6, 8, 10	Continuous professional development.	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	21	0.500	2:00
	Tue	13:00 - 17:00	wks 2-10	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	36.8	0.876	3:30
	Tue	17:00 - 17:45	wks 2-10	Continuous professional development.	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	36.8	0.164	0:39
	Wed	08:30 - 09:00	wks 2-10	Pre-Op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	36.8	0.110	0:26

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
H	Wed	08:30 - 21:00	wk 1 10 wk cycle	Consultant of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	5.2	0.408	1:33
S	Wed	09:00 - 13:00	wks 2-10	Planned in-patient operating sessions	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	36.8	0.876	3:30
S	Wed	13:30 - 13:30	wks 2-10	Post-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	36.8	0.110	0:26
	Wed	13:30 - 17:30	wks 2, 4, 6, 8, 10	Day Obstetric unit	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	21	0.500	2:00
S	Thu	08:30 - 12:30	wks 2-10	Continuous professional development.	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	36.8	0.876	3:30
H	Thu	08:30 - 21:00	wk 1 10 wk cycle	Consultant of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	5.2	0.408	1:33
S	Thu	12:30 - 18:00	wks 2-10	Day surgery 45 minutes travel from Craigavon Area Hospital. 45 minutes travel to Craigavon Area Hospital.	Southern Health and Social Care Tru..	Daisy Hill Hospital	DCC	36.8	1.205	4:49
H	Fri	08:30 - 18:30	wk 1 10 wk cycle	Consultant of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	5.2	0.310	1:14
	Fri	09:00 - 13:00	wks 2, 4, 6, 8, 10	Gynaecology clinic Comments: Consultant only Gynae clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	21	0.500	2:00

PA Breakdown

	Main Employer PAs	Total PAs	Total hours
Direct Clinical Care (DCC)	8.918	8.918	35:00
Supporting Professional Activities (SPA)	1.540	1.540	6:09
Total	10.459	10.459	41:09

On-call summary

Rota Name	Location	Weekday Freq	Weekend Freq	Category	Supplement	PAs
O&G (1:10/1:20) Cat A	Craigavon Area Hospital	10	10	A	3%	1.050
Type		Normal		Premium	Cat.	PA
				Total:		1.050
Predictable	n/a		n/a	DCC		0.170
Unpredictable	n/a		n/a	DCC		0.880
The total PAs arising from your on-call work is:		1.050				
Your availability supplement is:		3% (based on the highest supplement from all your rotas)				

Balance between Direct Clinical Care and Other Programmed Activities

Supporting Professional Activities including participation in training of other staff, medical education, continuing professional development, formal teaching of other staff, audit, job planning, appraisal, research, clinical management and local clinical governance activities are recognised within the Southern Health and Social Care Trust. The Trust expects that all consultants undertake a minimum of 1.5 SPA's (6 hours) in their job plan every week. The Trust also recognises that there are various activities as identified by the Associate Medical

Directors in each directorate and approved by the Medical Director or the relevant Service Director where additional SPA time will be necessary. If a newly appointed consultant becomes involved in these additional SPA commitments, the precise balance of Programmed Activities in their job plan will be reviewed on appointment and agreed as part of their individual Job Plan review.

Programmed Activities for additional HPSS responsibilities and external duties will also be allocated for special responsibilities that have been formally approved and/or appointed by the Trust.

TERMS AND CONDITIONS:

This post will be contracted in accordance with:

Consultant Terms and Conditions which can be viewed at:

[CLICK HERE](#)

Your salary scale will be in accordance with the NHS Remuneration for your grade, which can be viewed at: [CLICK HERE](#)

If you would like any additional information about this post, for example details of the specialty or existing staff, please contact Dr G McCracken (Clinical Director) on (028)

Personal Information
redacted by the USI

GENERAL REQUIREMENTS:

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. Adhere at all times to all Trust policies/codes of conduct, including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
 - standards of attendance, appearance and behaviour
4. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

5. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.
6. It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

SOUTHERN HEALTH & SOCIAL CARE TRUST**PERSONNEL SPECIFICATION**

JOB TITLE: Consultant – Obstetrics & Gynaecology – Craigavon Area Hospital

DIRECTORATE: Acute Services

HOURS: Full-time

Ref No: 738170XX

March 2017

SALARY: £76,001 - £102,466 per annum

Notes to applicants:

1. **Your application form:** You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should do this for both essential and desirable criteria requirements. All essential criteria requirements listed below must be met by the stated closing date, unless otherwise stated.
2. Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.

ESSENTIAL CRITERIA – these are criteria all applicants **MUST** be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

1. Hold Full registration with the General Medical Council (London) with Licence to Practice or be able to obtain by time of appointment;¹
2. Hold MRCOG or equivalent qualification.
3. Entry on the GMC Specialist Register via
 - CCT (proposed CCT date must be within 2 months of interview)
 - CESR or
 - European Community Rights
4. Hold a full current driving license valid for use in the UK and have access to a car on appointment.²

¹ If successful at interview, applicants will be required to provide proof of their GMC application. Applicants must be registered, with a licence to practice at the time of appointment.

² This criterion will be waived in the case of a suitable applicant who has a disability which prohibits them from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.

The following are essential criteria which will be measured during the interview stage.

5. Ability to communicate effectively with colleagues, patients, relatives, GPs, nurses and other agencies.
6. Enthusiasm and ability to work under pressure.
7. Good organisational and management skills
8. Supportive and tolerant
9. Ability to work within a multidisciplinary team
10. Ability to supervise junior medical staff.
11. Caring attitudes to patients
12. Good leadership skills.

DESIRABLE CRITERIA – these will only be used where it is necessary to introduce additional job related criteria to ensure files are manageable. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being short listed

1. Have a special interest to complement the development of the department.
2. Further Higher Degree
3. Additional clinical experience/ training that may be required
4. Evidence of management and administration experience
5. Completed Special skills modules appropriate to the post.

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www.planetware.com

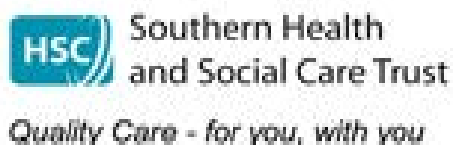


<http://www.mourne-mountains.com/mourne/>



<http://www.armagh.co.uk>

SOUTHERN TRUST JOB DESCRIPTION CONSULTANT PHYSICIAN – RESPIRATORY MEDICINE (with subspecialty in Asthma)

**Approval:**

APPROVED BY ROYAL COLLEGE OF PHYSICIANS – 26 OCTOBER 2017

- JOB TITLE:** Consultant Physician – Respiratory Medicine (with subspecialty in Asthma)
- DEPARTMENT:** Respiratory Medicine
- BASE/LOCATION:** All posts are appointed to the Southern Health and Social Care Trust. The base hospital for this post is **CRAIGAVON AREA HOSPITAL** however the post holder may be required to work on any site within the Southern Health and Social Care Trust.
- REPORTS TO:** Dr P Murphy – Associate Medical Director – Medicine & Unscheduled Care Division
- ACCOUNTABLE TO:** Mrs E Gishkori– Director of Acute Services

The Trust is seeking to recruit to this Consultant Physician - Respiratory Medicine with subspecialty in Asthma based in Craigavon Area Hospital. Applicants with a subspecialty interest will be welcome. This is a new post.

SUMMARY OF POST:

- This post will participate in a 1:14 on-call rota. Current pay supplement: 1%
- This post will attract a salary of £76,001 - £102,466 per annum.
- This is a full-time position, however anyone interested in working part-time / job share is also welcome to apply.
- Annual leave will be 32 days per annum initially rising to 34 days after 7 years' seniority, plus 10 statutory and public holidays
- The post also has an attractive study leave entitlement of up to 30 days paid leave with expenses in any period of three years.
- A relocation package may also be available if appropriate.
- The Southern Trust has established a dedicated revalidation support team which ensures all doctors have an annual appraisal with a trained appraiser and supports all doctors through the revalidation process. The Trust has also appointed corporate, Consultant and SAS Leads for appraisal and revalidation.
- The Trust offers a medical mentoring scheme which can be viewed on the Southern Docs website [CLICK HERE](#)

Personal Information
redacted by the USI

- The Trust supports the requirements for continuing professional development (CPD) as laid down by the GMC and is committed to providing time and financial support for these activities.
- The post will attract all the terms and conditions and employment benefits associated with an NHS post e.g. NHS indemnity; access to NHS pension scheme and many additional benefits such as child care vouchers etc.

THE SOUTHERN TRUST:

The Southern Trust is one of the largest employers in Northern Ireland and Craigavon Area and Daisy Hill hospitals form the Southern Trust Acute Hospital Network - serving a population of over 360,000. Each year in our hospital network there are approximately 63,000 inpatient admissions; 25,000 day cases; 300,000 outpatient appointments; 116,000 Emergency Department attendances; and over 6,000 births. Statistics updated in 2015

The Southern Trust's acute hospital network was reaffirmed in 2016 as one of the UK's Top Hospitals for the fifth consecutive year. The national CHKS Top 40 Hospitals programme recognises acute sector organisations for their achievements in healthcare quality, improvement and performance. The Top Hospitals award is based on the evaluation of over 20 key performance indicators covering safety, clinical effectiveness, health outcomes, efficiency, patient experience and quality of care. As well as being placed in the Top 40 Hospitals, the Southern Trust was shortlisted for the first time ever for the CHKS National Data Quality Improvement Award. Our vision is to 'to deliver safe, high quality health and social care services, respecting the dignity and individuality of all who use them'

WHY SHOULD YOU WORK FOR US?

The Southern Trust was the first Trust in Northern Ireland to invest and implement in a fully electronic job planning system which is available for all permanent consultant and SAS doctors. This makes it much easier for doctors to maintain an up to date job plan to ensure they are paid correctly and to support the revalidation and appraisal process. Doctors in longer term temporary posts may also be able to use this system. As well as Corporate and Departmental Induction each new permanent medical employee will have an opportunity to have an informal meeting with the Medical Director at the end of month three / four of commencement with the Trust during which time they can explore the option of job shadowing a non-clinical manager within their speciality for a morning / afternoon. This will be facilitated via the relevant Associate Medical Director. There is also a fully embedded revalidation and appraisal process which supports all doctors with all of their appraisal and revalidation requirements. Opportunities also exist for doctors to avail of the Trust medical mentoring scheme.

The Southern Trust is keen to become an employer of choice for SAS doctors who choose to spend their career with us. The Trust has been proactive in encouraging the role of SAS doctors within the Trust and has a number of trained SAS Medical Appraisers and Mentors. Regular lunchtime SAS Link-Up sessions are held across the Trust which provides an opportunity for the SAS group of doctors to establish relationships and network with each other. A regional SAS Conference is also hosted by the Trust each

year and a number of initiatives are being developed to support and retain our doctors within their chosen specialties. Our doctors play a vital role in the care and treatment of our patients and in return you can expect a positive experience that will support your development as a key member of the Southern Trust. But don't just take our word for it – listen to the comments of a few of our European doctors who have chosen to relocate from their home country and make a career with the Southern Trust:

<https://www.youtube.com/watch?v=PmfX1fiAoac>

<https://www.youtube.com/watch?v=IPMi3xDKUXQ>

<https://www.youtube.com/watch?v=bV7EnYNN9Ns>

SOUTHERN TRUST – IN THE SPOTLIGHT

The Southern Trust is one of the largest employers in Northern Ireland. Follow us on Twitter to hear all the latest news <https://mobile.twitter.com/southernhsct> or visit our YouTube channel for more news: https://www.youtube.com/channel/UC0YNNjgHJwX4WKregeR_IDQ/videos.

Some of our key achievements in 2015/16:

A day in the life of Southern Trust

[CLICK HERE](#)

Consultant Geriatrician recognised at prestigious Institute of Health Care Management Awards

[CLICK HERE](#)

First UK Hospital to Trial Groundbreaking Physio for Critically ill Patients

[CLICK HERE](#)

First Trust in NI to trial new baby heart screening test:

[CLICK HERE](#)

UK Wide Recognition for Daisy Hill Anaesthetist:

[CLICK HERE](#)

Junior doctors rank Southern Trust among top 10 UK providers to work for: [CLICK HERE](#)

Southern Trust Anaesthetists Ranked Top in Northern Ireland

[CLICK HERE](#)

WORK OF THE DEPARTMENT

At Craigavon Area Hospital there are 131 medical beds providing continuous emergency take-in for approximately 11,000 admissions annually. Most acute medical admissions are to the 32 bedded Medical Admissions Unit, from which patients are discharged after treatment, or transferred to another medical ward for ongoing treatment. The Respiratory ward has 18 Respiratory plus 17 Medical beds. In addition, approximately 16,000 outpatient episodes occur annually in medicine. There is also clinical room designed for elective pleural procedures and ultrasound.

MEDICAL STAFFING OF DEPARTMENT

Dr R P Convery	Consultant Physician (Respiratory Medicine)
Dr A John	Consultant Physician (Respiratory Medicine)
Dr L Polley	Consultant Physician (Respiratory Medicine)
Dr N Chapman	Associate Specialist (Respiratory Medicine)

Office facilities and secretarial support will be provided within the Directorate.

SUPPORT SERVICES

A full range of professions allied to medicine is available including physiotherapy, occupational therapy and dietetics. There is a pharmacy department on site, which also provides an area service. The Department of Radiodiagnosis provides general radiographic and radiological procedures, specialised radiological examinations, ultrasound, nuclear medicine, CT scanning and MRI scanning. A DEXA scanning service is available in South Tyrone Hospital. The Area Laboratory Service is based at Craigavon Area Hospital site and provides on-site facilities for haematology, bacteriology, clinical chemistry and histopathology. Secretarial support will be provided from within the Directorate.

LIBRARY FACILITIES & TEACHING

Craigavon Area Hospital has a Medical Education Centre with excellent library facilities provided in association with the Medical Library at the Queen's University, Belfast. There is access to electronic online medical databases, such as Med-line Cochrane and Up to Date. Regular teaching and training sessions take place in the Medical Education Centre. Craigavon Area Hospital is a recognised teaching hospital for the Queen's University Medical School and attracts a large number of undergraduates. Craigavon Area Hospital is responsible for undergraduate medical teaching for third year students onwards.

DUTIES OF THE POST

The post holder will join the other five respiratory physicians (3 at CAH, 2 at DHH) one Associate Physician (CAH), one rotating Specialty Trainee (ST) in CAH and 2 Staff Grades (DHH). 2 more Staff Grades and a second rotating Specialty Trainee are planned for the CAH site. This expansion is to facilitate a Respiratory Ambulatory Care Service in the Southern Trust.

There are also plans in the future to establish 'Hot Clinics', staffed by one consultant and one ST or Specialty Doctor - patients will be seen at this clinic as an alternative to acute admission, and for early review after discharge from the Respiratory Unit. The frequency of this clinic will be under review, depending on demand and capacity.

The post holder, while on duty in acute medicine during the hours of Mon-Fri 9.00 am -5.00 pm will share responsibility with their consultant colleague for providing real time phone advice to GPs. The post holder will liaise closely with colleagues in the Emergency Department/AMU and will be responsible with those colleagues for the development of joint guidelines for common respiratory conditions and pathways of care.

The post holder's main interest will be Respiratory Medicine, however a sub-specialty interest will be accommodated and allocated 1 PAs / week. A further PA will be allocated for the development of the Trustwide Respiratory Ambulatory Service.

A major focus of the post would involve Quality Improvement projects, Multiprofessional Audit and Research. The Southern Trust has a track record of high quality research and links with the Respiratory Research Network.

ORGANISATIONAL RELATIONSHIP

The post holder will:

- He/she will be expected to work flexibly with the existing Respiratory physicians, with job plan variation from week to week, facilitating cross-cover, within the contracted hours of duty.
- He/she will be expected to work with professional clinical colleagues and with local managers in the efficient running and development of respiratory and ambulatory medical services.

SUPPORTING PROFESSIONAL ACTIVITY

Participation in the audit of the structure, process and outcomes of medical services is a requirement of the directorate. The post holder will be expected to adhere to and participate in the Trust's Clinical Governance procedures.

The doctors in the Southern Trust already have access to a mentoring service in an informal basis. However the Trust is proceeding to making this a formal mentoring service for doctors.

PROPOSED JOB PLAN

This will be an 10.41 PA post with the appointee contributing to the 1 in 14 out of hours on-call rota. A provisional job plan is outlined below which illustrates the content, but not necessarily the distribution of the individual fixed sessions.

The post holder will be expected to work 2 public holidays/yr. In the absence of one consultant on leave, there will be restricted out of hours cover (i.e. no cross cover or prospective cover out of hours).

The successful applicant would be ward based as the 'Respiratory Physician of the Week' on a 1 in 5+ basis.

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS				Total	Prem	
				DCC	SPA	APA	EPA			
Mon	9.00 – 13.00	Ambulatory Care	CAH	4.0						
	13.00 – 14.00	Student Teaching	CAH		1.0					
	14.00 – 17.30	Videobronchoscopy	CAH	1.75	1.75					

		SPA(alternate weeks)							
Tues	09.00 – 12.00	Ward work	CAH	3.0					
	12.00-14.30	Clinical admin/Service Development	CAH	2.5					
Wed	08.15 – 12.15	Asthma Clinic	CAH	4					
	12.15 – 13.45	Lung Cancer MDM	CAH	1.5					
	13.45 – 16.45	Clinical Admin/speciality MDM alternate weeks	CAH	3.0					
Thurs	9.00 – 12.45	SPA	CAH		3.75				
	12.45 – 14.00	ED Asthma Link Meeting	CAH	1.25					
	14.00 – 17.00	Ward work	CAH	3.0					
Fri	09.00 – 13.00	Respiratory Clinic	CAH	4.0					
	13.00 – 15.00	Team Radiology Meeting	CAH	2.0					
	14.30 – 16.30	SPA/Physicians meeting	CAH		1.5				
TOTAL HOURS				30	8				Total
TOTAL PROGRAMMED ACTIVITIES				7.5	2.0				9.5

Programmed Activities	Number of PA's/ Sessions
Direct Clinical Care	7.5
Supporting Professional Activities	1.5 Core# 0.5 Common
Premium time	
On call	0.91
Total PA's	10.41

Emergency Work	
On-call Rota Frequency:	1 in 14 (or less)
Agreed Category: (consultants only)	Category B
On-call % Supplement	1%

This is a basic 10PA job plan with an additional temporary 0.41PA which will be offered to the doctor on appointment. #Common SPAs will be reviewed at the initial Appraisal meeting at 3 months into appointment.

Balance between Direct Clinical Care and Other Programmed Activities

The Trust expects that all consultants undertake a minimum of 1.5 SPA's (6 hours) in their job plan every week. The Trust also recognises that there are various activities as identified by all the Associate Medical Directors in each directorate and approved by the Medical Director where additional SPA time will be necessary. Where a newly appointed consultant will be involved in these additional SPA commitments, the precise balance of Programmed Activities in their job plan will be reviewed on appointment and agreed as part of their individual Job Plan review. These Supporting Professional Activities (i.e. **Common SPAs**) may include participation in training of other staff, medical education, continuing professional development, formal teaching of other staff, audit, job planning,

appraisal, research, clinical management and local clinical governance activities are recognised within the Southern Health and Social Care Trust.

Programmed Activities for additional HPSS responsibilities and external duties will also be allocated for special responsibilities that have been formally approved and/or appointed by the Trust.

TERMS AND CONDITIONS:

This post will be contracted in accordance with:

Consultant Terms and Conditions which can be viewed at:

[CLICK HERE](#)

Your salary scale will be in accordance with the NHS Remuneration for your grade, which can be viewed at: [CLICK HERE](#)

If you would like any additional information about this post, for example details of the specialty or existing staff, please contact the Medical Staffing Office on

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Personal
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GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.
4. Adhere at all times to all Trust policies including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
5. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
6. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

7. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.
8. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

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

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

SOUTHERN HEALTH & SOCIAL CARE TRUST**PERSONNEL SPECIFICATION**

JOB TITLE: Consultant Physician – Respiratory Medicine (with subspecialty in Bronchiectasis or Interstitial Lung Disease) - Craigavon Area Hospital

DIRECTORATE: Acute

HOURS: Full time

SALARY: £76,001 - £102,466 per annum **October 2017**

Notes to applicants:

1. **Your application form:** You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should do this for both essential and desirable criteria requirements. All essential criteria requirements listed below must be met by the stated closing date, unless otherwise stated.
2. Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.

You MUST demonstrate all necessary shortlisting criteria on the Trust's standard application form or you may not be shortlisted.

ESSENTIAL CRITERIA – these are criteria all applicants **MUST** be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

1. Hold Full registration with the General Medical Council (London) with Licence to Practice;
2. Hold a higher professional diploma i.e. MRCP or equivalent qualification;
3. Entry on the GMC (London) Specialist Register via
 - CCT in General Medicine / Respiratory Medicine (proposed CCT date must be within 6 months of interview)
 - CESR or
 - European Community Rights
4. Hold a full current driving license valid for use in the UK and have access to a car on appointment.¹

¹ This criterion will be waived in the case of a suitable applicant who has a disability which prohibits them

The following are essential criteria which will be measured during the interview stage.

5. Knowledge of evidence based approach to clinical care.
6. Understanding of the implication of clinical governance.
7. Have an interest in teaching and research.
8. Ability to lead and engender high standards of care.
9. Ability to develop strategies to meet changing demands.
10. Willingness to work flexibly as part of a team.
11. Good communication and interpersonal skills.
12. Ability to work well within a multidisciplinary team.
13. Ability to effectively train and supervise medical undergraduates and postgraduates.

DESIRABLE CRITERIA – these will only be used where it is necessary to introduce additional job related criteria to ensure files are manageable. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being short listed

1. Hold ALS certification.
2. Have some formal training in teaching methods.
3. Have management experience.
4. Have interest in Information Technology.

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from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.



SOUTHERN TRUST JOB DESCRIPTION

CONSULTANT ONCOPLASTIC BREAST SURGEON



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



Approval:



APPROVED BY JOHN MOOREHEAD RSPA FOR RCS ENG ON 16 DECEMBER 2015

JOB TITLE: Consultant Oncoplastic Breast Surgeon

DEPARTMENT: Surgery and Elective Care – Southern Health and Social Care Trust

BASE/LOCATION: All posts are appointed to the Southern Health and Social Care Trust. The base hospital for this post is **CRAIGAVON AREA HOSPITAL** however the post holder may be required to work on any site within the Southern Health and Social Care Trust.

REPORTS TO: Mr M Haynes - Clinical Director – Surgery & Elective Care

RESPONSIBLE TO: Associate Medical Director – Surgery & Elective Care

ACCOUNTABLE TO: Mrs E Gishkori – Director of Acute Services

SUMMARY OF POST:

- This is a replacement post.
- There is no on-call associated with this post.
- This post will attract a salary of **£75,249 - £101,451 per annum**.
- This is a full-time position, however anyone interested in working part-time / job share is also welcome to apply.
- Annual leave will be 32 days per annum initially rising to 34 days after 7 years' seniority, plus 10 statutory and public holidays.
- The posts also has an attractive study leave entitlement of up to 30 days paid leave with expenses in any period of three years.
- A relocation package may also be available if required.
- The Southern Trust has established a dedicated revalidation support group which ensures all doctors have an annual appraisal with a trainer appraiser and supports all doctors through the revalidation process. The Trust has also appointed a Consultant and SAS Lead for appraisal and revalidation.
- The Trust offers a medical mentoring scheme which can be viewed on the Southern Docs website <http://www.southerndocs.hscni.net/wp-content/uploads/2016/01/Medical-Mentoring-Guidance-Nov2015.pdf>.

- The Trust supports the requirements for continuing professional development (CPD) as laid down by the GMC and is committed to providing time and financial support for these activities.
- The post will attract all the terms and conditions and employment benefits associated with an NHS post e.g. NHS indemnity; access to NHS pension scheme and many additional benefits such as child care vouchers etc.

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the Southern Trust:

<https://vimeo.com/155571807>

<https://vimeo.com/155571800>

<https://vimeo.com/155571809>

Access code: ateam

SOUTHERN TRUST – IN THE SPOTLIGHT

The Southern Trust is one of the largest employers in Northern Ireland. Follow us on Twitter to hear all the latest news <https://mobile.twitter.com/southernhsct> or visit our YouTube channel for more news: https://www.youtube.com/channel/UC0YNNjgHJwX4WKregeR_IDQ/videos.

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<https://www.youtube.com/watch?v=eDkEYDEq298>

Consultant Geriatrician recognised at prestigious Institute of Health Care Management Awards

<http://www.southerntrust.hscni.net/3286.htm>

First UK Hospital to Trial Groundbreaking Physio for Critically ill Patients

<http://www.southerntrust.hscni.net/about/3270.htm>

First Trust in NI to trial new baby heart screening test:

<http://www.southerntrust.hscni.net/about/3210.htm>

UK Wide Recognition for Daisy Hill Anaesthetist:

<http://www.southerntrust.hscni.net/about/3192.htm>

Junior doctors rank Southern Trust among top 10 UK providers to work for:

<http://www.southerntrust.hscni.net/about/3121.htm>

Southern Trust Anaesthetists Ranked Top in Northern Ireland

<http://www.southerntrust.hscni.net/about/3027.htm>

Southern Trust Breast Service

The current breast service provides both symptomatic, family history and Breast Screening to the local population. Breast surgery offered by the team encompasses Breast Oncology Surgery, Sentinel Node Biopsy, immediate and delayed reconstruction. In addition routine benign breast surgery is also performed.

This service is currently delivered by two Consultant Surgeons, one Associate Breast Specialist, and two senior surgical Staff Grades. It functions as part of an MDT that includes three consultant radiologists, two oncologists, one consultant geneticist, and three breast care nurses. Currently this service is provided across all hospital sites and the successful applicant would work within the current team structure.

Overview of Breast Service Activity

Table 1: Breast Outpatient Activity by Year

Fiscal Year	New Attendances	Review Attendances	Total
2012/13	3656	1457	5113
2013/14	3906	1221	5127
2014/15	4357	2004	6361
2015/16 – 01 Apr to 31 Oct	2692	1058	3750

Table 2: Breast Surgery Episodes with a Procedure Code B27-B37 or B39

Fiscal Year	Non-Elective Admissions	Elective Admissions	Day Cases
2012/13	13	215	100
2013/14	12	220	102
2014/15	17	255	118

MEDICAL STAFFING OF DEPARTMENT

CRAIGAVON AREA HOSPITAL - MEDICAL STAFFING

Consultant Surgeons with their special interests

Mr E Mackle	-	Upper & Lower GI – Surgery & Elective Care Division - SHSCT
Mr G Hewitt	-	Lower GI
Mr C Weir	-	General / Vascular Surgery
Mr E Epanomeritakis	-	Upper & Lower GI
Mr A Lewis	-	General/ Vascular Surgery
Mr M Yousaf	-	Upper & Lower GI
Mr D McKay	-	Lower GI Surgery and Laparoscopic Surgery
Mr A Neill	-	Lower GI Surgery and Laparoscopic Surgery
Miss H Mathers	-	Breast Surgery
Vacant post	-	Breast Surgery
Ms S Yoong	-	General Surgery

Junior Staff

4 Specialist Registrars/Specialty Trainees
 1 Associate Specialist
 2 Clinical Fellows (Trust doctors/Registrar level)
 2 Staff Grade/ Specialty Doctors
 5 Specialty Trainees / FTSTA's (core trainee level)
 2 Foundation Year 2 doctors (F2s)
 11 Foundation Year 1 doctors (F1s)

KEY DUTIES / RESPONSIBILITIES FOR BREAST SURGEON

The post holder will, in co-operation with colleagues, share the breast surgical elective and emergency workload. The elective work will include in-patient care, operating and outpatient

clinics. The Breast Team will be responsible for emergency breast services. It is acknowledged that historically the requirement for emergency assessment/treatment of breast cases is very rare, there would however be the expectation that should the need arise the Breast Team would accommodate the same.

The department has a strong record in teaching and supervision of junior surgical staff and medical students.

Office accommodation and secretarial support will be provided.

PROPOSED JOB PLAN / ROTA PATTERN

A provisional job plan is outlined below which illustrates the content, but not necessarily the distribution of the individual fixed sessions. It is indicative only and may be subject to change following discussion with your clinical manager to deliver against service delivery.

	TIME	WORK ACTIVITY	LOCATION	HOURS				Total	Prem
				DCC	SPA	APA	EPA		
Mon	09.00 – 13.00	Reconstruction/ Review Clinic	CAH	4	0			8.5	0
	13.00 – 17.30	Theatre Post-op ward round	CAH	4.5	0				
Tues	09.00 – 10.00	Teaching	CAH	1	0			7	0
	10.00 – 13.00	SPA	CAH	0	3				
	13.00 – 16.00	SPA	CAH	0	3				
Wed	09.00 – 13.00	Patient admin	CAH	4	0			8	0
	13.00 – 17.00	Breast MDT and results	CAH	4	0				
Thur	09.00 – 13.00	Results/review clinic	CAH	4	0			8	0
	13.00 – 17.00	Patient Admin	CAH	4	0				
Fri	09.00 – 13.00	OPD	CAH	4	0			8.5	0
	13.00 – 17.00	Theatres							
	17.00 – 17.30	Post-op Ward Round	CAH	4.5	0				
TOTAL HOURS				34	6			40	0
TOTAL PROGRAMMED ACTIVITIES				8.5	1.5			10	0

Programmed Activities	Number of PA's/ Sessions
Direct Clinical Care	8.5
Supporting Professional Activities	1.5
Premium time	
On call	
Total PA's	10PA

Emergency Work	
On-call Rota Frequency:	
Agreed Category: (consultants only)	
On-call % Supplement	

Balance between Direct Clinical Care and Other Programmed Activities

The Trust expects that all consultants undertake a minimum of 1.5 SPA's (6 hours) in their job plan every week. The Trust also recognises that there are various activities as identified by all the Associate Medical Directors in each directorate and approved by the Medical Director where additional SPA time will be necessary. Where a newly appointed consultant will be involved in these additional SPA commitments, the precise balance of Programmed Activities in their job plan will be reviewed on appointment and agreed as part of their individual Job Plan review. These supporting professional activities may include participation in training of other staff, medical education, continuing professional development, formal teaching of other staff, audit, job planning, appraisal, research, clinical management and local clinical governance activities are recognised within the Southern Health and Social Care Trust.

Programmed Activities for additional HPSS responsibilities and external duties will also be allocated for special responsibilities that have been formally approved and/or appointed by the Trust.

TERMS AND CONDITIONS:

This post will be contracted in accordance with:

Consultant Terms and Conditions which can be viewed at:

<https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/revised-consultants-terms.pdf>

Your salary scale will be in accordance with the NHS Remuneration for your grade, which can be viewed at: <https://www.dhsspsni.gov.uk/sites/default/files/publications/dhssps/hsc-tc8-1-2015.pdf>

(updated February 2015)

If you would like any additional information about this post, for example details of the specialty or existing staff, please contact the Medical Staffing Office on

Personal Information redacted by the USI

GENERAL REQUIREMENTS:

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. Adhere at all times to all Trust policies/codes of conduct, including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
 - standards of attendance, appearance and behaviour
4. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information

Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

5. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.
6. It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service.

SOUTHERN HEALTH & SOCIAL CARE TRUST**PERSONNEL SPECIFICATION**

JOB TITLE: Consultant Oncoplastic Breast Surgeon – Craigavon Area Hospital

DIRECTORATE: Acute Services

HOURS: Full-time

September 2016

SALARY: £75,249 - £101,451 per annum

Notes to applicants:

1. **Your application form:** You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should do this for both essential and desirable criteria requirements. All essential criteria requirements listed below must be met by the stated closing date, unless otherwise stated.
2. Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.

You MUST demonstrate all necessary shortlisting criteria on the Trust's standard application form or you may not be shortlisted.

ESSENTIAL CRITERIA – these are criteria all applicants **MUST** be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

1. Hold Full registration with the General Medical Council (London) with Licence to Practice or be able to obtain by time of appointment;¹
2. Hold FRCS or an equivalent qualification;
3. Entry on the GMC (London) Specialist Register via:
 - CCT in the specialty (proposed CCT date must be within 6 months of interview)
 - CESR or
 - European Community Rights
4. Have a sub-specialty interest in Breast Surgery including reconstructive and oncoplastic surgery.
5. Hold a full current driving license valid for use in the UK and have access to a car on appointment.²

¹ If successful at interview, applicants will be required to provide proof of their GMC application. Applicants must be registered, with a licence to practice at the time of appointment.

The following are essential criteria which will be measured during the interview stage.

6. Ability to work well within a multidisciplinary team.
7. Ability to lead and engender high standards of care.
8. Ability to develop strategies to meet changing demands.
9. Willingness to work flexibly as part of a team.
10. Good communication and interpersonal skills.
11. Ability to effectively train and supervise medical graduates and postgraduates.
12. Good leadership skills.
13. Enthusiasm and ability to work under pressure.
14. Good organisational and management skills.
15. Caring attitude to patients.

DESIRABLE CRITERIA – these will only be used where it is necessary to introduce additional job related criteria to ensure files are manageable. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being short listed

1. Higher Degree e.g. MD/MCh or equivalent.
2. Research/Publications.
3. Have some formal training in teaching methods.
4. Have management experience.

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² *This criterion will be waived in the case of a suitable applicant who has a disability which prohibits them from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.*



www.planetware.com



<http://www.mourne-mountains.com/mournes/>



<http://www.armagh.co.uk>

SOUTHERN TRUST JOB DESCRIPTION CONSULTANT PHYSICIAN – GENERAL MEDICINE & GASTROENTEROLOGY (3 POSTS)



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



Approval:	<i>APPROVED BY ROYAL COLLEGE OF PHYSICIANS – 11TH OCTOBER 2017</i>
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JOB TITLE: Consultant Physician (3 Posts)

DEPARTMENT: General Medicine and Gastroenterology

BASE/LOCATION: All posts are appointed to the Southern Health and Social Care Trust. The base hospital for this post is **CRAIGAVON AREA HOSPITAL** however the post holder may be required to work on any site within the Southern Health and Social Care Trust.

REPORTS TO: Dr P Murphy – Associate Medical Director – Medicine & Unscheduled Care Division

ACCOUNTABLE TO: Mrs E Gishkori – Director of Acute Services

SUMMARY OF POST:

- These posts will participate in a 1:14 on-call rota. Current pay supplement: 1%
- These posts will attract a salary of £76,001 - £102,466 per annum.
- These are full-time positions, however anyone interested in working part-time / job share is also welcome to apply.
- Annual leave will be 32 days per annum initially rising to 34 days after 7 years' seniority, plus 10 statutory and public holidays
- The posts also has an attractive study leave entitlement of up to 30 days paid leave with expenses in any period of three years.
- A relocation package may also be available if appropriate.
- The Southern Trust has established a dedicated revalidation support team which ensures all doctors have an annual appraisal with a trained appraiser and supports all doctors through the revalidation process. The Trust has also appointed corporate, Consultant and SAS Leads for appraisal and revalidation.
- The Trust offers a medical mentoring scheme which can be viewed on the Southern Docs website [CLICK HERE](#) Personal Information redacted by the USI
- The Trust supports the requirements for continuing professional development (CPD) as laid down by the GMC and is committed to providing time and financial support for these activities.
- The posts will attract all the terms and conditions and employment benefits associated with an NHS post e.g. NHS indemnity; access to NHS pension scheme and many additional benefits such as child care vouchers etc.

THE SOUTHERN TRUST:

The Southern Trust is one of the largest employers in Northern Ireland and Craigavon Area and Daisy Hill hospitals form the Southern Trust Acute Hospital Network - serving a population of over 360,000. Each year in our hospital network there are approximately 63,000 inpatient admissions; 25,000 day cases; 300,000 outpatient appointments; 116,000 Emergency Department attendances; and over 6,000 births. Statistics updated in 2015

The Southern Trust's acute hospital network was reaffirmed in 2016 as one of the UK's Top Hospitals for the fifth consecutive year. The national CHKS Top 40 Hospitals programme recognises acute sector organisations for their achievements in healthcare quality, improvement and performance. The Top Hospitals award is based on the evaluation of over 20 key performance indicators covering safety, clinical effectiveness, health outcomes, efficiency, patient experience and quality of care. As well as being placed in the Top 40 Hospitals, the Southern Trust was shortlisted for the first time ever for the CHKS National Data Quality Improvement Award. Our vision is to 'to deliver safe, high quality health and social care services, respecting the dignity and individuality of all who use them'

WHY SHOULD YOU WORK FOR US?

The Southern Trust was the first Trust in Northern Ireland to invest and implement in a fully electronic job planning system which is available for all permanent consultant and SAS doctors. This makes it much easier for doctors to maintain an up to date job plan to ensure they are paid correctly and to support the revalidation and appraisal process. Doctors in longer term temporary posts may also be able to use this system. As well as Corporate and Departmental Induction each new permanent medical employee will have an opportunity to have an informal meeting with the Medical Director at the end of month three / four of commencement with the Trust during which time they can explore the option of job shadowing a non-clinical manager within their speciality for a morning / afternoon. This will be facilitated via the relevant Associate Medical Director. There is also a fully embedded revalidation and appraisal process which supports all doctors with all of their appraisal and revalidation requirements. Opportunities also exist for doctors to avail of the Trust medical mentoring scheme.

The Southern Trust is keen to become an employer of choice for SAS doctors who choose to spend their career with us. The Trust has been proactive in encouraging the role of SAS doctors within the Trust and has a number of trained SAS Medical Appraisers and Mentors. Regular lunchtime SAS Link-Up sessions are held across the Trust which provides an opportunity for the SAS group of doctors to establish relationships and network with each other. A regional SAS Conference is also hosted by the Trust each year and a number of initiatives are being developed to support and retain our doctors within their chosen specialties. Our doctors play a vital role in the care and treatment of our patients and in return you can expect a positive experience that will support your development as a key member of the Southern Trust. But don't just take our word for it – listen to the comments of a few of our European doctors who have chosen to relocate from their home country and make a career with the Southern Trust:

<https://www.youtube.com/watch?v=PmfX1fiAoac>

<https://www.youtube.com/watch?v=IPMi3xDKUXQ>

<https://www.youtube.com/watch?v=bV7EnYNN9Ns>

SOUTHERN TRUST – IN THE SPOTLIGHT

The Southern Trust is one of the largest employers in Northern Ireland. Follow us on Twitter to hear all the latest news <https://mobile.twitter.com/southernhsct> or visit our YouTube channel for more news: https://www.youtube.com/channel/UC0YNNjgHjwX4WKregeR_IDQ/videos.

Some of our key achievements in 2015/16:

A day in the life of Southern Trust

[CLICK HERE](#)

Consultant Geriatrician recognised at prestigious Institute of Health Care Management Awards

[CLICK HERE](#)

First UK Hospital to Trial Groundbreaking Physio for Critically ill Patients

[CLICK HERE](#)

First Trust in NI to trial new baby heart screening test:

[CLICK HERE](#)

UK Wide Recognition for Daisy Hill Anaesthetist:

[CLICK HERE](#)

Junior doctors rank Southern Trust among top 10 UK providers to work for: [CLICK HERE](#)

Southern Trust Anaesthetists Ranked Top in Northern Ireland

[CLICK HERE](#)

DUTIES OF THE POST:

- The post holders will join 6 other Gastroenterologists in the Trust – three in Craigavon Area Hospital and three in Daisy Hill Hospital. There is a GI staff grade and GI registrar on both sites.
- The post holders will share inpatient general medical cover in a 'physician of the week' model on a 1 in 5 rota.
- The post holders will help provide the outpatient and inpatient endoscopic service and also provide GI outpatients.
- ERCP skills will be preferable but not essential.
- The post holders will be expected to supervise junior medical staff in their duties and to be involved in the teaching and training of medical students and junior medical staff.
- To maintain professional standards and obligations as set out by the General Medical Council and comply in particular with the GMC's guidance on Good Medical Practice as amended or substituted from time to time.
- Carry out any work related to and reasonably incidental to the duties set out in your job plan or rota including keeping of records and the provision of reports, the proper delegation of tasks and maintaining skills and knowledge.

CONTINUING PROFESSIONAL DEVELOPMENT

The Trust supports the requirements for CPD, as laid down by the Royal College and is committed to providing time and financial support for these activities.

REVALIDATION

The Trust has the required arrangements in place, as laid down by the Royal College to ensure that all doctors have an annual appraisal with a trained appraiser and supports doctors going through the revalidation process.

WORKLOAD FIGURES

A full range of Gastroenterology and General Medical services are provided at Craigavon Area Hospital. Gastroenterology outpatient services are also provided at Armagh Community Hospital and South Tyrone Hospital, Dungannon. Endoscopy lists are also provided at South Tyrone Hospital.

At Craigavon Area Hospital there are 131 medical beds providing continuous emergency take-in for approximately 11,000 admissions annually. In addition, approximately 16,000 outpatient episodes occur annually in medicine.

Activity figures for 1 April 13 – 31 March 2014

General Medicine/Gastroenterology Outpatient Attendances:

New	4770
Review	<u>2912</u>
TOTAL	7682

Gastroenterology Daycases:

Non Scopes	597
Scopes	<u>2533</u>
TOTAL	3130

Number of Inpatient Finished Consultant Episodes for General Medicine/Gastroenterology:
14,209

GASTROENTEROLGY MEDICAL STAFFING***Craigavon Area Hospital***Consultant

Dr P Murphy (Associate Medical Director)
Dr A Murdock
Dr S Bhat
Dr M Gibbons

Specialty Doctor

Dr Patrice McGrath

Daisy Hill HospitalConsultants

Dr S Murphy

Dr C Hillemand

Dr C Braniff

Specialty Doctor

Dr M Hussain

Office facilities and secretarial support will be provided within the Directorate.

SUPPORT SERVICES

A full range of Allied Health Professions is available including physiotherapy, occupational therapy and dietetics. There is a pharmacy department on site, which also provides an area service. The Department of Radiodiagnosis provides general radiographic and radiological procedures, specialised radiological examinations, including PTC and endoscopic ultrasound, ultrasounds, nuclear medicine, CT scanning and MRI scanning. A DEXA scanning service is available in South Tyrone Hospital.

The Area Laboratory Service is based at Craigavon Area Hospital site and provides on-site facilities for haematology, bacteriology, clinical chemistry and histopathology. Secretarial support will be provided from within the Directorate.

LIBRARY FACILITIES & TEACHING

Craigavon Area Hospital has a Medical Education Centre with excellent library facilities provided in association with the Medical Library at the Queen's University, Belfast. There is access to electronic online medical databases, such as Med-line and Cochrane. Regular teaching sessions take place in the Medical Education Centre and general practitioners are invited to participate in and attend meetings. Craigavon Area Hospital is a recognised teaching hospital for the Queen's University Medical School and attracts a large number of undergraduates. Craigavon Area Hospital is responsible for undergraduate medical teaching for third year students onwards.

ORGANISATIONAL RELATIONSHIP

The post holder will:

- be the fourth physician with responsibility for gastroenterology in Craigavon Area Hospital. He/she will be expected to have an interest that complements those of the existing gastroenterologists and to work flexibly with them. An interest in ERCP or nutrition would be preferable.
- provide outpatient gastroenterology services at Craigavon Area Hospital and potentially at South Tyrone Hospital, Armagh Community Hospital or Banbridge Polyclinic.
- provide 2 endoscopy sessions per week at least one being on the Craigavon Area Hospital site.
- be expected to work with professional colleagues and local managers in the efficient

running of medical services.

SUPPORTING PROFESSIONAL ACTIVITY

Attendance at and participation in the audit of the structure, process and outcomes relating to these issues is a requirement of the division. The post holder will be expected to adhere to and participate in the Trust's Clinical Governance procedures.

The doctors in the Southern Trust already have access to a mentoring service in an informal basis. However the Trust is proceeding to making this a formal mentoring service for doctors.

PROPOSED JOB PLAN / ROTA PATTERN

A provisional job plan is outlined below which illustrates the content, but not necessarily the distribution of the individual fixed sessions. It is indicative only and may be subject to change following discussion with your clinical manager to deliver against service delivery.

CONSULTANT JOB PLAN (PHYSICIAN OF THE WEEK – 1 IN 5 WEEKS)

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS				Total	Prem	
				DCC	SPA	APA	EPA			
Mon	09.00 - 13.00	Physician of the week	CAH	4				8		
	13.00 - 17.00	Physician of the week	CAH	4						
Tues	09.00 - 13.00	Physician of the week	CAH	4				8		
	13.00 - 17.00	Physician of the week	CAH	4						
Wed	09.00 - 13.00	Physician of the week	CAH	4				8		
	13.00 - 17.00	Physician of the week	CAH	4						
Thurs	09.00 - 13.00	Physician of the week	CAH	4				8		
	13.00 - 17.00	Physician of the week	CAH	4						
	09.00 - 13.00	Physician of the week	CAH	4				8		
Fri	13.00 - 17.00	Physician of the week	CAH	4						
TOTAL HOURS				40				40.0		Total
TOTAL PROGRAMMED ACTIVITIES				10						10PA

CONSULTANT JOB PLAN (FIXED WEEKS - 4 IN 5)

DAY	TIME	WORK ACTIVITY	LOCATION	HOURS				Total	Prem	
				DCC	SPA	APA	EPA			
Mon	09.00 - 13.00	Admin	CAH	4				8		
	13.00 - 17.00	List	STH	4						
Tue	09.00 - 13.00	IP endoscopy/Referrals	CAH	4				8		

	13.00 - 17.00	SPA	CAH		4					
Wed	09.00 - 13.00	Clinic	ACH							
			CAH	4					8	
	13.00 - 17.00	SPA			4					
Thurs	09.00 - 13.00	Clinic	CAH	4						
	13.00 - 14.00	GI Cancer MDM		1						
	14.00 - 17.00	ERCPs / Subspeciality	CAH	3					8	
Fri	09.00 - 13.00	List		4					8	
		Clinical meeting / medical business meeting / audit meeting / M&M meeting / CPD								
	13.00 - 17.00		CAH	2						
TOTAL HOURS				32	8				40.0	Total
TOTAL PROGRAMMED ACTIVITIES				8	2					10PA

N.B. The above job plan is only draft and will be open for discussion with the Associate Medical director.

Job Plan	Direct Clinical care PAs	PAs
4 out of 5 weeks	8 x 4 weeks	32
1 out of 5 weeks	10 x 1 week	10
	Average DCC PAs	8.4

Job Plan	SPAs	
4 out of 5 weeks	2 x 4 weeks	8
1 out of 5 weeks	0 x 1 weeks	0
	Average SPAs	1.6

Programmed Activities	Number of PA's/ Sessions
Direct Clinical Care	8.4
Supporting Professional Activities	1.6
Premium time	
On call	1.0
Total PA's	11

Emergency Work	
On-call Rota Frequency:	1 in 14 (or less)
Agreed Category: (consultants only)	Category B
On-call % Supplement	1%

Balance between Direct Clinical Care and Other Programmed Activities

The Trust expects that all consultants undertake a minimum of 1.5 SPA's (6 hours) in their job plan every week for personal CPD and revalidation purposes. The Trust also recognises that there are various activities as identified by all the Associate Medical Directors in each directorate and approved by the Medical Director where additional SPA time will be necessary. Where a newly appointed consultant will be involved in these additional SPA commitments, the precise balance of Programmed Activities in their job plan will be reviewed on appointment and agreed as part of their individual Job Plan review. These Supporting Professional

Activities may include participation in training of other staff, medical education, continuing professional development, formal teaching of other staff, audit, job planning, appraisal, research, clinical management and local clinical governance activities are recognised within the Southern Health and Social Care Trust.

Programmed Activities for additional HPSS responsibilities and external duties will also be allocated for special responsibilities that have been formally approved and/or appointed by the Trust.

TERMS AND CONDITIONS:

This post will be contracted in accordance with:

Consultant Terms and Conditions which can be viewed at:

[CLICK HERE](#)

Your salary scale will be in accordance with the NHS Remuneration for your grade, which can be viewed at: [CLICK HERE](#)

If you would like any additional information about this post, for example details of the specialty or existing staff, please contact the Medical Staffing Office on Personal Information redacted by the USI.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.
4. Adhere at all times to all Trust policies including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
5. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
6. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

7. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.
8. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.
9. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.
10. Available / able to work any 5 days out of 7 over the 24 hour period, which may include on-call / stand-by / sleep-in duties, shifts, night duty, weekends and Public Holidays if required immediately on appointment or at a later stage following commencement in response to changing demands of the service.

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

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

SOUTHERN HEALTH & SOCIAL CARE TRUST**PERSONNEL SPECIFICATION**

JOB TITLE: Consultant Physician – General Medicine & Gastroenterology
Craigavon Area Hospital (3 Posts)

DIRECTORATE: Acute

HOURS: Full time

SALARY: £76,001 - £102,466 per annum

October 2017

Notes to applicants:

1. **Your application form:** You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should do this for both essential and desirable criteria requirements. All essential criteria requirements listed below must be met by the stated closing date, unless otherwise stated.
2. Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.

You MUST demonstrate all necessary shortlisting criteria on the Trust's standard application form or you may not be shortlisted.

ESSENTIAL CRITERIA – these are criteria all applicants **MUST** be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

1. Hold Full registration with the General Medical Council (London) with Licence to Practice;
2. Hold a higher professional diploma i.e. MRCP, MRCGP or equivalent qualification;
3. Entry on the GMC (London) Specialist Register via
 - CCT in Gastroenterology & General Medicine (proposed CCT date must be within 6 months of interview)
 - CESR or
 - European Community Rights
4. Hold a full current driving license valid for use in the UK and have access to a car on appointment.¹

¹ This criterion will be waived in the case of a suitable applicant who has a disability which prohibits them from driving but who is able to organise suitable alternative arrangements in order to meet the requirements of the post in full.

The following are essential criteria which will be measured during the interview stage.

1. Knowledge of evidence based approach to clinical care.
2. Understanding of the implication of clinical governance.
3. Have an interest in teaching and research.
4. Ability to lead and engender high standards of care.
5. Ability to develop strategies to meet changing demands.
6. Willingness to work flexibly as part of a team.
7. Good communication and interpersonal skills.
8. Ability to work well within a multidisciplinary team.
9. Ability to effectively train and supervise medical undergraduates and postgraduates.

DESIRABLE CRITERIA – these will only be used where it is necessary to introduce additional job related criteria to ensure files are manageable. Applicants should therefore make it clear on their application form whether or not they meet these criteria. Failure to do so may result in you not being short listed

1. Have ERCP experience
2. Hold ALS certification.
3. Have some formal training in teaching methods.
4. Have management experience.
5. Have interest in Information Technology.

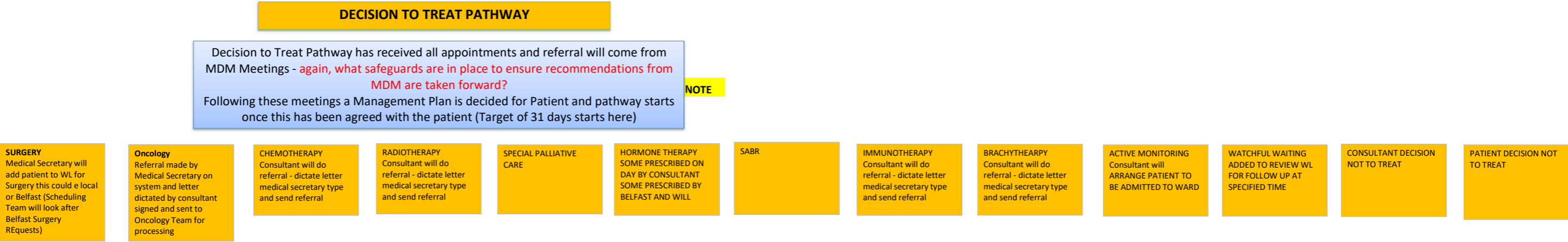
WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Glossary of terms:

1. **Data Mapping Process**- Template used to map patients journey through a service based on best practice guidelines and recommendations
2. **Clinical Governance**- These are the 7 elements included in clinical governance framework. Individually and collectively they allow an organisation to establish how well they are performing, identify areas for quality improvement, to safeguard and maintain standards and provide assurance that a service is functioning and delivering high quality safe care.
3. **QI**- Quality Improvement
4. **Governance Pillars**- these are 7 key elements that demonstrate the quality of a service. These are specific to healthcare
5. **Datix**- Healthcare incident reporting system. Used for example when a patient falls, when there has been a near miss issue that others can learn from.
6. **Care Opinion**- Electronic service to submit feedback. Positive and Negative. Came to SHSCT last year and in process of rollout
7. **10,000 Voices**- patient survey framework. Team in SHSCT that can target/ tailor surveys to teams/ specialities
8. **CNS**- Clinical Nurse Specialist (includes Cancer specific Nurse Specialists)
9. **HNA**- Holistic Needs Assessment. This is a forum for CNS to complete with patients with a diagnosis and focuses on the needs of the patient, information, support and care planning. We have had electronic HNA training and sessions established in Head and Neck and Urology Teams and will roll out to all cancer specialities.
10. **KPI**- Key Performance Indicator. These are specific to individual teams/ specialist nurses and are elements of the role they must complete. These are subject to audit and benchmarking.
11. **SIP**- Staff in Post. This is the physical number of staff you have available in a team (Includes those on sick leave/ mat leave etc). Staff available reflects the staff who are actually available to work.
12. **DOH**- Department of Health
13. **MDM**- Multidisciplinary Team Meeting .A meeting that includes representation from multiple specialities/ teams
14. **MDT**- Multidisciplinary Team. A team composed of members from differing specialities
15. **SOP**- Standard Operating Procedure. Based on Policy/ Guidelines and used to detail to specific workings of a task. Standardised for all to follow.
16. **NICAN**- Northern Ireland Cancer Network. Regional network incorporating the 5 Trusts delivering care to Cancer Patients.
17. **Minimum Data Set**-Standardised agreed required information.
18. **PHA**- Public Health Agency
19. **NQI's**- National Quality Indicators- monthly audit completed on set standards of care for eg clinical observation recording, missed medications, pressure area care and falls risk management.
20. **KSF**- knowledge and skills framework. Yearly appraisal format used to assess performance over past year, skills development and planning for year aheads goals and objectives including additional training/education required.

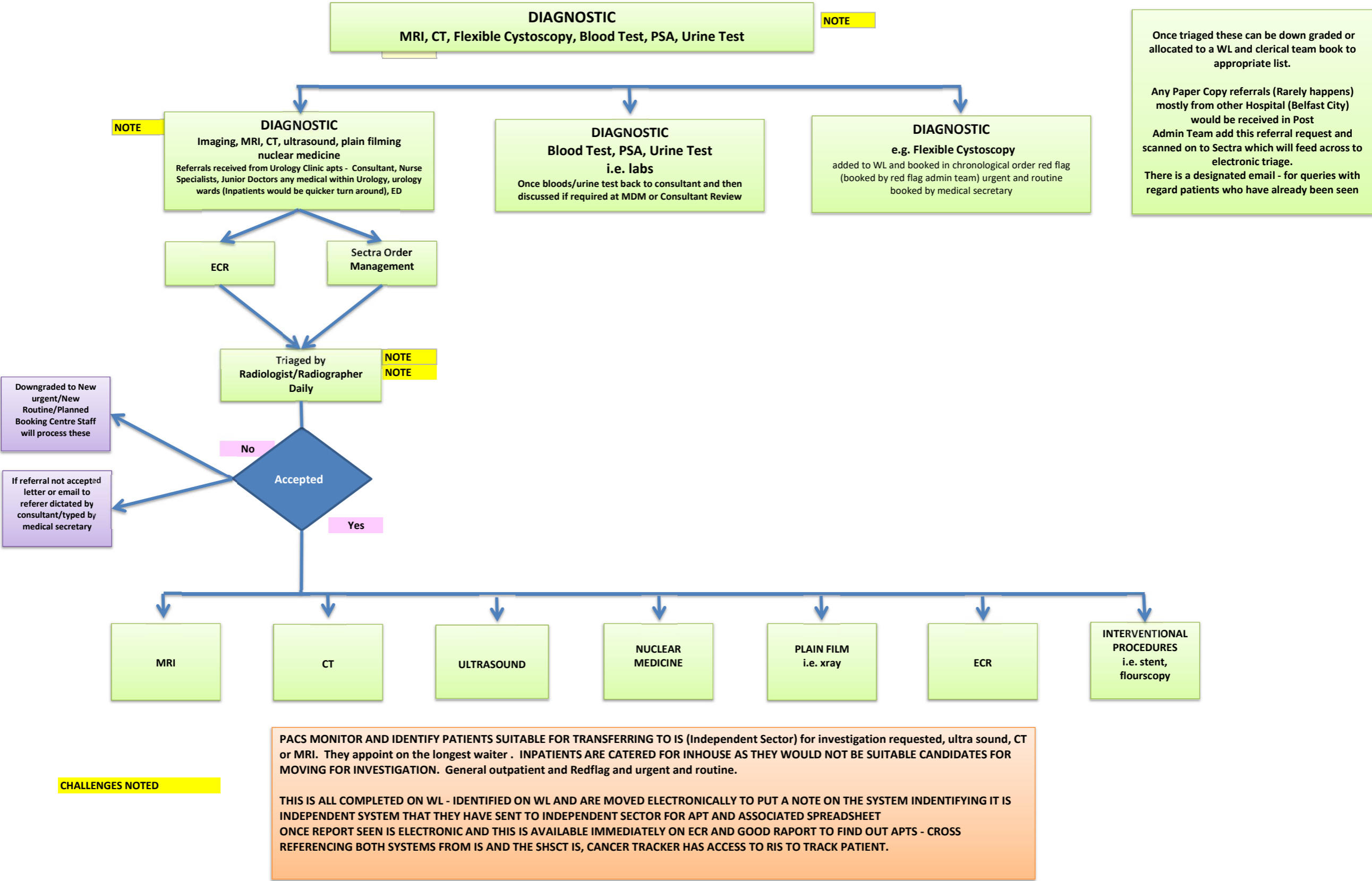
21. **HOS**- Head of Service. Line Manager within structure of a service.
22. **Code of Conduct**- Professional Regulations Nurses and Doctors are bound to.
23. **Sharepoint**- In Trust website that contains “tiles” for specific areas/ services etc and contains all supporting guidance
24. **Pathology**- Laboratory examination of body tissue for diagnostics purposes
25. **Quoracy**- having enough members and representation from specialities to carry out the business of a meeting.
26. **CaPPS**- Cancer Patient Pathway System
27. **SAI's**- Serious Adverse Incidents. Trust specific which involves a screening process with multiple panel members who determine the cause of incident and associated learning.
28. **CPES**- Cancer Patient Experience Survey

DRAFT



Note Following these first definitive treatment - Tracker No longer tracks (Not Funded) after this apt

Decision to treat
Length of time from decision to treat made to referrals sent how does this compare to standards, what are the standards?



NOTE: Additional steps may be required for children, adults at risk, those with physical/learning difficulties and those who require assistance with language

NEW REFERRAL PATHWAY UROLOGY SERVICES

NOTE
NOTE

Referrals
How many referrals (%) contain required/ mandatory

CCG Referral form
What fields are on it? What fields are considered mandatory?

Triage
What % of routines and urgents are being triaged within 3 days? source: validation reports
What % of red flags are triaged within the day?

Patient Status
Breakdown of referrals by priority
How many were downgraded? Do these align with

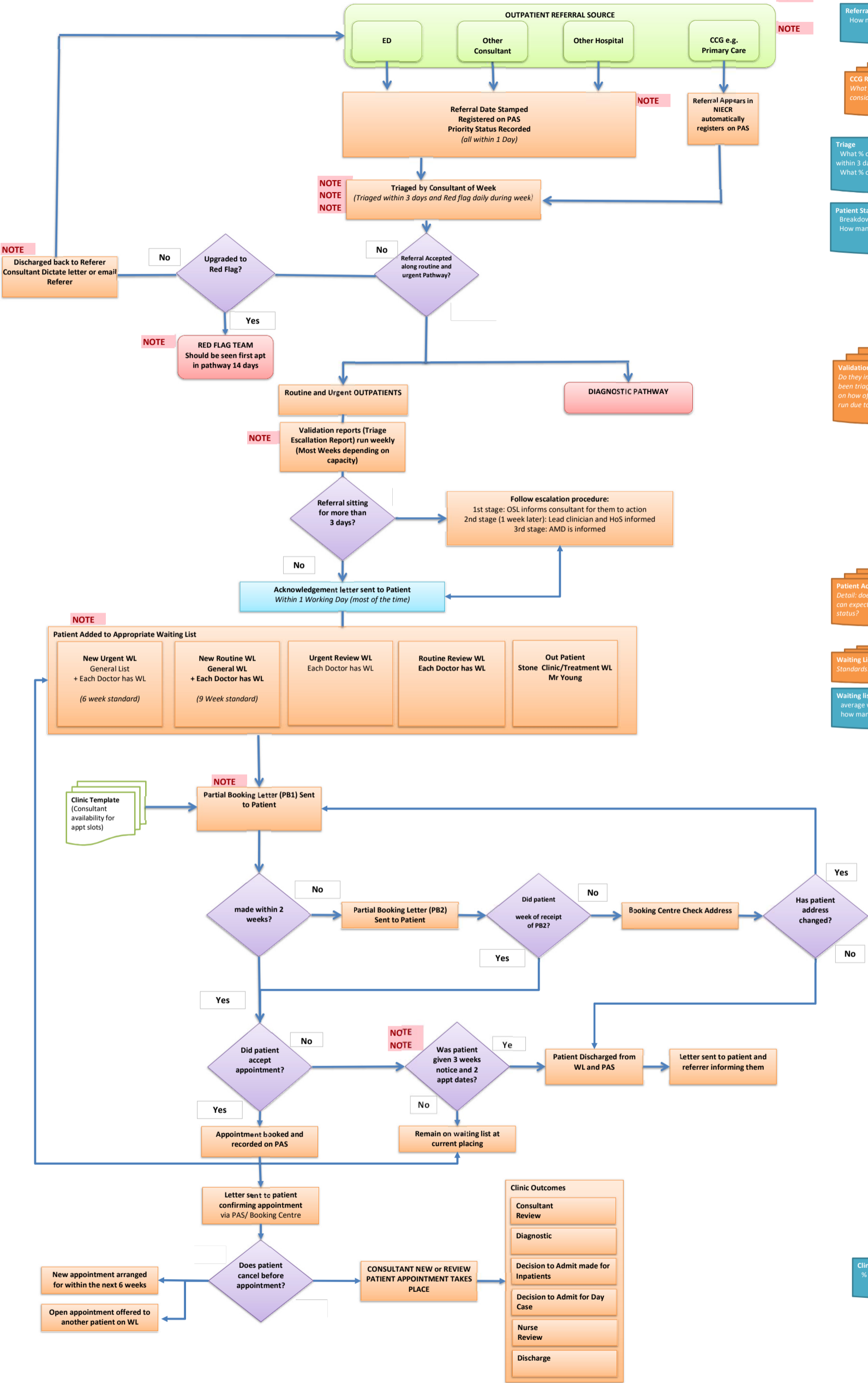
Validation reports
Do they include reason as to why patient hasn't been triaged within standard? Need to expand on how often and why validation reports are not run due to capacity issues.

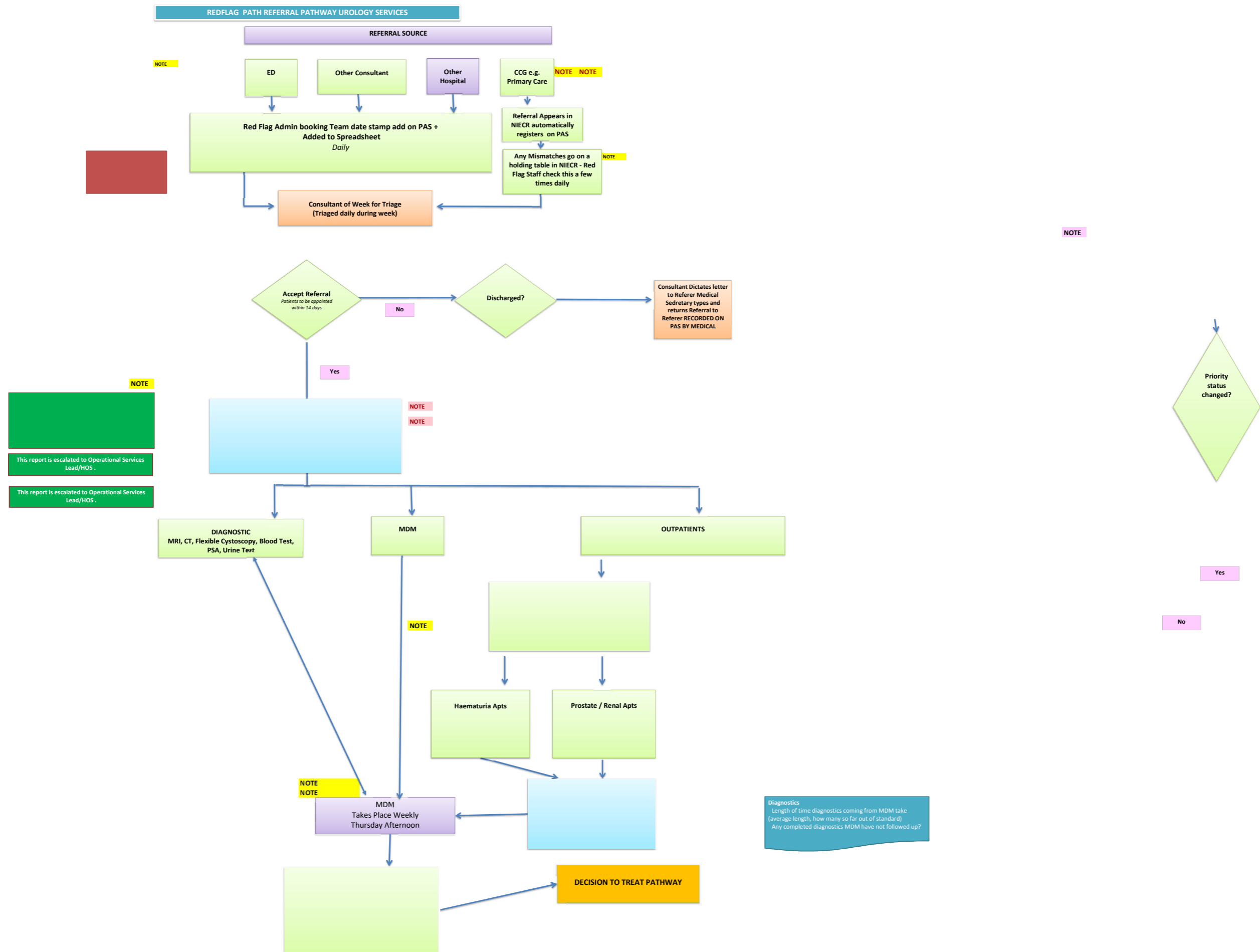
Patient Acknowledgement letter
Detail: does it inform the patient of when they can expect to be seen based on their priority status?

Waiting Lists
Standards: time to be seen

Waiting list standards
average wait
how many within standard (%)

Clinic Outcomes
% breakdown





Characteristics of an Effective Multidisciplinary Team (MDT)

Self Assessment and Feedback Questionnaire

Urology MDT, May 2021

Version 2 – 12th April 2021

*Based on National Cancer Action Team
(NCAT) Guidance (February 2010)*

1. The Multidisciplinary Team

Membership

No.	Effective MDT Characteristic	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
1.1.1	All relevant professions/disciplines – core & extended members - are represented in the team in line with the Manual of Cancer Services.	Partial	Annual report	Issue re. cover for radiology and oncology at the MDT Additional radiologist has been recruited by the Trust and following a period of absence for a sabbatical will be able to provide cover Oncology representation has been raised at a regional level
1.1.2	The MDT co-ordinator is recognised as a core member of the team – they sit where they can hear and see everything.	Fully	Operational Policy	
1.1.3	Cross cover/deputies with authority to support recommendations are in place to cover planned (and where possible unplanned) absences - advanced notice is given of core member absence so that this cover (or alternative management) can be organised if possible.	Partially	Operational Policy	See 1.1.1 in relation to cover for radiology and oncology
1.1.4	Members have the level of expertise and specialization required by the MDT in question	Fully	Professional registration Ongoing professional development	

	– where there are no relevant peer review measures or accreditation for these roles the issue of clinical competence is for the relevant professional body or the Trust to determine.		Organisational policy sets out individual roles / specialties of the MDT members	
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Attendance

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
1.2.1.	MDT members (core and extended) have dedicated time included in their job plans to prepare for, travel to (if necessary) and attend MDT meetings – the amount of time is negotiated locally to reflect their workload and varies according to discipline and cancer type.	Partially	Job plans for members which include prep time and attendance at MDT meetings	Spec palliative CNS attends MDT when is able but has no protected time to prepare and attend
1.2.2	Core members are present for the discussion of all cases where their input is needed – it is for the chair to decide (in consultation with others as he/she sees fit) whether there is adequate representation at a single meeting to make safe recommendations about any/all patients and the action to take if not.	Fully	Operational Policy Attendance / Minutes of the MDT meetings	
1.2.3	Every effort should be made to ensure that a clinician who has met the patient whose case is being discussed is present at the meeting.	Fully	Operational Policy Minutes / outcomes of the MDT meeting	

1.2.4	The chair is responsible for raising concerns about non-attendance of particular members (or their deputies) and escalating these concerns if regular non-attendance is impacting on the quality of MDT working/recommendations. Frequent non-attendance is addressed during appraisal processes & job plan reviews.	Fully	Staff appraisal Review of Job plans Action plan from peer review	Usually only an issue if core members leave or change Regular review of individual core/cover attendance and MDT quoracy to flag attendance issues Operational policy (page 9) states that attendance records will be calculated on a quarterly basis and fed back to individual core members
1.2.5	A register of attendance is maintained – members signing in and out (with times) supports assessment of attendance.	Partially	MDT minutes	Attendance is recorded by MDT Co-coordinator, sign in/out is not used as some members video-link
1.2.6	Extended members and non-members attend for the cases that are relevant to them.	Fully	MDT minutes	
1.2.7	Anyone observing MDT meetings should be introduced to team members and their details included on the attendance list.	Partially		Medical student attendees are not recorded

Leadership

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
1.3.1	There is an identified leader/chair of the MDT and a deputy to cover when necessary – the leader and the chair do not have to be the same person	Fully	Operational Policy details the MDT Lead clinician / cover and the arrangements for chairing the MDT meetings	The Urology Consultants rotate the chair / deputy roles for the MDT



1.3.2.	The MDT chair is responsible for the organisation and the running of the MDT meetings.	Fully	Operational Policy details the role of the MDT	
1.3.3.	<p>The chair has skills in the following areas:</p> <ul style="list-style-type: none"> • meeting management; • listening & communication; • interpersonal relations; • managing disruptive personalities & conflict; • negotiations; • facilitating effective consensual clinical decision making; • Time-management. 	Fully	Advanced Communication Skills Training	<p>As there are different chairs of the MDT, how do we ensure they have all the relevant skills?</p> <p>Consideration of a bespoke MDT training course for chairs and members..?</p>
1.3.4.	<p>The chair:</p> <ul style="list-style-type: none"> • prepares and/or agrees the agenda with the MDT coordinator; • ensures the meeting is quorate and takes action if not; • ensures all relevant cases are discussed and prioritized as necessary; • ensures all relevant team members are included in discussions; • ensures discussions are focused and relevant; • ensures good communications/a pro-discussion environment; • promotes evidence-based and patient-centered recommendations and ensures that eligibility for relevant clinical trial recruitment is 	Fully	<p>Minutes of MDT meeting:</p> <ul style="list-style-type: none"> -List of cases discussed -Outcomes of discussion recorded -Identified actions and by whom <p>MDM report</p> <p>CAPPs / NIECR</p>	



	<p>considered;</p> <ul style="list-style-type: none"> • ensures the current patient discussion and treatment/care plan recommendations are complete before the next patient discussion starts; • ensures relevant demographic and clinical data items are recorded; • ensures recommendations are clearly summarised, recorded and fed back to the patient, GP and clinical team within a locally agreed timeframe; • ensures that it is clear who is going to take any resulting actions post meeting and that this is minuted. 			
1.3.5.	<p>The MDT leader (who may also be the chair) has a broader remit not confined to the MDT meetings. They are responsible for:</p> <ul style="list-style-type: none"> • issues of governance e.g. setting clear objectives/purpose for the team/what is expected of members etc; • ensuring that others in the organisation have an understanding of the role of the MDT and why it is important in cancer care; • negotiating locally for funding/resources needed for the MDT to be effective; • escalating issues of concern that may impact on safety of MDT 	Fully	<p>Adhering to role of MDT Lead Clinician as set out in the Operational Policy</p> <p>Annual General Meeting</p> <p>X2 Business Meetings per annum with Service Managers / senior personnel to escalate concerns as required</p> <p>Attendance / participation in relevant meetings as required</p>	<p>Delivery of action points can be challenging. It is important to ensure that recurrent issues / themes do not continue to drift from one meeting to another</p>

	Recommendations etc.			
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Team working & culture

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
1.4.1.	Each MDT member has clearly defined roles and responsibilities within the team which they have signed up to and which are included in their job plans.	Fully	MDT members job plans	
1.4.2.	<p>The team has agreed what is acceptable team behavior/etiquette including:</p> <ul style="list-style-type: none"> • mutual respect & trust between team members; • an equal voice for all members - different opinions valued; • resolution of conflict between team members; • encouragement of constructive discussion/debate; • absence of personal agendas; • Ability to request and provide clarification if anything is unclear. 	Fully	Completed once in every 5 years for appraisal – patient and colleague feedback	Maybe consider a 360 questionnaire regarding MDT Behaviours/etiquette..?
1.4.3.	MDT members play a role in sharing learning and best practice with peers.	Fully	Participation and presentation of audits, both at a local and regional level	<p>A log of audits is held centrally in the trust.</p> <p>In the main, it is up to clinicians to do their own</p>

				<p>audits. There can be a degree of bias in relation to what audits are completed compared to what may be required.</p> <p>Quality improvement initiatives are ad-hoc – need to capture evidence to measure improvement</p> <p>Does the MDT need to consider developing a log of completed and planned audits / service improvement initiatives..?</p>
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Personal development & training

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
1.5.1.	Team members recognise the need for continued learning and individual members are supported to gain the necessary knowledge and skills for their roles and responsibilities within the MDT and for their respective professional role – support is available from the team, the organisation and nationally as	Fully	<p>Annual appraisal of medical team members</p> <p>Revalidation process – present evidence of CPD</p> <p>Training / education register of attendance at CPD events</p>	<p>Annual appraisal runs outside of MDT – self relying on members to undertake appropriate CPD</p> <p>Does this need to be collated centrally for the MDT members and updated on an annual basis..?</p>

	appropriate and members take up relevant CPD opportunities.			Consider developing a bespoke MDT training course, it would help to consolidate the Trust's expectations of MDTs
1.5.2.	There are networking opportunities to share learning and experiences with other MDTs in the same Trust and potentially in other Trusts in the Network or beyond.	Not in place		Set up a bi-annual meeting of MDT leads to share learning and experiences Provide opportunity for MDT Leads to sit-in in other MDT meetings to review practice / share learning and support opportunity for developing
1.5.3.	There is access to training opportunities as required to support an individual's role in the MDT in areas such as: <ul style="list-style-type: none"> • leadership skills; • chairing skills; • advanced communication skills including listening, presenting and, where relevant, writing; • time management; • confidence & assertiveness; • use of IT equipment e.g. video-conferencing; • knowledge of anatomy, oncology, radiology & pathology (for members not expert in these areas). 	Fully	Appraisal ACST register Details of training completed	Bespoke course for MDT's – mandatory training for new appointees for MDT core members, including CNS's and other specialities
1.5.4.	There is a teaching & training role for	Fully	Attendance of medical	Junior staff – could be more

	MDTs both within the team itself (eg. bringing patient cases back) and beyond (eg. for clinicians in training).		students / clinicians-in-training at the MDT	actively involved in the MDT
			Appraisal documentation..?	

2. Infrastructure for Meetings

Physical environment of meeting venue

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
2.1.1.	There is a dedicated MDT room in a suitable (quiet) location with sound proofing if necessary to ensure confidential discussions.	Fully	The MDT takes place in the tutorial room, MEC, each week with video-conferencing facilities to enable communication via video to Daisy Hill Hospital and the Specialist MDT	
2.1.2.	The room is environmentally appropriate in size and layout ie. All team members have a seat and are able to see and hear each other and view all presented data (eg. diagnostics) within and across hospital trusts.	Fully		

Technology & equipment (availability & use)

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
2.2.1.	Rooms where MDT meetings take place	Fully	As per 2.1.1	



	<p>have:</p> <ul style="list-style-type: none"> • access to equipment for projecting and viewing radiology images including retrospective images; • facilities for projecting and viewing specimen biopsies/resections and accessing retrospective pathology reports; • connection to relevant IT systems; • access to a database or proforma to enable documentation of recommendations in real-time; • projection facilities so members can view and validate the recommendations being recorded; • facilities (when needed) to see and speak to members who are off site (eg. video-conferencing) and share all information that will be viewed (eg. images and reports) with them. 			
2.2.2.	<p>There is commitment/buy-in from all sites to provide technology and equipment (including video-conferencing) that is good quality and reliable, up to at least a minimum network wide specification, which takes into account issues such as:</p>	Fully		<p>Is the technology / equipment spec kept under review and by whom..?</p>

	<ul style="list-style-type: none"> standards of data transfer; image quality; bandwidth - speed for loading images, time delay for discussions; inter-hospital compatibility / cross-site co-ordination etc. <p>This specification is kept under review and updated in light of technological advances.</p>			
2.2.3	There is technical support for MDT meetings so that assistance can be provided in a timely fashion (ie. during the meetings) if there are problems with any IT systems or video-conferencing links during the meeting – the quality of MDT decision making can be seriously affected when equipment fails.	Fully	The trust has a contract with HSL who manage pexip, video-conferencing systems, desktop client. There is support available for staff via email or a helpline telephone number	

3. Meeting Organisation & Logistics

Scheduling of MDT meetings

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
3.1.1.	MDT meetings take place regularly (as set out in Manual of Cancer Services).	Fully	Annual report – details the MDT meetings & attendance / quoracy	
3.1.2.	MDT meetings are held during core	Fully	MDT is held each Thursday at 2.15pm, with video-link to the	

	hours where possible - ('core hours' are defined locally and included in staff job plans) and are set up so as not to clash with related clinics that core members need to attend – such clinics follow MDT meetings where feasible.		Specialist MDT at 3.30pm and finishes by 5pm. Core members have time allocated in job plans to attend the MDT outside of clinics.	
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Preparation prior to MDT meetings

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
3.2.1.	Processes are in place to ensure that all patients diagnosed with a primary cancer have their case considered by the relevant MDT and it is clear when patient cases can be taken back to MDTs including when discussion of patients with metastatic disease/recurrence should take place.	Fully	Operational Policy details purpose of MDT, patients discussed and the process to re-discuss patients if required	
3.2.2.	There is a locally agreed cut-off time for inclusion of a case on the MDT list/agenda and team members abide by these deadlines – there is flexibility for cases that may need to be added at the last minute due to clinical urgency..	Fully	Operational Policy details the cut-off day/time for patients to be added to the MDT list and there is flexibility to add cases due to clinical urgency if required	
3.2.3.	Cases are organised on the agenda in a way that is logical for the	Partially	Cases are alphabetical for main body of the meeting	This could be improved by implementing protocolised pathways for more straight

	tumour area being considered and sufficient time is given to more complex cases – the structure of the agenda allows, for example, the pathologist to leave if all cases requiring their input have been discussed.		A small number of cases are set aside for regional meeting	forward cases which just need to be registered and signed off by the MDT Chair. The other more complex cases would be listed for discussion.
3.2.4.	The structured agenda/patient list is circulated prior to the meeting if members agree this would be useful.	Fully	The MDT list is circulated to all members prior to the MDM	
3.2.5.	A locally agreed minimum dataset of information about patients to be discussed should be collated and summarised prior to MDT meetings wherever possible – this should include diagnostic information (pathology and radiology), clinical information (including co-morbidities, psychosocial and specialist palliative care needs) and patient history, views and preferences where known. It is important that any data items collected locally that are in existing national datasets or are within the NHS Data Dictionary are in line with these data definitions and codes when collected.	Partially		Use of a MDT proforma would help to ensure a minimum dataset is completed for each patient being presented – reviewed by chair re. which goes to protocol and what requires discussion
3.2.6.	Members know what information	Not in place		Use of a MDT proforma would help to ensure a minimum

	from the locally agreed minimum dataset of information they will be expected to present on each patient so that they can prepare and be ready to share this information (or have delegated this to another member if they cannot attend) prior to and/or at the meeting.			dataset is completed for each patient being presented
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Organisation/administration during MDT meetings

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
3.3.1.	It is clear who wants to discuss a particular patient and why they are being discussed.	Partially	MDT list and referring consultant	Use of MDT proforma would help to improve this
3.3.2.	A locally agreed minimum dataset of information is presented on each patient including diagnostic information (pathology and radiology), clinical information (including co-morbidities, psychosocial and specialist palliative care needs) and patient history, views and preferences – the focus is on what the team need to hear to make appropriate recommendations on the patient in question. It may not, for example, be necessary to show/discuss the pathological or radiological findings	Partially		Improve listing of patients by indicating which aspects need to be reviewed e.g. pathology, radiology

	in all cases.			
3.3.3.	There is access to all relevant information at the meeting including patient notes, test results/images/samples (past and present) and appointment dates (or a proforma /summary record with the necessary information) along with access to PAS, radiology & pathology systems etc – relevant past material should be reviewed prior to the meeting if it is not accessible during the meeting.	Fully	<p>Access to patient notes & test results through NIECR available during the MDM if required</p> <p>Access to PAS, radiology & pathology systems is available as required though material is usually reviewed prior to the meeting</p>	
3.3.4.	Electronic databases are used to capture recommendations during the meeting (including the rationale for the decision and any uncertainties or disagreements about the recommendations) – a standard pro-forma is used where such a database is not available.	Partially	<p>CAPPs system is an electronic database which is used to collect data on patients and document MDT decisions.</p> <p>Investigation plans and treatment recommendations are formulated during the meeting and recorded in narrative format by the MDT Co-ordinator.</p>	
3.3.5.	Core data items are collected during the meeting and cancer datasets completed in real time (where feasible) – training may be required to ensure accurate recording of real-time information to minimise the impact on (i.e. slowing down) the	Not in place	<p>The CAPPs system is not populated in real time during the MDT meeting. The MDT Co-ordinator will populate the patient data after the meeting and will be quality assured by the Chair</p> <p>Summaries agreed at meeting,</p>	Further discussion/work required to explore how to streamline process.

	MDT discussion. Some MDTs will wish to collect as much of the core data items before the meeting to save time – the function of the MDT is then to check these are correct. It is important that any data items collected locally that are in existing national datasets or are within the NHS Data Dictionary are in line with these data definitions and codes when collected.		paper notes, circulate to chair, read, approve, circulate final version to all members of team. Data fields on CAPPs are regionally agreed.	
3.3.6.	Mobile phones are off or on silent during the meeting and if phone calls have to be taken during the meeting the person taking the call leaves the room.	Fully		
3.3.7.	There is effective chairing and co-ordination throughout the meeting.	Fully	MDT lists and outcomes are completed during the allocated time	

Post MDT meeting/co-ordination of services

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
3.4.1.	Processes are in place: <ul style="list-style-type: none"> for communicating MDT recommendations to patients, GPs and clinical teams within locally agreed timeframes e.g. patient clinics on the same or next day as MDT meetings 	Partial	Some of the consultant clinics take place the week after the MDT All patients are offered a core	



	<p>where feasible;</p> <ul style="list-style-type: none"> • for ensuring that patients' information needs are assessed and met; • to ensure actions agreed at the meeting are implemented; • to ensure the MDT is notified of significant changes made to their recommended treatment/care plan; • to manage referral of patient cases between MDTs (including to MDTs in a different Provider); • to track patients through the system to ensure that any tests, appointments, treatments are carried out in a timely manner e.g. Within cancer waits standards where applicable. 	<p>Fully</p> <p>Not in place</p> <p>Not in place</p> <p>Fully</p> <p>Partial</p>	<p>information pack and additional info as required. All patients are provided with a permanent record of consultation detailing their diagnosis and treatment plan.</p> <p>Operational Policy outlines process for referrals between MDTs</p> <p>Patients are tracked from diagnosis up until the 1st definitive treatment (31 day & 62 day pathways).</p>	<p>All pathway breaches are discussed at the monthly SHSCT Cancer Performance meetings with presentation from the Assistant Director, Head of Service and Operational Service Leads from each the clinical specialities. Report outcomes are shared and learning is identified for onward sharing / implementation within the clinical specialty.</p>
3.4.2.	Relevant items from cancer datasets are completed (if this has not been done in real time at the meeting).	Fully	This is completed by the MDT Co-ordinator post-MDT	

4. Patient Centered Clinical Decision-Making

Who to discuss?

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
4.1.1.	There are local mechanisms in place to identify all patients where discussion at MDT is needed.	? Not sure		Red flag referrals from GPs and other consultants are triaged and depending on outcome are put on 31 day and 62 day pathways which are tracked.
4.1.2	There are referral criteria in place so it is clear when to send a case to the MDT for consideration i.e. clarity on: <ul style="list-style-type: none"> • which patients should be discussed by the MDT; • the clinical questions that need to be addressed by the MDT; • what information has to be available for the MDT discussion to be productive; • when to refer a patient on to another MDT (e.g. from a local to a specialist MDT). 	Fully	Operational policy	
4.1.3	There is local agreement about if/when patients with advanced/recurrent disease should be discussed at MDT meetings.	Partial		<p>Patients are not necessarily brought back to the MDT and is based on the consultant's decision</p> <p>Review and update the operational policy in relation to this</p>

4.1.4	A clinician can bring the case of a private patient to the MDT for discussion provided there is time on the agenda - any reimbursement arrangements are for local determination.	Not in place		
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Patient-centered care

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
4.2.1.	Patients are aware of the MDT, its purpose, membership, when it meets and that their case is being/has been discussed and are given the outcome within a locally agreed timeframe.	Fully	MDT Patient Leaflet provided to patients detailing purpose of the MDT and the roles of the health care professionals Consultant meets with patient following MDT to discuss diagnosis and agree treatment plan	
4.2.2	A patient's views/preferences/holistic needs are presented by someone who has met the patient whenever possible.	Fully	Patient's holistic needs are considered as part of the MDT discussion. This is documented and the outcomes are recorded in the MDT Proforma.	
4.2.3	A named individual at the MDT has responsibility for identifying a key worker for the patient.	No	Key worker not identified at the MDT meeting – this may happen afterwards	
4.2.4	A named individual at the MDT has responsibility for ensuring that the patient's information needs have been (or will be) assessed and	Fully	This is usually the Consultant responsible for patient's care	

	addressed.			
4.2.5	Patients are given information consistent with their wishes, on their cancer, their diagnosis and treatment options including therapies which may be available by referral to other MDTs, sufficient to make a well informed choice/decision on their treatment and care.	Fully	<p>Core information is available to all patients depending on their wishes, along with additional information in relation to their specific cancer</p> <p>All patients are provided with a permanent record of consultation detailing their diagnosis and treatment plan.</p>	

Clinical Decision-Making Process

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
4.3.1	A locally agreed minimum dataset of information is provided at the meeting i.e. the information the MDT needs to make informed recommendations including diagnostic information (pathology and radiology), clinical information (including co-morbidities, psychosocial and specialist palliative care needs) and patient history, views and preferences. It is important that any data items collected locally that are in existing national datasets or are within the NHS Data Dictionary are in line with	Not in place		An MDT Proforma would help with this

	these data definitions and codes when collected.			
4.3.2	MDTs consider all clinically appropriate treatment options for a patient even those they cannot offer/provide locally.	Fully	Forms part of MDT discussion and is recorded on MDT outcomes proforma	
4.3.3.	MDTs have access to a list of all current and relevant clinical trials (including eligibility criteria) particularly those in the NCRN portfolio and consider patients' suitability for appropriate clinical trials as part of the decision-making process - the relevant trial coordinator/ research nurse attends MDT meetings where feasible.	Partial		Patients who are referred to the Specialist MDT will have access to clinical trials as they are usually regional trials
4.3.4.	Standard treatment protocols are in place and used whenever appropriate	Fully	Operational policy Adherence to NICAN clinical management guidelines	
4.3.5	A patient's demographic profile and co-morbidities are always considered - age does not in itself act as a barrier to active treatment.	Fully	Forms part of MDT discussion and outcome for treatment	
4.3.6	A patient's psychosocial and supportive & palliative care issues are always considered (e.g. via holistic needs assessment).	Fully	As above	
4.3.7	A patient's views, preferences and	Fully	Patient's views are considered and help to inform decision in	

	needs inform the decision-making process when relevant/possible		relation to treatment plan	
4.3.8	<p>The clinical–decision making process results in clear recommendations on the treatment/care plan resulting from the meeting. These recommendations are:</p> <ul style="list-style-type: none"> • evidence-based (eg. in line with NICE and/or cancer network guidelines); • patient-centered (in line with patient views & preferences when known and taking into account co-morbidities); • in line with standard treatment protocols unless there is a good reason against this, which should then be documented. 	Fully	Adherence to NICAN Clinical management guidelines, NICE Guidance and the MDT Operational Policy	
4.3.9	MDT recommendations are only as good as the information they are based on – if there are concerns that key data is missing this should be documented.	Fully	This is recorded in MDT outcomes proforma. A Patient maybe deferred to the next MDT meeting.	
4.3.10	Where a recommendation cannot be made because of incomplete data or where new data becomes available at a later stage it should be possible to bring the patient case back to the MDT for further discussion.	Fully		
4.3.11	It is clear who will communicate the MDT recommendation(s) to the patient, GP and clinical team, how	Fully	Detailed in the Operational Policy	

	and by when and this is minuted.			
4.3.12	MDTs collect social demographic data (on age, ethnicity and gender as a minimum) and consider that data periodically to reflect on equality of access to active treatments and to other aspects of treatment, care and experience – Information relating to these issues will/should be on PAS / NIECR / CAPPS (based on NHS Data Dictionary definitions) and MDTs should link up to the source of these data rather than create separate data capture processes.	Partial	Not sure if ethnicity is collected?	

5. Team Governance

Organisational support

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
5.1.1.	<p>There is Organisational (employer) support for MDT meetings and MDT membership demonstrated via:</p> <ul style="list-style-type: none"> recognition that MDTs are the accepted model by which to deliver safe and high quality 	Fully	Through MDT members job plans	

	cancer care; • adequate funding/resources in terms of people, time, equipment and facilities for MDT meetings to operate effectively (as set out in this document).	Partial	Issues with cover for Radiology and Oncology	Need more resource for audit and tracking
5.1.2.	Trusts consider their MDTs' annual assessments and act on issues of concern (see 5.3.10).	Not in place		

Data collection, analysis and audit of outcomes

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
5.2.1.	Data collection resource (i.e. the ability to capture relevant information in a timely manner etc) is available to the MDT.	Partial	Histology, stage and grade are captured Radiological info All treatment options captured – free text is used to generate an outcome	Due to volume of cases presented, the MDT Co-ordinator populates data after the meeting. This is sent to the Chair for approval before it is available. There may be a delay in availability of data on CAPPs.
5.2.2.	Key information that directly affects treatment decisions (e.g. staging, performance status and co-morbidity) is collected by the MDT.	Partial	Performance & co-morbidity is recorded in the free text box, there is no structured data fields to capture this	

5.2.3.	Mandated national datasets are populated prior to or during MDT meetings where possible and appropriate – if this is not possible this takes place shortly after the meetings.	Partial		CAPPs datasets are populated after MDT Under current legislation regarding the use of secondary data, the MDT is not able to provide data for national datasets
5.2.4.	Data collected during MDT meetings (including social demographic data extracted from PAS) is analyzed and fed back to MDTs to support learning.	Not in place		This is not currently happening and would require further resource to support this. It would be useful to support the MDT with forward planning, and provide assurance in relation to meeting standards / guidelines by providing a systematic review of MDT activity
5.2.5.	The MDT takes part in internal and external audits of processes and outcomes and reviews audit data (eg. to confirm that treatment recommendations match current best practice and to consider trial recruitment) taking action to change practice etc where necessary.	Partial		Limited audits due to lack of resource available to support
5.2.6.	MDTs consider and act on clinical outcomes data as they become available eg. through peer review, NCIN clinical reference groups etc.	Not in place		Clinical outcomes data not available through peer review
5.2.7.	Patient experience surveys include questions relevant to MDT working and action is taken by MDTs to implement improvements needed in response to	Partial	NI Cancer Patient Experience Survey Local patient surveys	Don't ask specific questions on MDT working

	patient feedback.			
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Clinical governance

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
5.3.1	Data collection resource (i.e. the ability to capture relevant information in a timely manner etc) is available to the MDT.	Partial		Very limited due to lack of support available
5.3.2	<p>There are agreed policies, guidelines or protocols for:</p> <ul style="list-style-type: none"> • how the MDT operates; • who the core and extended members are; • the roles of members; • how members should work together; • how changes in clinical practice are to be managed; • communications post meetings eg. To patients, GPs and other clinical colleagues. 	Fully	Operational Policy	
5.3.3	User Partnership Groups are given the opportunity to advise on the development of MDT policy and practice – they are given feedback in response to their advice including actions taken in response to their recommendations.	Not in place		<p>There is a Trust Cancer Service User Group who have acted as a readers panel in relation to the MDT patient information leaflet.</p> <p>This group is currently being re-established and the terms of reference reviewed. There is</p>






				scope to explore how the group can support the development of the MDT.
5.3.4	MDT policies, guidelines and protocols are reviewed at least annually	Fully	MDT operational policy is reviewed annually. An annual report and work plan is produced in relation to previous year MDT activity.	
5.3.5	<p>There are mechanisms in place to:</p> <ul style="list-style-type: none"> record the MDT recommendation(s) versus the actual treatment given and to alert the MDT if their treatment recommendation(s) are not adopted and the reason for this – the MDT has regular opportunities to review and act on learning from such cases; ensure that the MDT is alerted to serious treatment complications and adverse or unexpected events/death in treatment - the MDT has regular opportunities to review and act on learning from such cases. 	Not in place		<p>Needs to be considered but will require dedicated support in relation to ongoing audit of MDT outcomes Reinforces importance of role of CNS at clinics</p> <p>Department of Health Patient Safety regulations does not overlap with cancer services</p>
5.3.6	<p>There are strategies in place to monitor:</p> <ul style="list-style-type: none"> the proportion of patients discussed without sufficient information to make recommendations/ take action at 	Not in place		Needs to be considered but will require dedicated support to ensure regular auditing

	that meeting; <ul style="list-style-type: none"> the proportion of patients offered and/or receiving information recommended by the MDT. 			
5.3.7	The MDT shares good practice and discusses local problem areas with MDTs within its own trust/Network.	Partial	There is an opportunity through the regional Clinical Reference Group to share good practice and highlight areas of concern	There is no formal mechanism locally for MDTs to do this but should be considered. Would be useful to sit in on other MDTs to review practice.
5.3.8	The MDT has representation on the Clinical Reference Group (CRG) for its cancer site and that representative attends the meetings or sends a deputy.	Fully	Annual report details MDT attendance at the CRG	
5.3.9	Significant discrepancies in pathology, radiology or clinical findings between local and specialist MDTs should be recorded and be subject to audit.	Not in place	Discrepancies may be recorded but are not audited	
5.3.10	MDTs reflect, at least annually, on equality issues, for example, that there is equality of access to active treatments and other aspects of treatment, care and experience for all patients.	Not in place		Needs to be considered but will require dedicated support
5.3.11	The MDT assesses (at least annually) its own effectiveness/performance and where possible benchmarks itself against similar MDTs making use of cancer peer review processes and other national tools as they become available – results of the assessment are acted on by the MDT or employing	Partially	The MDT was peer reviewed in September 2015 and submitted self-assessments in 2016 and 2017	

	organisation.			
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NCAT Section / Characteristic	Generic issue	Action/s to address	Action Product	Action owner	Action End date	Status update	RAG rating	Evidence when completed	Cross-reference to Urology SAI recommendation/s
Section 1: The Multidisciplinary Team									
1.1.1 / 1.1.3	All relevant specialities are represented in the team, cross cover for some specialities	Audits of attendance at MDM should be more regular (?quarterly) rather than review at annual business meeting - this will also assure on quoracy and allow for issues to be addressed earlier	Audit of MDT Attendance on regular basis	MDT Administrator / Projects Officer & MDT Leads	Will be on-going quarterly	Dr Tariq has written to all MDT Leads to ensure that attendance is being accurately recorded at MDT meetings. Audits of attendance to take place on a monthly basis starting from Feb 2022. Quorarcy to be shared with MDT Leads and Cancer Management Team	<div></div>	Monthly report of all MDT attendances available and circulated to the MDT Leads and Cancer Management Team for review and further escalation if required	Recommendation 1
1.2.1	Dedicated time in job plans for preparation & attendance at MDT	Ensure job plans of all MDT members has dedicated time included to prepare and attend the MDT meeting	Review of MDT Job plans	Dr Tariq / C.Quin	Dec-21	Dr Tariq has written to the surgical & medical directors to clarify that MDT time is included in the job plans of all MDT members. Attendance at the MDT meeting has been confirmed for all tumour sites. Preparation time is not included and falls under the time allocated for general patient admin time. C.Quin has checked with all CNS's - they all attend MDTs as required though not all have formal job plans. C.Quin to link with J.Davenport to confirm oncology input to the local MDTs.	<div></div>	Confirmation received per speciality that all core MDT members have dedicated time to prepare and attend MDT. Confirmation received by BT in relation to oncology input to local MDTs.	Recommendation 1; Recommendation 4
1.2.6	Extended members / non-members attend for cases relevant to them	To be agreed by the MDT and detailed in the MDT operational policy	MDT Operational Policy	MDT Leads / SIL / MDT Administrator	30th Jan 2022	Discuss with MDT Leads and include agreed process in the MDT operational policy	<div></div>	Detailed in MDT Operational Policies	Recommendation 1
1.3.5	MDT Leader has a broader remit not confined to MDT meetings	Develop role description of the MDT Lead and ensure adequate time is allocated in their job plan	Job description for MDT Lead role	Dr Tariq; Stephen Wallace	Jan-22	Dr Tariq has liaised with Stephen Wallace in relation to MDT Lead role description. A draft has been circulated to all MDT Leads for review / comment.	<div></div>	MDT Lead role description agreed and signed off	Recommendation 7
1.4.1	Each member has clearly defined roles / responsibilities in the team which they have signed up and included in their job plans	Define and detail the roles and responsibilities of all members involved in the MDM meetings	Review of MDT operational policies to ensure all MDT members roles are clearly defined; Review of MDT job plans	MDT Leads; MDT Administrator & Projects Officer; Medical & Surgical Speciality:AMD	Mar-22	MDT Administrator & SIL to review all MDT Operational policies with MDT Lead to ensure roles and responsibilities are included.	<div></div>	Clearly detailed in the MDT Operational policies	Recommendation 1
1.5.2	Networking opportunities to share learning & experiences with other MDTs locally	Provide opportunity for MDTs to meet locally, at least once per year, to share learning and experiences	Set up an Annual networking meeting for all MDTs	Dr Tariq; CD for Cancer; AD for Cancer services	Mar-22	Dr Tariq to contact MDTs Leads for feedback on the format and content of an annual networking event and to seek a date early 2022	<div></div>	An annual networking event is arranged if agreed by MDT Leads	Recommendation 6
Section 2: Infrastructure for meetings	0								
3.2.5	Locally agreed minimum dataset of information about patients for discussion collated and summarised prior to meeting (pathology, radiology, clinical, co-morbidities, psychosocial & spec palliative care needs	To develop MDT Proforma per tumour site with locally agreed minimum dataset	MDT Proforma	MDT Administrator / Projects Officer & MDT Leads	Mar-22	MDT proforma for Urology MDT agreed and will be rolled out from 4 Jan 22. Proformas for Lung, UGI and LGI to be considered next.	<div></div>	Each MDT has a proforma implemented for referrals to the MDM	Recommendation 1
3.2.6	Members know what info from locally agreed minimum dataset of info they will be expected to present	To be detailed in the MDT Proforma	MDT Proforma	MDT Administrator / Projects Officer & MDT Leads	Mar-22	To be developed in a phased approach for all MDTs, beginning with Urology MDT (Jan 22)	<div></div>	Each MDT has a proforma implemented for referrals to the MDM	Recommendation 1
3.3.1/3.3.2	It is clear who wants to discuss a patient & why being discussed / a locally agreed dataset of information is presented on each patient including diagnostic information	To develop MDT Proforma per tumour site with locally agreed minimum dataset, clear reason for discussion and sign off from the presenting clinician	MDT Proforma	MDT Administrator / Projects Officer & MDT Leads	Mar-22	To be developed in a phased approach for all MDTs, beginning with Urology MDT	<div></div>	Each MDT has a proforma implemented for referrals to the MDM	Recommendation 5
3.3.5	Core data items are collected during meetings and datasets completed in real time	Review and agreement of which data fields should be completed during MDT discussion and by whom, this should be detailed in MDT Principles/Protocol	Audit process agreed to review and monitor	MDT Leads; MDT Administrator / Projects Officer & MDT Co-ordinators; OSL	Mar-22	To start with Breast & Gynae MDTs as they have more experienced trackers once MDT Administrator has settled into post	<div></div>	Completion of core data fields during MDT meeting & process implemented to check compliance	Recommendation 5
3.4.1	Processes in place to ensure patients info needs are assessed and met; to ensure actions agreed are implemented;	CNS to use the Cancer Information Recording form to record the information provided by the clinical team to the patient and file in the patient notes: All patients receive a written record of their management plan with diagnosis and contact details before they leave clinic	Audits to check completion of Cancer information recording form & permanent record of consultation	HOS Cancer and MDT Administrator / Projects Officer	Feb-22	Audits to take place when MDT Administrator is in post	<div></div>	Roll out of audits to check compliance	Recommendation 2
3.4.2	ensure MDT is notified of significant changes made to recommended treatment/care-plan	Any variation from recommended treatment/careplan should be documented at a MDT meeting. Develop an SOP with a clear pathway on whose role it is to capture , record and document and how this will be done per MDT for any patients that have declined further treatment.	Develop SOP; Include in MDT Principle's document; agree audit process to check compliance	MDT Leads; MDT Administrator & Project Officer	Mar-22	SOP to be developed. Principles document developed and agreed. Audit process to be agreed.	<div></div>	Roll out of audits to check compliance	Recommendation 5
Section 4: Patient Centred Clinical Decision-making									
4.1.1	Local mechanisms to identify all patients where discussion at MDT is needed	Define and detail what failsafe mechanisms are in place to ensure that there is a safety net to identify all patients who require MDT discussion	Failsafe mechanism agreed with Pathology	Pathology Clinical Lead; MDT Administrator & Project Officer	Dec-21	A report has been developed by Cellular Pathology & Lab service in Belfast and is currently being reviewed and tested.	<div></div>	Process in place to run a report to enable a cross-check across all the MDTs	Recommendation 5

4.1.3	Local agreement about if/when patients with advanced/recurrent disease should be discussed	MDT site specific agreement if/when patients with advanced or recurrent disease are listed for discussion and this is detailed in operational policy	To be guided by what is agreed and funded regionally	OSL; HOS Cancer; MDT Administrator & Projects Officer	Mar-22	Regional discussion required to agree enhanced tracking definitions and funding secured to implement		To be guided by what is agreed and funded regionally	Recommendation 4
4.2.3	Named individual at MDT has responsibility for identifying a key worker for the patient	To be detailed in MDT Principles doc and audit process required; additional field to be added to CAPPs to identify key worker	MDT Principles document; CAPPs	MDT Leads; HOS Cancer; SIL; MDT Administrator & Project Officer	Feb-22	Principles doc agreed, audit process to be set up once the additional field is added to CAPPs		Audit process agreed and implemented across all MDTs	Recommendation 5 & Recommendation 2
4.2.4	Named individual at MDT ensures patients information needs are assessed and addressed	To be detailed in MDT Principles doc and key worker identified on CAPPs	MDT Principles document - audit of compliance to be agreed	MDT Leads; HOS Cancer; SIL; MDT Administrator & Project Officer	Feb-22	Principles document agreed. Meetings ongoing with CNS's to ensure that patient info needs are assessed and this is documented appropriately.		Audit proces in place to monitor	Recommendation 2
4.3.1	A locally agreed minimum dataset of info is provided at the MDT meeting	To develop MDT Proforma per tumour site with locally agreed minimum dataset	MDT Proforma	MDT Leads; MDT Administrator & Project Officer	Mar-22	Proforma for Urology MDT developed and agreed, this will be used from 4 Jan 2022. Next tumour sites for consideration are Lung, LGI and UGI.		Audit process agreed and implemented across all MDTs	Recommendation 1; Recommendation 5; Recommendation 8
4.3.3	MDTs have access to all current clinical trials, consider patients suitability, relevant research nurses attends MDT where feasible	Ensure that all MDTs have access to clinical trials and recruitment is considered as appropriate	MDT Principles document	Clinical research nurses; Peter Sharpe; Irene Knox;	Ongoing	When Principles doc is agreed by MDT Leads, process will be agreed to ensure that MDTs are aware of clinical trials and consider patients suitability		Audit process agreed and implemented across all MDTs	Recommendation 1;
4.3.12	MDTs collect social demographic data (age, ethnicity & gender) & consider data periodically to reflect on equality of access to active treatments	To review systems to identify how this information can be collected and agree a clear process on how this info is captured, whose role it is to do this and when this will be considered by the MDTs	Data collection	OSL/ MDT Administrator & Project Officer / SIL	Feb-22	MDT Administrator to raise at next regional CAPPs meeting. M.Haughey to check with NICR.		Data is collected and reviewed by MDT Leads	Recommendation 6
Section 5: Team Governance									
5.1.1	Organisational support demonstrated via adequate funding/resources in terms of people, time, equipment for MDT meetings to operate effectively	Review of MDT Leads job plans, clear process in place to escalate any issues that may impact negatively on the effectiveness of the MDT meeting, new MDT room suitable equipped for meetings	MDT job plans; MDT room for meetings; process in place to escalate issues of concern, monthly Cancer checkpoint meetings, attendance at MDT AGMs	Cancer Services Management Team	Jan-22	MDT Leads job plans all reviewed; room allocated for MDT meetings; MDT Administrator post; regular meetings set up to escalate issues / concerns		MDT job plans reviewed and adequate time allocated; new MDT room operational for MDMs; clear process in place to escalate concerns; monthly checkpoint meetings; Cancer management attendance at MDT AGMs	Recommendation 9
5.1.2	Trusts consider their MDTs annual assessments and act on issues of concern	Cancer Services team attend MDT annual meetings and process in place to enable escalation of MDT areas of concern	Clear process in place and communicated to all MDT Leads to escalate issues of concern; Representation from Cancer Management Team at MDT annual business meetings	Cancer Services Management Team	Feb-22	Escalation Process agreed and circulated to all MDT Leads; Schedule of MDT business meetings to be agreed at start of each year and communicated to management team to ensure		MDT annual meetings to be agreed for 2022 and Cancer services management representation agreed for all meetings; escalation of other issues of concern as per agreed	Recommendation 3
5.2.1	Data collection resource is available to the MDT	Identify what data support is required by MDTs and explore funding sources with Trust SMT and commisioners	Data resource allocated	AD / HOS Cancer / OSL /	Feb-21	The MDT Administrator took up post on 04/01 and additional data support will be considered		Adequate data support is available to all the MDTs	Recommendation 6
5.2.2	Key info that directly affects treatment decisions is collected by MDT (staging, performance status, co-morbidity)	To ensure this info is captured in the MDT Proforma	Sytems review / MDT Proforma	MDT Administrator / Projects Officer; OSL; MDT Leads	Feb-22	This has started with the Urology MDT and will be rolled out across all of the MDTs in a phased approach		Key info is collected	Recommendation 5
5.2.3	Mandated national datasets are populated prior to or during MDT meetings or shortly afterwards	Detailed in MDT Principles doc and clear process detailed on what info is collected and by whom	MDT Principles document	MDT Co-ordinator / OSL / MDT Administrator	30th Nov	Draft presented to MDT Leads at Cancer checkpoint meeting and to the Urology Task & Finish Group meeting. Document is now finalised.		Principles doc states what datasets are populated and defines how this will be monitored	Recommendation 6
5.2.4	Data collected during MDT meetings (including social demographic data) is analysed and fed back to MDT to support learning	Agree what data is collected, who will collect & analyse it and when this will be shared with the MDTs for consideration	Data collection process agreed per MDT	MDT Leads; MDT Co-ordinator; OSL; SIL	Mar-22	Liaise with HSCB to get a regional steer on social demographic collected. M.Haughey to check with NICR.		Data collected is analysed and fed back to the MDT for review and learning	Recommendation 6
5.2.5	MDT takes part in internal and external audits of processes & outcomes, reviews audit data and takes action to change practice where necessary	MDTs to identify and agree their audits at the annual business meeting including whi will lead and what support is required	Completion and and log of audits per MDT	MDT Leads / Dr Tariq / AD / Clinical audit team	Mar-22	Dr Tariq to write to MDT Leads to seek input on completion and review of future audits and the process for this to be discussed and agreed. Additional audit resource to be secured from the Clinical Audit Team		MDTs to take part in audits, both internal and external, and takes action as appropriate. All audits are logged.	Recommendation 6
5.2.7	Patient experience surveys include questions relevant to MDT working and action is taken to implement improvements in response to pt feedback	Local patient experience surveys per MDT should be rolled out at least once every two years.	Patient experience surveys	CNS's / SIL / MDT Leads	Mar-22	Scope what patient experience surveys have been undertaken and identify any gaps across MDT teams		All MDTs undertake patient experience surveys and action plans developed in response to findings	Recommendation 6
5.3.1	Data collection resource is available to the MDT	Identify what data is required for the MDTs and by whom and how often	Data resource calculated	OSL / MDT Administrator / HOS Cancer / MDT Leads	Feb-21	This will be considered further once the MDT Administrator has had to time to settle into the post		Data support is available to all MDTs	Recommendation 6
5.3.3	User Partnership Groups are given the opportunity to advise on the development of MDT policy and practice	Re-establish the Cancer Service User Group and agree the process for involvement in MDT policy and practice	Establishment of Cancer Service User Group	HOS Cancer; SIL ; Macmillan HWB Manager	Feb-22	Terms of reference developed; recruitment process underway; Group is re-established. Further discussion required to agree process for MDT involvement.		Trust cancer service user group is involved in the development of MDT policy and practice	Recommendation 6
5.3.5	Mechanisms in place to record MDT recommendation v actual treatment given and alert MDT if these are not adopted and reason for this; ensure MDT is alerted to serious treatment complications and adverse/unexpected events/death in treatment	To be detailed in MDT Principles document including quality indicator to audit; additional resource to support this needs to be identified and secured.	MDT Principles Document; Additional resource secured	AD; DMD; OSL; MDT Administrator & Projects Officer	Mar-22	Principles document is agreed.Further work required to scope out what support is required to undertake audits. BT audit process to be reviewed.		Mechanisms and audit process are in place	Recommendation 8

5.3.6	Strategies in place to monitor: proportion of pts discussed without sufficient information to make recommendations & proportion of patients offered and/or receiving information recommended by MDT	Agree how this data is collected & analysed for MDTs, by whom and when this will be shared with the MDTs for consideration	Data collection & analysis - AUDITS	MDT Leads; MDT Administrator & Project Officer;	Jan-22	To be agreed with MDT Leads once MDT Administrator & Projects Officer is settled into post		Agreed mechanism and audit process in place	Recommendation 1; Recommendation 2
5.3.7	MDT shares good practice & discusses local problem areas with MDTs in own trust/network	Provide opportunity for MDTs to meet locally to share learning and experiences (see 1.5.2)	MDT networking event	Cancer Services Management Team	Feb-22	Dr Tariq has contacted MDT Leads to seek feedback on whether an event is required or to agree other mechanisms to share learning		Agreed mechanism in place between MDTs to share learning	Recommendation 3
5.3.9	Significant discrepancies in pathology, radiology or clinical findings between local and specialist MDTs should be recorded and subject to audit	This is currently done on a one-to-one basis, a process needs to be developed and implemented	To develop an MDT Communications Protocol	MDT Administrator / MDT Leads /	Mar-22	Dr Tariq to liaise with MDT Leads to discuss process. M.Haughey and A.Muldraw to review BT communications protocol in relation to communication back to local MDTs and advise accordingly.		Agreed process and audit in place	Recommendation 6
5.3.10	MDTs reflect annually on equality issues	Data to be agreed and collected for MDT annual reports for review & reflection by the MDT members	Data collection	MDT Leads / MDT Administrator & Projects Officer	Mar-22	Data and process for collection to be agreed when MDT Administrator & Projects Officer is settled into post. M.Haughey to check with NICR.		Process agreed to collect data which are reviewed by MDTs	Recommendation 1; Recommendation 6
Additional areas	Overall governance of MDT and decisions arising from MDTs	Review of JDs for ADs, CDs and AMDs – both for cancer and specialties.	Process set up to review JDs	AMD / Medical Directorate / Specialities	Mar-22	This is ongoing via the Medical Directorate			Recommendation 6; Recommendation 7

RAG Rated Scale for Actions	
	Action not progressed
	Process in progress
	Process complete and action implemented



Urology Services

Our staff would really value your feedback on the services that they are providing. Your story might be about you, or someone close to you. You can say what happened, what was good, and what could have been better. Care Opinion allows you to leave your feedback in a number of ways:



Online with text -
www.careopinion.org.uk



Online with Images -
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Free post leaflet – write or draw



Freephone: 0800 122 3135

For further information on Care Opinion please contact:
Christine Armstrong or Mairead Casey, Patient and Client Experience Facilitators

Christine: Personal Information redacted by the USI Mairead: Personal Information redacted by the USI



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Christine: Personal Information redacted by the USI Mairead: Personal Information redacted by the USI

Brainstorm For Urology Cancer QI Project (Feb 22)

Questionnaire

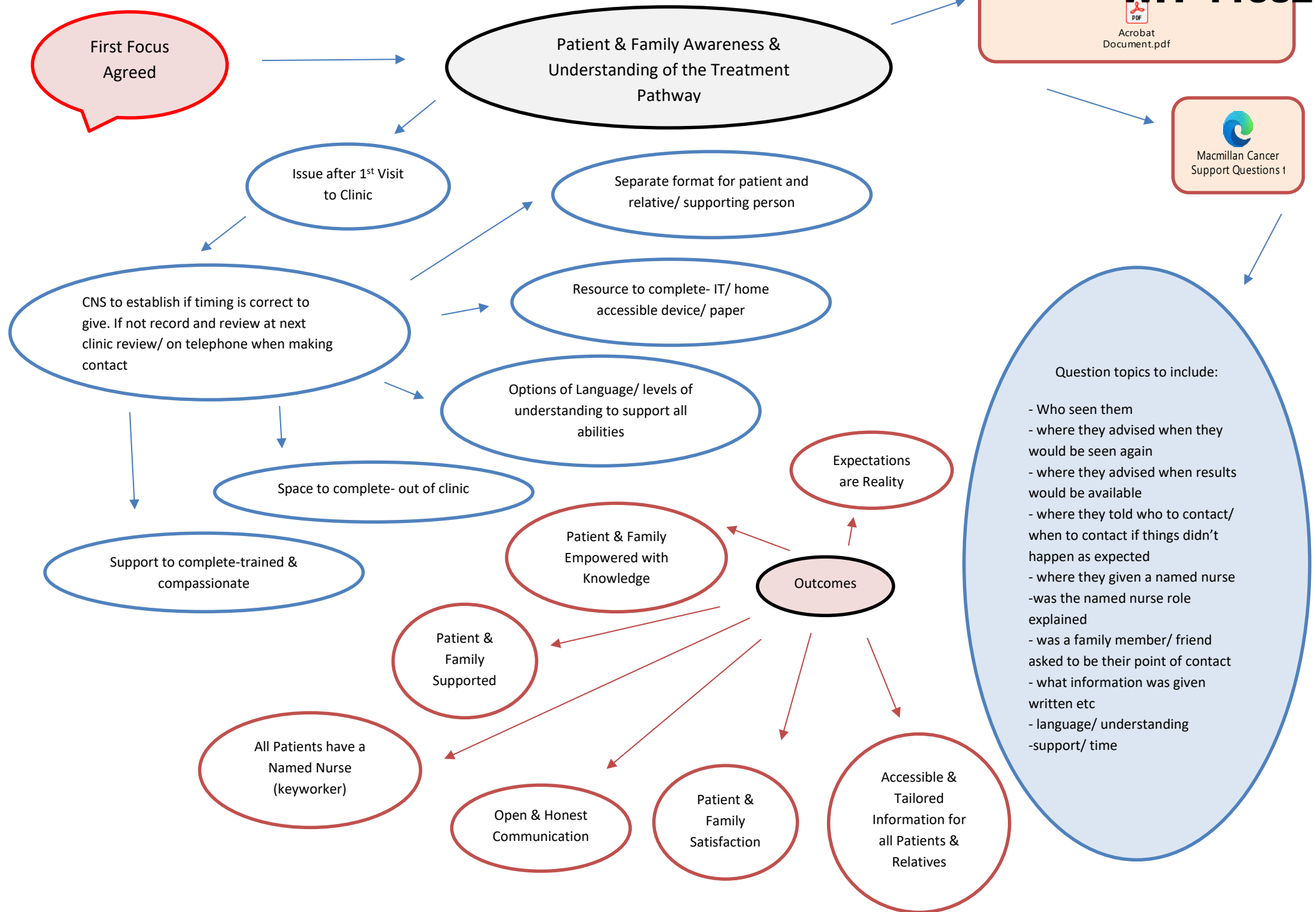
- Format- Paper Copy & online form. Automated bounce back email to thank for completion
- Separate questionnaire for patient and family/ support system
- Who completes this?
- Timing of Giving to Patients/ Family – Link with CNS for timing/ patient continuity
- Phased approach- sectioned for different stages
- Accessibility of technology- tablets for unit/ not all patients have access at home
- Multiple language options
- Assistance for patients/ relatives- eg reading/writing difficulties. Support from people who are trained
- Space to do away from clinic/ safe comfortable space

Knowledge

- What do patients/ families know about their treatment pathway
- Do patients/ families know the timescales associated with each stage
- Do patients know who to contact if they don't get what is expected
- Do patients feel empowered to ask about their journey of things not happening as expected
- Prompts for questions for patients to ask
- Is the information provided accessible/ available for all languages and abilities/ understanding

Process

- Patient passport for patients to prevent repetition of information
- MDT Hard copy of notes for those who cannot access online HNA for example
- Summary sheets detailing last scan/last appointment
- Journal options to allow thoughts and feelings to be recorded for patient and relatives
- Flow Diagrams for specific cancer pathways and when to expect for eg HNA
- Contact details at each stage & prompts for eg “if you have not received your appointment by....please ring....”
- Infographic for keeping handy- stages of process/ what to do and when
- How CNS collaborate/communicate when patient has more than one cancer site- streamline of reviews to prevent repetition
- Openness/ Honesty & Duty of Candour from staff to patients.





Title	Guidance for HSC staff on the provision of information to people affected by cancer	
Developed by	HSC Trust Cancer Information Leads – see Appendix 3	NICaN Service Improvement Lead for Patient Information – see Appendix 4
Version Control	Final version 1.0 issued May 2017	
Implementation	All Trusts	
Contact Person (s)	HSC Trust Cancer Information Leads	NICaN Office Tel: Personal Information redacted by the USI
Review Date	June 2019	
Group Responsible	HSC Trust Cancer Information Leads	



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Section 1: General Information

1. Purpose

This Guidance has been developed to support the implementation of generic information packs across cancer health and social care (HSC) services.

2. Scope

This Guidance relates to all HSC staff. It is not limited to specialist cancer services and staff.

People receive health and social care services, directly related to their cancer investigations, diagnosis or otherwise, in various settings and from a wide range of HSC staff. Staff could be asked directly for cancer-related information or could identify a need for cancer-related information in their patient/client.

In this Guidance, 'information' means both clinical and non-clinical information. It is used to describe 'permanent' information for example, leaflets, booklets, web-based material, and audio-visual material.

This Guidance should be read and implemented in conjunction with the Trust policy on informed consent.

3. Aims/objectives

- To improve patient safety and patient/carer experience
- To help HSC Trusts achieve and evidence their delivery of patient information-related elements of patient safety alerts e.g. National Patient Safety Agency (NPSA)
- To help HSC Trusts achieve and evidence their delivery of the patient information standard in the Service Framework for Cancer Prevention, Treatment and Care
- To help HSC Trusts achieve and evidence their delivery of the patient information-related measures in Peer Review
- To help Service managers understand their responsibility in supporting the implementation of generic cancer information packs
- To help staff understand their responsibilities to provide information to people affected by cancer
- To help staff use generic information packs as a tool to do so.



4. Roles and responsibilities:

4a. HSC Trust leads for cancer patient information

Each HSC Trust has nominated a lead for cancer patient information.

The main role of the Cancer Information Lead is to provide advice to Trust managers on the implementation of network-agreed generic information packs in the Trust.

The role crosses several boundaries, notably between specialist and non-specialist cancer services, and between primary, secondary and tertiary care. The Cancer Information Lead is a resource and guide who communicates with those who have service responsibility to people affected by cancer.

Each Trust's Cancer Information Lead nomination is outlined in Appendix 2.

4b. NICaN role for Patient Information

The NICaN role for patient Information is the coordination of the work of groups developing generic information packs and support to the work of Trust Cancer Information Leads.

4c. Staff providing specialist and non-specialist cancer care

The main roles of staff relevant to this Guidance are to provide appropriate information to patients in line with cancer information pathways and to record such provision as evidence for audit.

5. Context

Patients and carers cannot express preferences about care and make choices on involvement in decision making unless they have access to appropriate and timely information. Furthermore informed consent for investigations or treatment for example cannot be obtained if patients do not have the appropriate information.

The DHSSPS report on its Regional Audit of Consent in 2007 states that,

"Seeking consent is a process of providing information, discussion and decision making. Consent for a (procedure or) treatment must be based on the patient having the information they need to make a valid decision. They can be given the information to read, and have time to discuss it with their family, carers or healthcare professionals before giving consent to the treatment."

As patients and staff move between different Health & Social Care (HSC) organisations throughout Northern Ireland it is important that the information used across the HSC is standardised".

Staff must adhere to their Trust's policy on seeking informed consent and should consult NICaN to see if regional information for investigations or treatment has been agreed.

Many patients report that they receive inadequate information from health and social care professionals. The Northern Ireland Cancer Patient Experience Survey, 2015 showed that only 64%



of patients reported having received information on the type of cancer they had at diagnosis compared to 72% in England. It also showed that only 66% of patients reported having received information on the type of operation they were having compared to 76% in England (i).

Information materials of high quality should be available in places where patients can access them readily, with patients being offered them at key stages in the patient pathway (ii).

While good face to face communication skills are vital, patients also need access to other sources of information. Studies have shown that some patients only remember one tenth of what they were told during a consultation. Face to face communication needs to be backed up with high quality, accurate information that the patient can return to in their own time (iii).

Surveys have consistently shown nine out of ten people diagnosed with cancer want to receive information about their disease, its diagnosis, treatment options, side effects, and clinical outcome. It can enable them to feel informed and subsequently empowered to make their own choices, rather than having these imposed on them.

Studies have revealed that patients who are well-informed, experience less anxiety, and are more likely to cope with their illness than those who are ill-informed or uninformed (iv, v, vi).

There is evidence that leaflets specific to a condition are read by patients (vii) and evidence that patients receiving written information are more satisfied with the information they are given (viii).

Cancer has become a chronic disease that people live with for a number of years. Many of these people have an on-going need for care, rehabilitation, information and support. This might include information about the long-term side-effects of treatment and other 'survivorship issues' that can help an individual regain a sense of normality in their lives e.g. sexuality, fertility, financial issues, employment, and sources of support such as counselling and support groups.

The Service Framework for Cancer Prevention, Treatment and Care (DHSSPS, 2010)(ix) includes standards that aim to improve the patient experience. It builds on several other regional policy documents that address patient information, including Cancer Services: Investing in the future (Campbell Report, 1996)(x) and The Cancer Control Programme (DHSSPS 2006) (xi).

This Framework is currently under review however Health and Social Care (HSC) Trusts are still required to actively monitor performance against framework standards. This includes a specific standard on the provision of information.

All people affected by cancer should be offered good information to support them throughout their cancer journey. This information should be tailored to their needs both in content and the way in which it is given (DHSSPS, 2010).

In recent years, there has been development work undertaken by Cancer Services within Northern Ireland to regionally agree high quality information for people affected by cancer. This guidance aims to help HSC staff understand how they can improve patient experience through making use of such work.



Section 2: Generic Information Packs

6. What is a generic information pack?

A generic information pack is an agreed core set of information given at or close to diagnosis of cancer. The current pack contains:

1. The Cancer Guide (Macmillan)
2. Information for you booklet (NICAN)
3. Benefits advice service leaflet (Macmillan CAB)
4. Living with and beyond cancer, survivorship website flyer (NICAN)
5. Macmillan support and information centre/service information (Local Trust)

The information resources have been identified as offering clear, accurate and well written information likely to be relevant to everyone diagnosed with cancer. This core generic pack can be added to throughout the cancer journey, to reflect the information needs of individuals e.g. Cancer Specific or treatment information, advice on talking to children etc.

Staff with any queries about tumour-specific information should direct them to Trust specialist staff for those cancer types in the first instance. The Cancer Information Manager/ Health and Wellbeing Coordinator within each trust may also be able to help (see Appendix 3 for list of managers).

7. Where can staff find information packs?

Generic information packs are available from Cancer Information Managers / Health and Wellbeing Coordinators or Clinical Nurse Specialists within each trust.

(See Appendix 3 for list of cancer information managers/health and wellbeing coordinators)



Section 3: Providing information

8. The interaction between information provider and recipient

There are a number of steps involved in a basic interaction between an information provider and the patient/carer. This includes selecting or sourcing information in alternative formats as needed.

These steps are outlined in Appendix 1.

See section 9 below for reference to complex interactions.

9. Skills development in information provision

Communication is a core competency within the Knowledge and Skills Framework (KSF). Each staff member's training needs on information provision, particularly complex interactions, should be assessed and addressed at their KSF appraisal.

10. Recording information provision

It is important that the Trust is able to evidence that information has been offered.

All staff providing information should record that the generic information pack has been offered and should file this in the patient's/client's case note. This could be achieved by using the keyworker sticker for example. Cancer Information Leads or Information Mangers within each trust should be contacted to determine the documentation method agreed locally.

Section 4: Monitoring and review

11. Monitoring:

The Trust will regularly and robustly monitor their implementation of this Guidance.

12. Review:

This Guidance will be reviewed in June 2019



References

- i. Northern Ireland Cancer Patient Experience Survey, 2015
- ii. Improving Supportive and Palliative Care for Adults with Cancer, National Institute for Clinical Excellence, 2004
- iii. NHS Cancer Plan, 2000
- iv. The Quality of Life. Fallowfield L. London Human Horizons Series Souvenir Press 1990
- v. Information needs of cancer patients in the west of Scotland Meredith C, Symonds P, Webster L, Lamont D, Pyper E, Gillis CR, Fallowfield L. BMJ 1996 313 724-726
- vi. How much truth and to whom? Respecting the autonomy of cancer patients when talking with their families-ethical theory and patients' view. Benson J, Britten N. BMJ 1996 313 729-731
- vii. Edwards, M. (1990) "Satisfying Patients' Needs for Surgical Information". British Journal of Surgery vol. 77. pp 463-5
- viii. Mayberry, J. (1988) "Information Booklets for Patients with Inflammatory Bowel Disease" International Disability Studies. Vol. 10 pp 179-80
- ix. The Service Framework for Cancer Prevention, Treatment and Care, DHSSPS, 2010
- x. Campbell Report, 1996
- xi. The Cancer Control Programme, DHSSPS 2006



Appendices

Appendix 1 - The information interaction

(Based on Macmillan Cancer Support, Managing Cancer Information Materials 3rd edition)

Appendix 2 - Cancer Information Leads as at January 2017

Appendix 3 - HSC Information post holders as at January 2017



Appendix 1: The information interaction

(Based on Macmillan Cancer Support, Managing Cancer Information Materials 3rd edition)

Beginning	<ol style="list-style-type: none"> 1.Be approachable 2.Use open body language and eye contact 3.Listen to the person's concerns 4.Try not to interrupt, but be ready to speak when they are finished
Explore the content of the enquiry	<ol style="list-style-type: none"> 1.Use open questions to tease out information needs 2.Consider topics included on the information pathway 3.The person's real issue of concern may not always be their opening question 4.Establish any information they have previously received on the topic 5.Reflect back what they have said
Clarify and summarise	<ol style="list-style-type: none"> 1.Clarity the question to ensure you have interpreted their needs correctly 2.Describe and agree together what they need 3.If there are a range of issues, consider prioritising some– do this with the person and check that they are happy to do so
Guide enquirer through range of options appropriate to them and their query These options may be you providing information yourself, or you signposting them somewhere else	<ol style="list-style-type: none"> 1. Consider resources listed in the information pathway. <ul style="list-style-type: none"> –Published leaflets –Non-print resources, e.g. CD –Guided internet search –Listening support –Counselling –Signposting to specialist services 2. Consider the person's information capacity. Do they need information in another language, an 'alternative format' or at a higher/lower literacy level? Remember you may have a statutory duty here (you can ask your Equality Manager for more information about this) 3.Go through the benefits and limitations of the options 4.Do not overwhelm the person 5.Agree and provide the information materials 6. If you don't know the answer to their question, signpost the person to an appropriate source. Do not risk giving wrong information 7.Offer the person written details of any websites or organisations and any resources you do not have to hand
Identify how to end and clarify enquirer's choices	<ol style="list-style-type: none"> 1. Consider putting a timeframe on the end of the enquiry, e.g. "During the next five minutes or so, we'll go through what we've just discussed, and then I'll leave you to look through the information". 2.Check you have answered their question(s) 3.Confirm options and close the enquiry, e.g. "I think I have given you all of the information you have asked for, but let me know if there is anything else you need" 4.Ensure the person knows how they can get more information 5.Record the information you offered and whether the person took it up



Appendix 2: Cancer Information Leads

Trust	Name	Designation
BHSCT	Margaret McManus	Information Manager, Macmillan Support and Information Centre
NHSCT	Pat McClelland	Clinical Services Manager
SEHSCT	Mary Jo Thompson	Clinical Manager for Cancer Services
SHSCT	Fiona Reddick	Head of Service
WHSCT	Elizabeth England	Lead Cancer Nurse

Appendix 3: HSC Information post holders

Trust	Name	Designation
BHSCT	Margaret McManus(BCH),	Information Manager
	Angela Small (RVH)	Information Manager
	Lindsey Anderson (BCH)	Information and Support Radiographer
SEHSCT	Karen Kelly	Health and Wellbeing Coordinator
NHSCT	Norma Adams	Information and Support Manager
WHSCT	Martha Magee	Information Manager
SHSCT	Sharon Clarke	Health and Wellbeing Coordinator

Appendix 4: NICaN Service Improvement Lead for Patient Information (Oct 14- ? 15)

Organisation	Name	Designation
NICaN	Edel Aughey	Service Improvement Lead for Information (Jan 15- Oct 15)

WHISTLEBLOWING POLICY

Policy Checklist

Name of Policy:	Whistleblowing Policy and Procedure for Raising Concerns at Work	
Purpose of Policy:	The Public Interest Disclosure (Northern Ireland) Order 1998 was introduced to safeguard anyone who raises concerns, and this policy encompasses the requirements of that Order. The policy provides a mechanism for staff to raise concerns about a range of matters at an early stage and in the right way thereby developing a culture of responsible openness and constructive criticism regarding all aspects of the Trust's activities including clinical care.	
Directorate responsible for Policy	Directorate of Human Resources & Organisational Development	
Name & Title of Author:	Vivienne Toal - Head of Employee Engagement & Relations	
Does this meet criteria of a Policy?	Yes	
Staff side consultation?	Yes	
Equality Screened by:	Vivienne Toal – Head of Employee Engagement & Relations	
Date Policy submitted to Policy Scrutiny Committee:	30 th March 2015	
Policy Approved/Rejected/Amended	Approved subject to amendments	
Communication / Implementation Plan required?	Yes	
Any other comments:		
Date presented to SMT	April 2015	
Director Responsible	Mr Kieran Donaghy	
SMT / Trust Board Approved/Rejected/Amended	Approved	
Date returned to Directorate Lead for implementation (DHR&OD)	30 th March 2015	
Date received by Employee Engagement & Relations for database/Intranet/Internet	30 th March 2015	
Date for further review	March 2017	

POLICY DOCUMENT – VERSION CONTROL SHEET	
Title	Title: Whistleblowing Policy Version: 2_0 Reference number/document name:
Supersedes	Supersedes: Whistleblowing Policy version 1
Originator	Name of Author: Vivienne Toal Title: Head of Employee Engagement & Relations
Policy Scrutiny Committee & SMT approval	Referred for approval by: Vivienne Toal Date of Referral: Policy Scrutiny Committee Approval SMT approval: As Above
Circulation	Issue Date: September 2017 Circulated By: Vivienne Toal Issued To: Directors, Assistant Directors, Heads of Service for onward distribution to staff.
Review	Review Date: March 2017 Responsibility of (Name): Vivienne Toal Title: Head of Employee Engagement & Relations



Quality Care - for you, with you

WHISTLEBLOWING POLICY

AND

PROCEDURE FOR RAISING ISSUES OF CONCERN AT WORK

Author	Vivienne Toal, Head of Employee Engagement & Relations
Directorate responsible	Human Resources & Organisational Development
Date	March 2015
Review date	March 2017

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1.0 INTRODUCTION TO POLICY

The Southern Health & Social Care Trust is committed to promoting a culture of openness in which staff are encouraged to raise concerns without fear of reprisal and victimisation; and to ensuring that health and social care services are provided with the highest standards of integrity and honesty. The Trust expects all employees to maintain high standards in all areas of practice. All employees are therefore strongly encouraged to report any perceived wrongdoing by the organisation, its employees or workers that fall short of these principles.

Each of us at one time or another has concerns about what is happening at work. Usually these concerns are easily resolved. However, when they are about dangers to or ill treatment of service users, staff or the public, issues relating to the quality of care provided, patient safety, professional misconduct, unlawful conduct, financial malpractice, fraud, health and safety, or dangers to the environment, it can be difficult to know what to do.

You may be worried about raising such issues. You may want to keep the concerns to yourself, perhaps feeling it's none of your business or that it's only a suspicion. You may feel that raising the matter would be disloyal to colleagues, managers or the organisation. You may decide to say something but find you have spoken to the wrong person or raised the issue in the wrong way and are not sure what to do next. You may also not be clear how your own professional code of conduct relates to Trust procedures.

2.0 PUBLIC INTEREST DISCLOSURE (NORTHERN IRELAND) ORDER 1998

The Public Interest Disclosure (Northern Ireland) Order 1998 was introduced to protect anyone who raises concerns from detriment and / or dismissal, and this policy encompasses the requirements of that Order. The Order protects employees or workers who make "protected disclosures", i.e. who reports wrongdoing within the workplace. This policy provides a process to enable employees or workers to inform the organisation about any wrongdoing in the workplace which they believe has occurred, or is likely to occur. Protection is against victimisation, disciplinary action or dismissal for employees who raise genuine concerns.

The Order 1998 has a tiered approach to disclosures which most easily gives workers protection for raising a concern internally. It is intended that this policy and associated procedure provide reassurance to staff who wish to raise such matters internally. Guidance from a range of regulatory / professional bodies encourages registrants to raise their concerns internally to ensure maximum level of protection under the Public Interest Disclosure Act.

Further details of the Order can be found using the following web address:
<http://www.pcaw.co.uk/law/pida.htm>.

3.0 PURPOSE AND AIMS

Purpose

The Senior Management Team of the Trust is committed to running the organisation in the best way possible and to do so we need the help of those who work for us. We have this policy in place to reassure those who work for us that it is safe and acceptable to speak up and to enable all workers to raise any concerns that they may have at an early stage and in the right way.

There may be times when, after staff have raised a concern under this policy, it is deemed to be more appropriate to be dealt with differently. However this should not stop staff raising concerns under this Policy.

This policy aims to:

- Provide an avenue for you to raise a concern internally as a matter of course, and receive feedback on any action taken;
- Provide for matters to be dealt with quickly and appropriately and ensure that they are taken seriously;
- Reassure you that you will be protected from reprisals or victimisation for raising the concern in good faith;
- Allow you to take the matter further if you are dissatisfied with the Trust's response.

4.0 POLICY STATEMENT

The Trust would rather that you raised the matter when it is just a concern rather than waiting for proof. It is important to raise any concerns at an early stage, on the basis of any level of concern or relevant information. Indeed, if you have serious suspicions that an offence has been committed, you have a responsibility to report them as soon as possible. We all have a responsibility to protect the Trust, its service users, staff and public. **If in doubt – raise it!**

If something is troubling you that you think the Trust should know about or look into, please use the Procedure for Raising Concerns at Work – see section 10.0. You should never accuse individuals directly, and telling the wrong persons may jeopardise an investigation.

What we do ask is that in order to qualify for protection under this policy, you must:

- Act in good faith (effectively this means honestly) and

- Genuinely believe the information you are going to impart is accurate and
- Not act maliciously.

Our assurances to you

Your safety

The Chair, Chief Executive & Trust Board are committed to this Policy. If you raise a genuine concern under this Policy, you will not be at risk of losing your job or suffering any form of retribution as a result. Provided you are acting in good faith, it does not matter if you are mistaken. Of course, this same assurance is not extended to someone who maliciously raises a matter they know is untrue, and in such cases disciplinary action will be considered.

Your confidence

Confidentiality

The Trust will not tolerate the harassment or victimisation of anyone raising a genuine concern under this Policy. However, we recognise that you may nonetheless want to raise a concern in confidence. If you ask us to protect your identity by keeping your confidence, we will respect your request and it will not be disclosed without your consent. However a situation may arise where we are not able to resolve the concern without revealing your identity (for instance because evidence is needed in court, or the Trust has to act on the information), and this will be discussed with you in advance of any disclosure.

Anonymous allegations

Remember that if you do not tell us who you are, it will be much more difficult for us to look into the matter or to protect your position or to give you feedback. You are encouraged to put your name to any issue of concern you are raising. Allegations expressed anonymously and/or with little detail or information are much less powerful and more difficult to address but may be considered at the discretion of the Trust. Whilst we will give due consideration to anonymous reports, we cannot follow the procedure set out in Section 11.0 for any concerns raised anonymously. The Trust endeavours to promote a supportive environment in which you are able to express your concerns in confidence, thereby hopefully negating the need for raising concerns anonymously.

5.0 SCOPE OF POLICY

This Policy applies to you whether you are a permanent, temporary or bank employee. The Trust is also very dependent on a wide range of contractors, suppliers, and others not directly employed by the Trust such as agency staff, trainees, volunteers, secondees, or a student or anyone on a work experience placement – the policy applies to all individuals in these categories where there are concerns about the activities of the Trust.

6.0 HOW WE WILL HANDLE YOUR CONCERN

Members of staff, including students, can seek support and guidance from their Trade Union or professional organisation when raising a concern. Staff may be represented at any stage of the procedure by a trade union representative or colleague where appropriate.

Once you have told us of your concern, we will look into it to assess initially what action should be taken. This may involve an internal enquiry or a more formal investigation. We will tell you who is handling the matter, how you can contact him/her, the timescale for action and whether your further assistance may be needed.

All staff who raise a concern will be automatically allocated support from the Head of Employee Engagement & Relations or a nominated deputy throughout the investigation process in line with section 8.0.

When you raise the concern you may be asked how you think the matter might best be resolved. If you do have any personal interest in the matter, we do ask that you tell us at the outset. If your concern falls more properly within the Grievance Procedure we will tell you.

While the purpose of this policy is to enable us to investigate possible malpractice and take appropriate steps to deal with it, we will give you as much feedback as we properly can and confirm our response in writing. Please note that we may not be able to tell you the precise action we take where this would infringe a duty of confidence owed by us to someone else.

7.0 RESPONSIBILITIES

7.1 Your responsibilities

The Trust wishes to encourage you to highlight areas where you are aware of inadequacies in the provision of services. In doing so concerns can be addressed at the earliest opportunity thus ensuring an overall improvement in the level of services provided to service users.

In particular you have a responsibility to:

- report any genuine concern of wrongdoing or malpractice preferably to your line manager or alternatively via one of the other options set out in the procedure in section 10.0. Proof of wrongdoing is not required, merely a genuine and reasonable concern. At the same time, you have an equal responsibility not to raise issues maliciously, where no potential evidence or indication of malpractice or danger exists; and

- familiarise yourself with and to understand the procedure for raising concerns outlined in section 11.0.
- be aware that information given unjustifiably to the media may unreasonably undermine public confidence in the Trust and Health and Social Care generally.

7.2 Our Responsibilities

All **managers** contacted by a member of staff, are responsible for:

- ensuring at the earliest opportunity that the appropriate action is taken in line with section 10, considering the nature and seriousness of the concern raised, including informing others, responding to concerns quickly and in confidence, taking all concerns seriously. This action will include deciding how any person, against whom an allegation is made, is informed of the matter, ensuring that the investigation is not jeopardised by the disclosure.
- supporting and reassuring those raising concerns – it is recognised that raising concerns can be difficult and stressful
- responding to all concerns without pre-judging
- recording all concerns, including the date the concern was raised, dates of interviews with employees, who was present at each interview and the action agreed
- keeping all records safely and securely

The **Trust's Senior Management Team**, through the Director of Human Resources & Organisational Development is responsible for:

- ensuring that these procedures are explained to all new staff, as part of Trust Induction
- protecting the interests and confidentiality of staff, for treating any concerns raised seriously, and for investigating them fairly and thoroughly
- ensuring that an investigation report relating to each Whistleblowing concern raised is considered as part of the Trust's Corporate / Clinical & Social Care Governance arrangements.

8.0 SUPPORT FOR EMPLOYEES

It is recognised that raising concerns can be difficult and stressful. Advice and support is available from the Head of Employee Engagement & Relations or a nominated deputy

throughout any investigation process. The Head of Employee Engagement & Relations will not undertake an investigation role in any whistleblowing case but will oversee any investigation undertaken and provide support to the individual raising the concern throughout the process, ensuring that feedback is provided at appropriate stages of the investigation.

The Trust also provides Carecall services to all employees through its Employee Assistance Programme; this service is free to all employees and is available 24/7. Contact details are: 0808 800 0002.

The Trust will take steps to minimise any difficulties which you may experience as a result of raising a concern. For example if you are required to give evidence at disciplinary proceedings, the Head of Employee Engagement & Relations will arrange for you to receive advice about the process.

If you are dissatisfied with the resolution of the concern you have raised or you consider you have suffered a detriment for having raised a concern, this should be raised initially with the Head of Employee Engagement & Relations.

9.0 EQUALITY AND HUMAN RIGHTS CONSIDERATIONS

This policy has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. The policy will therefore not be subject to an equality impact assessment.

Similarly, this policy has been considered under the terms of the Human Rights Act 1998, and was deemed compatible with the European Convention Rights contained in the Act.

10.0 ALTERNATIVE FORMATS

This document can be made available on request in alternative formats, e.g. plain English, Braille, disc, audiocassette and in other languages to meet the needs of those who are not fluent in English.

11.0 COPYRIGHT

The supply of information under the Freedom of Information does not give the recipient or organisation that receives it the automatic right to re-use it in any way that would infringe

copyright. This includes, for example, making multiple copies, publishing and issuing copies to the public. Permission to re-use the information must be obtained in advance from the Trust.

12.0 PROCEDURE FOR RAISING CONCERNS AT WORK

There are a range of options from which you can choose if you wish to raise a concern.

Concerns are best raised in writing. You should set out the background and history of the concerns, giving where possible:

- names,
- dates,
- places, and
- the reasons why you are particularly concerned about the situation.

If you do not feel able to put the concern in writing, you can of course raise your concern via telephone or in person. A statement can be taken of your concern which can be recorded for you to verify and sign.

12.1 How to raise a concern internally

Staff should raise any concern internally using one of the options listed below:

➤ Option 1

Managers have a vital role to play in ensuring that you and your colleagues are able to make constructive contributions and to feel that your ideas are welcomed, appreciated and where appropriate, acted upon in a positive manner.

You are therefore encouraged in the first instance to raise concerns with your line manager. You may wish to involve a Trade Union representative or colleague to advise or assist you. As soon as you have a concern, you should make an immediate note of it. You should write down all the relevant details – what was said or done, date, time, names etc.

➤ Option 2

If, for any reason, you feel unable to raise the concern with your line manager, please raise the matter with another senior person you can trust. This might be another manager or a Senior HR representative and again you may wish to involve a Trade Union representative or colleague.

➤ Option 3

If you feel that the concern is so serious that it cannot be discussed with any of the above you can contact:-

- | | | |
|---|---|--|
| ➤ Director of Human Resources & OD | direct line | Personal Information redacted by the USI |
| ➤ Chief Executive | direct line | Personal Information redacted by the USI |
| ➤ Non –Executive Director
(See Appendix 2 for names) | contacted through the Chair's office
direct line | Personal Information redacted by the USI |

The contact address for any of the above is: -

Southern HSC Trust Headquarters, Craigavon Area Hospital, Lurgan Road, PORTADOWN, BT63 5QQ

12.2 Response required from internal managers / Director to whom concerns are reported

Stage 1

ALL whistleblowing concerns MUST be notified by internal managers to the Director of Human Resources & Organisational Development for logging and investigation. The Director of Human Resources & Organisational Development will ensure that the Head of Employee Engagement & Relations is notified of the concern to ensure support can be provided to the employee.

The manager / Director should be clear on the range of other Trust policies and procedures in the event that the concern raised might be more appropriately dealt with under another policy / procedure e.g. Grievance Procedure, Working Well Together Procedure, Maintaining High Professional Standards (Medical & Dental staff). Advice from Employee Engagement & Relations may help to clarify this at any early stage.

Any internal manager / Director to whom a concern is raised must then arrange to meet with the employee to discuss the concern without delay along with a representative from the Employee Engagement & Relations team.

The manager / Director and HR representative should establish the background and history of the concerns, including names, dates, places, where possible, along with any other relevant information. The manager should also explore the reason why the employee is particularly concerned about the matter.

A record should be made of all discussions at this stage by the manager and Employee Engagement & Relations.

It may be necessary with anonymous allegations to consider whether it is possible, based on limited information provided in the complaint, to take any further action. Where it is

decided that further action cannot be justified, the reasons for this decision should be documented and retained by the Employee Engagement & Relations Department.

Stage 2

Once the preliminary facts / issues of concern have been established, the approach to investigating the concern must be discussed and agreed. A record should be made of the decisions and/or agreed actions which should be signed and dated.

Stage 3

Within 10 working days of the concern being received, the manager receiving the concern must write to the employee:

- Acknowledging that the concern has been received;
- Indicating how the matter will be dealt with;
- Providing an estimate as to how long it will take to provide a final response; and/or
- Telling the employee whether any initial enquiries have been made; and
- Telling the employee whether further investigations will take place and if not why not; and /or
- Letting the employee know when s/he will receive further details if the situation is not yet resolved; and
- Providing the employee with details of whom to contact should s/he be dissatisfied with this response (see 10.4 below)

Advice from Employee Engagement & Relations should be sought when drafting the letter of response.

11.3 How to raise a concern externally

If you are unable to raise the matter internally as outlined above in Options 1 to 3, or if you feel it has not been dealt with properly, we would rather you raise it with an appropriate external agency, detailed in Option 4 below, than not at all.

➤ **Option 4.**

Provided that you are acting in good faith and have evidence to back up the concern, your concern may also be raised with: -

- Relevant Professional / Regulatory Bodies (e.g. Nursing & Midwifery Council, General Medical Council, Northern Ireland Social Care Council, Health Care Professions Council etc.)
- Statutory Bodies (e.g., Mental Health Commission, Regulation & Quality Improvement Authority (RQIA))
- The Health and Safety Executive for N. Ireland
- Department of Health, Social Services and Public Safety.

Contact addresses and telephone numbers are included in Appendix 1.

11.4 If You Remain Dissatisfied

If you are unhappy with the response you receive when you use this procedure, remember you can go to the other levels and bodies detailed in Section 10.3. While we cannot guarantee that we will always respond to all matters in the manner you might wish, we will do our best to handle the matter fairly and properly. By using this procedure, you will help us to achieve this.

12.0 SOURCES OF INDEPENDENT ADVICE AND FURTHER INFORMATION

You may also wish to access independent advice for example,

- A Trust JNCF Trade Union representative or any other recognised Trade Union official;

or

- The independent charity *Public Concern at Work*
 - telephone 0207 404 6609 where lawyers can give free confidential advice at any stage about how to raise a serious concern.

Northern Ireland Social Care Council

7th Floor Millennium House
Great Victoria Street
BELFAST
BT2 7AQ

Irrelevant information
redacted by the USI

Nursing & Midwifery Council

23 Portland Place
LONDON
W1B 1PZ

Irrelevant information
redacted by the USI

Regulation & Quality Improvement Authority (RQIA)

9th Floor Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Irrelevant information
redacted by the USI

General Medical Council

20 Adelaide Street
BELFAST
BT2 8GD

Irrelevant information
redacted by the USI

Health Professions Council

184 Kennington Park Road
LONDON
SE11 4BU

Irrelevant information
redacted by the USI

Department of Health, Social Services & Public Safety (DHSSPSNI)

Castle Buildings
Stormont
BELFAST
BT4 3SJ

Health & Safety Executive for Northern Ireland

83 Ladas Drive
BELFAST
BT6 9FR

Irrelevant information redacted by the USI

Mental Health Commission for Northern Ireland

4th Floor – Lombard House
10-20 Lombard Street
BELFAST
BT1 1RD

DHSSPS Fraud Hotline

Irrelevant information redacted by
the USI

List of Non-Executive Directors with whom a concern can be raised

Mrs Deirdre Blakely

Mr Edwin Graham

Mrs Siobhan Rooney

Mrs Hester Kelly

Mrs Elizabeth Mahood

Mr Raymond Mullan

Mr Roger Alexander

Contact can be made with any of the above Non-Executive Directors through the Office of the Chair on Irrelevant information redacted by the USI **.**

The Code

Professional standards of practice
and behaviour for nurses, midwives
and nursing associates

prioritise people

practise effectively

preserve safety

promote professionalism and trust

About us

The Nursing and Midwifery Council exists to protect the public. We do this by making sure that only those who meet our requirements are allowed to practise as a nurse or midwife in the UK, or a nursing associate in England. We take action if concerns are raised about whether a nurse, midwife or nursing associate is fit to practise.

It is against the law to claim to be, or to practise as, a nurse or midwife in the UK, or as a nursing associate in England, if you are not on the relevant part of our register.

It is also a criminal offence for anyone who, with intent to deceive, causes or permits someone else to falsely represent them as being on the register, or makes a false representation about them being on the NMC register.

Publication date: 29 January 2015

Effective from: 31 March 2015

Updated to reflect the regulation of nursing associates:
10 October 2018

A note on this version of the Code

All regulators review their Codes from time to time to make sure they continue to reflect public expectations. This new version of the Code is substantially similar to the 2015 version, but it has been updated to reflect our new responsibilities for the regulation of nursing associates. In joining the register, nursing associates will uphold the Code.

The current versions of our Code, standards and guidance can always be found on our website. Those on our register should make sure they are using the most up to date version of the Code.

For more information about the Code, please visit:

www.nmc.org.uk/code

Introduction

The Code contains the professional standards that registered nurses, midwives and nursing associates¹ must uphold. Nurses, midwives and nursing associates must act in line with the Code, whether they are providing direct care to individuals, groups or communities or bringing their professional knowledge to bear on nursing² and midwifery practice in other roles, such as leadership, education, or research. The values and principles set out in the Code can be applied in a range of different practice settings, but they are not negotiable or discretionary.

Our role is to set the standards in the Code, but these are not just our standards. They are the standards that patients and members of the public tell us they expect from health professionals. They are the standards shown every day by those on our register.

When joining our register, and then renewing their registration, nurses, midwives and nursing associates commit to upholding these standards. This commitment to professional standards is fundamental to being part of a profession. We can take action if those on our register fail to uphold the Code. In serious cases, this can include removing them from the register.

-
1. *Anyone practising as a registered nurse or midwife in the UK, or a nursing associate in England, has to be registered with us. The nursing associate role is being used only in England.*
 2. *We have used the word 'nursing' in this document to apply to the work of nurses and nursing associates. Nursing associates are a distinct profession with their own part of our register, but they are part of the nursing team.*
-

The Code sets out common standards of conduct and behaviour for those on our register. This provides a clear, consistent and positive message to patients, service users and colleagues about what they can expect of those who provide nursing or midwifery care.

The professions we regulate have different knowledge and skills, set out in three distinct standards of proficiency. They can work in diverse contexts and have different levels of autonomy and responsibility. However, all of the professions we regulate exercise professional judgement and are accountable for their work.

Nurses, midwives and nursing associates uphold the Code within the limits of their competence. This means, for example, that while a nurse and nursing associate will play different roles in an aspect of care, they will both uphold the standards in the Code within the contribution they make to overall care. The professional commitment to work within one's competence is a key underpinning principle of the Code (see section 13) which, given the significance of its impact on public protection, should be upheld at all times.

In addition, nurses, midwives and nursing associates are expected to work within the limits of their competence, which may extend beyond the standards they demonstrated in order to join the register.

The Code should be useful for everyone who cares about good nursing and midwifery.

- Patients and service users, and those who care for them, can use it to provide feedback to nurses, midwives and nursing associates about the care they receive.
- Those on our register can use it to promote safe and effective practice in their place of work.
- Employer organisations should support their staff in upholding the standards in their professional Code as part of providing the quality and safety expected by service users and regulators.
- Educators can use the Code to help students understand what it means to be a registered professional and how keeping to the Code helps to achieve that.

For the many committed and expert practitioners on our register, this Code should be seen as a way of reinforcing professionalism. Through revalidation, nurses, midwives and nursing associates provide evidence of their continued ability to practise safely and effectively. The Code is central to the revalidation process as a focus for professional reflection. This gives the Code significance in the professional life of those on our register, and raises its status and importance for employers.

The Code contains a series of statements that taken together signify what good practice by nurses, midwives and nursing associates looks like. It puts the interests of patients and service users first, is safe and effective, and promotes trust through professionalism.

Prioritise people

You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

- 1.1 treat people with kindness, respect and compassion
- 1.2 make sure you deliver the fundamentals of care effectively
- 1.3 avoid making assumptions and recognise diversity and individual choice
- 1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay
- 1.5 respect and uphold people's human rights

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

- 2.1 work in partnership with people to make sure you deliver care effectively
- 2.2 recognise and respect the contribution that people can make to their own health and wellbeing

The fundamentals of care include, but are not limited to, nutrition, hydration, bladder and bowel care, physical handling and making sure that those receiving care are kept in clean and hygienic conditions. It includes making sure that those receiving care have adequate access to nutrition and hydration, and making sure that you provide help to those who are not able to feed themselves or drink fluid unaided.

- 2.3 encourage and empower people to share in decisions about their treatment and care
- 2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care
- 2.5 respect, support and document a person's right to accept or refuse care and treatment
- 2.6 recognise when people are anxious or in distress and respond compassionately and politely

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

- 3.1 pay special attention to promoting wellbeing, preventing ill-health and meeting the changing health and care needs of people during all life stages
- 3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life
- 3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it
- 3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

4 Act in the best interests of people at all times

To achieve this, you must:

- 4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment
- 4.2 make sure that you get properly informed consent and document it before carrying out any action

- 4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process
- 4.4 tell colleagues, your manager and the person receiving care if you have a conscientious objection to a particular procedure and arrange for a suitably qualified colleague to take over responsibility for that person's care

5 Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you must:

- 5.1 respect a person's right to privacy in all aspects of their care
- 5.2 make sure that people are informed about how and why information is used and shared by those who will be providing care
- 5.3 respect that a person's right to privacy and confidentiality continues after they have died
- 5.4 share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality
- 5.5 share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand

You can only make a 'conscientious objection' in limited circumstances. For more information, please visit our website at www.nmc.org.uk/standards.

Practise effectively

You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay, to the best of your abilities, on the basis of best available evidence. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.

6 Always practise in line with the best available evidence

To achieve this, you must:

- 6.1 make sure that any information or advice given is evidence-based including information relating to using any health and care products or services
- 6.2 maintain the knowledge and skills you need for safe and effective practice

7 Communicate clearly

To achieve this, you must:

- 7.1 use terms that people in your care, colleagues and the public can understand
- 7.2 take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs
- 7.3 use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs
- 7.4 check people's understanding from time to time to keep misunderstanding or mistakes to a minimum
- 7.5 be able to communicate clearly and effectively in English

8 Work co-operatively

To achieve this, you must:

- 8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate
- 8.2 maintain effective communication with colleagues
- 8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff
- 8.4 work with colleagues to evaluate the quality of your work and that of the team
- 8.5 work with colleagues to preserve the safety of those receiving care
- 8.6 share information to identify and reduce risk
- 8.7 be supportive of colleagues who are encountering health or performance problems. However, this support must never compromise or be at the expense of patient or public safety

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

- 9.1 provide honest, accurate and constructive feedback to colleagues
- 9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance
- 9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times
- 9.4 support students' and colleagues' learning to help them develop their professional competence and confidence

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

- 10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event
- 10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
- 10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements
- 10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation
- 10.5 take all steps to make sure that records are kept securely
- 10.6 collect, treat and store all data and research findings appropriately

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

- 11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions
- 11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care
- 11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

12 Have in place an indemnity arrangement which provides appropriate cover for any practice you take on as a nurse, midwife or nursing associate in the United Kingdom

To achieve this, you must:

- 12.1 make sure that you have an appropriate indemnity arrangement in place relevant to your scope of practice

For more information, please visit our website at www.nmc.org.uk/indemnity.

Preserve safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

- 13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care
- 13.2 make a timely referral to another practitioner when any action, care or treatment is required
- 13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence
- 13.4 take account of your own personal safety as well as the safety of people in your care
- 13.5 complete the necessary training before carrying out a new role

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

- 14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm.

- 14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers
- 14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

- 15.1 only act in an emergency within the limits of your knowledge and competence
- 15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly
- 15.3 take account of your own safety, the safety of others and the availability of other options for providing care

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

- 16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices
- 16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

The professional duty of candour is about openness and honesty when things go wrong. "Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress." Joint statement from the Chief Executives of statutory regulators of healthcare professionals

- 16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can
- 16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so
- 16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern
- 16.6 protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised

For more information, please visit our website at www.nmc.org.uk/raisingconcerns.

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

- 17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse
- 17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information
- 17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

- 18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs
- 18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs
- 18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines
- 18.4 take all steps to keep medicines stored securely
- 18.5 wherever possible, avoid prescribing for yourself or for anyone with whom you have a close personal relationship

Prescribing is not within the scope of practice of everyone on our register. Nursing associates don't prescribe, but they may supply, dispense and administer medicines. Nurses and midwives who have successfully completed a further qualification in prescribing and recorded it on our register are the only people on our register that can prescribe.

For more information, please visit our website at www.nmc.org.uk/standards.

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

- 19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place
- 19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)
- 19.3 keep to and promote recommended practice in relation to controlling and preventing infection
- 19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

Human factors refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety – Health and Safety Executive. You can find more information at www.hse.gov.uk.

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

- 20.1 keep to and uphold the standards and values set out in the Code
- 20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment
- 20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
- 20.4 keep to the laws of the country in which you are practising
- 20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress
- 20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers
- 20.7 make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way

- 20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to
- 20.9 maintain the level of health you need to carry out your professional role
- 20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times

For more guidance on using social media and networking sites, please visit our website at www.nmc.org.uk/standards.

21 Uphold your position as a registered nurse, midwife or nursing associate

To achieve this, you must:

- 21.1 refuse all but the most trivial gifts, favours or hospitality as accepting them could be interpreted as an attempt to gain preferential treatment
- 21.2 never ask for or accept loans from anyone in your care or anyone close to them
- 21.3 act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care
- 21.4 make sure that any advertisements, publications or published material you produce or have produced for your professional services are accurate, responsible, ethical, do not mislead or exploit vulnerabilities and accurately reflect your relevant skills, experience and qualifications
- 21.5 never use your status as a registered professional to promote causes that are not related to health
- 21.6 cooperate with the media only when it is appropriate to do so, and then always protecting the confidentiality and dignity of people receiving treatment or care

22 Fulfil all registration requirements

To achieve this, you must:

- 22.1 keep to any reasonable requests so we can oversee the registration process
- 22.2 keep to our prescribed hours of practice and carry out continuing professional development activities
- 22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance

For more information, please visit our website at

www.nmc.org.uk/standards.

23 Cooperate with all investigations and audits

This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register.

To achieve this, you must:

- 23.1 cooperate with any audits of training records, registration records or other relevant audits that we may want to carry out to make sure you are still fit to practise
- 23.2 tell both us and any employers as soon as you can about any caution or charge against you, or if you have received a conditional discharge in relation to, or have been found guilty of, a criminal offence (other than a protected caution or conviction)
- 23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body.

- 23.4 tell us and your employers at the first reasonable opportunity if you are or have been disciplined by any regulatory or licensing organisation, including those who operate outside of the professional health and care environment
- 23.5 give your NMC Pin when any reasonable request for it is made

For more information, please visit our website at www.nmc.org.uk.

24 Respond to any complaints made against you professionally

To achieve this, you must:

- 24.1 never allow someone's complaint to affect the care that is provided to them
- 24.2 use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice

When telling your employers, this includes telling (i) any person, body or organisation you are employed by, or intend to be employed by, as a nurse, midwife or nursing associate; and (ii) any person, body or organisation with whom you have an arrangement to provide services as a nurse, midwife or nursing associate.

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

- 25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first
- 25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken

Throughout their career, all our registrants will have opportunities to demonstrate leadership qualities, regardless of whether or not they occupy formal leadership positions.

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www.nmc.org.uk

The nursing and midwifery regulator for England,
Wales, Scotland and Northern Ireland

Registered charity in England and Wales (1091434)
and in Scotland (SC038362)



Quality Care - for you, with you



Department of
Health

An Roinn Sláinte

Mánnystrie O Poustie

www.health-ni.gov.uk

CODE OF CONDUCT FOR HSC EMPLOYEES



SEPTEMBER 2016

HSC Code of Conduct for Employees

This Code of Conduct is about the values for which we, as HSC staff, stand. The Code sets out the core standards of conduct expected of all HSC Staff. It has been written to complement existing professional codes of practice.

Professional staff are expected to follow the code of conduct for their own professions as well as this code.

The code aims:

- To guide staff, managers and employers in the work that they do and the decisions and choices they have to make; and
- To reassure the public that these important decisions are being made against a background of professional standards and accountability.

Adherence to the Code is mandatory for all employees, regardless of their status and breaches of the Code will be regarded as serious.

HSC staff are highly principled and value-driven people who will welcome this Code and exemplify the expected behaviours. All staff within HSC are responsible for, and have a duty of care, to ensure their conduct does not fall below the standards detailed in this Code and that no act or omission, within the sphere of their role, harms the safety and well-being of patients/clients and service users and their families. The Code is a set of values which should inform development programmes and training for all staff. It should make us all think exactly how we are going to work, how we make the care and safety of patients our first concern and how we respect the public, patients, clients, service users relatives and carers. If, however, the conduct and behaviours of staff falls short of the public's expectations this reflects poorly on the HSC as seriously as failures by clinical and care staff.

Breaches of the Code must be investigated fairly and employers should adopt a proportionate approach. Just as the Code sets out how all staff should behave and their responsibilities, you also have rights. You have the right to be treated with respect, evaluated consistently and fairly, encouraged to maintain and improve your knowledge and skills and to be helped to balance your work and home lives properly. HSC Employers must provide and promote an organisational culture which values and supports staff and teams.

This Code of Conduct applies to **all** HSC Staff, across all HSC Trusts and HSC Arms Length Bodies. This code incorporates the principles contained within the Code of Conduct for HPSS Managers 2003 and supersedes it.

This Code is also consistent with the 7 principles of public life, ('the Nolan Principles') which applies to everyone working as a public office-holder and therefore should govern the conduct of all health and social care staff.¹

¹ <https://www.gov.uk/government/publications/the-7-principles-of-public-life>

1. INTRODUCTION

This Code of Conduct (the Code) sets out the standards of conduct expected of all staff in the Southern Health and Social Care Trust.

It presents the standards of conduct and behaviours required of all staff and informs employers, colleagues, patients/clients service users and the public about these.

The Code refers to “employees”, however, for the purposes of this document, this definition also applies to all workers (Agency & Bank), volunteers and work placements.

Adherence to the Code is an integral part of employees’ contractual responsibilities during their employment with the Southern HSC Trust.

- The behaviour of employees should reflect the organisation’s mission and values at all times.
- Employees must not use their privileged position to neglect, harm, abuse or exploit patients/clients/service users or their families.
- Employees should familiarise themselves with the contents of the Code and should act in accordance with the principles set out in it.

1.1 Overall principles & undertakings

As an HSC employee, I will observe the following principles:

- make the **care and safety of patients and clients** my first concern and act to protect them from risk;
- contribute to improving and protecting the health of the population as appropriate to my role;
- maintain **confidentiality**, respecting and protecting, at all times patients/clients, service users and their families’ right to confidentiality, privacy and dignity;
- **communicate openly and honestly** to promote the health and well-being of patients/clients, service users and their families.

- **respect** the public, patients, clients, relatives, carers, HSC employees and teams and partners in other agencies. I will also **show my commitment** to working constructively as a team member by working collaboratively with all my colleagues in the HSC and the wider community;
- **be accountable** and accept **responsibility** for my own work and be **honest and act with integrity**;
- sharing **responsibility for my own learning and development** in order to improve the quality of care to patients/ clients/service users and their families

Managers' Responsibilities

I will also endeavour to ensure that;

- HSC staff in my team are:
 - valued as individuals, colleagues and are treated with dignity and respect;
 - appropriately informed about the management of the HSC;
 - given appropriate opportunities to take part in continuous design, review and improvement of services;
 - have their ideas and realistic ambitions taken seriously;
 - given protection from harassment and bullying;
 - provided with a safe working environment;
 - helped to maintain and improve their knowledge and skills and developed to achieve their potential; and
 - helped to achieve a reasonable balance between their working and personal lives.

These principles are described in more detail in *Section 2* below.

2. DESCRIPTION OF PRINCIPLES

2.1 Care & safety of patients & clients

I will;

- use the resources available to me in an effective, efficient and timely manner having proper regard to the best interests of the public, patients and clients;
- be guided by the interests of patients and clients;
- ensure a safe working environment;
- act to protect patients and clients from risk by adhering to relevant legislation and putting into practice appropriate policies and procedures;
- work collaboratively with colleagues across all disciplines to support person-centred care/services.

2.2 Confidentiality

I will;

- respect patient, client and staff confidentiality;
- not, except in the performance my job role and duties with the organisation, divulge to any person in any manner whatsoever, any confidential information covering the business or transactions of the organisation and its activities and/or its patients, clients or employees², unless ordered to do so by a Court or Tribunal. I will make every effort to prevent disclosure of such information. I will not use social media to share information about the environment I work in or the patients/clients/service users for whom I care.
- comply with all relevant organisation policies in relation to the use of information associated with my role and in particular with reference to the personal use of social networking sites³.

²[Code of Practice on Protecting the Confidentiality of Service User Information](#)

³[Social Media Policy](#)

- comply with my obligations under the Data Protection Act (1998) and Freedom of Information Act (2000) through the Organisation's information governance training.⁴

2.3 Respect for others & working as a team

I will;

- respect and treat with dignity and fairness, the public, patients and clients, relatives, carers, HSC employees and partners in other agencies. I will not unlawfully discriminate against, victimise or harass against anyone on grounds of their gender, marital/civil partnership status, sexual orientation, community background, political opinion, religious belief, race, age disability, family status, whether or not they have dependents or are persons who have undergone, are undergoing or intend to undergo gender reassignment.
- seek to ensure that anyone with a genuine concern is treated reasonably and fairly
- show my commitment to working as part of the department and Organisation team

I will show my commitment to team working by working constructively with all my colleagues across the HSC and in the wider community, contributing to an environment in which:

- teams of staff are able to work together in the best interests of service users; and
- leadership is encouraged and developed at all levels and in all staff groups

2.4 Accountability, Responsibility, Honesty & Integrity

I will;

- establish and maintain clear and appropriate boundaries at all times in my relationships with patients/clients/service users and their families, and with colleagues, always behaving in a professional manner;

⁴ [Data Protection Policy](#)

- accept responsibility for my own work and ensure that I am responsible for answering any questions and complaints in an open, honest way.
- be honest and act with integrity and probity at all times and ensure that HSC resources are protected from fraud, bribery and other forms of corruption⁵
- not use my official position to receive, agree to accept or attempt to obtain any financial or other advantage for doing, or not doing, anything or showing favour, or disfavour, to any person⁶.
- not receive benefits of any kind from a third party which might reasonably be seen to compromise my personal judgment and integrity.
- not deceive or mislead my employer, or any other organisation it deals with, or the public during the course of my employment with the HSC.
- abide by the rules adopted by my employer in relation to private interest and possible conflict with public duty, the disclosure of official information and in any political activities.
- not misuse my official position or information acquired in my official duties to further my private interests or those of others.

I will ensure proper management of the performance of my team and I will seek to ensure that those I manage accept that they are responsible for their actions to both;

- the public and their representatives; and
- service users, relatives and carers by answering questions and complaints in an open and honest manner.

I will also;

- accept responsibility for the management of the performance of the people I manage;
- seek to ensure that judgements about colleagues (including appraisals and references) are consistent, fair and unbiased and include all information which

⁵ [Fraud Policy](#)

⁶ [Gifts, Hospitality & Sponsorship Policy](#), [Conflicts of Interest Policy](#), [Fraud Policy](#), [Bribery Policy](#)

affects a colleague's performance, eligibility for advancement/reward and conduct; and

- play my part in making sure that no-one is unlawfully discriminated against and that policies on equality, diversity and human rights are promoted and adhered to at all times.

2.6. Responsibility for my own learning and development

I will seek to;

- Participate in training and personal development required by my employer and take responsibility for the achievement of the competence essential for your role, in line with KSF and organisational requirements
- Keep up to date with best practice and maintain an up-to-date record of your own learning and development
- Share my learning as appropriate and contribute to the learning and development of others

3. Employee concerns about improper conduct

If you believe you are being required to act in a way which:

- is illegal, improper, or unethical;
- is in breach of a professional code;
- may involve possible maladministration, fraud or misuse of public funds; or
- is otherwise inconsistent with this Code

you should either raise the matter through your line management or alternatively, approach in confidence, a nominated officer under the Trust's Whistleblowing Policy⁷.

You should make yourself aware of the provisions of the Trust's Whistleblowing Policy.

The Chief Executive, who is the designated accounting officer for the Trust, has overall responsibility for propriety in a broad sense, including conduct and discipline.

⁷ [Whistleblowing Policy](#)

I will;

- act to protect service users from harm, injury or loss by identifying and reducing risk by putting into practice the appropriate support, supervisory and disciplinary procedures for staff;
- seek to ensure that anyone with a concern is taken seriously and treated fairly in accordance with relevant procedures; and
- contribute to the creation of an open and learning organisation where concerns about individuals perceived to be breaking the Code of Conduct can be raised without fear

4. AFTER LEAVING EMPLOYMENT

You should continue to observe your duty of confidentiality after you have left your employment with the HSC.

The Code

Professional standards of practice
and behaviour for nurses, midwives
and nursing associates

prioritise people

practise effectively

preserve safety

promote professionalism and trust

About us

The Nursing and Midwifery Council exists to protect the public. We do this by making sure that only those who meet our requirements are allowed to practise as a nurse or midwife in the UK, or a nursing associate in England. We take action if concerns are raised about whether a nurse, midwife or nursing associate is fit to practise.

It is against the law to claim to be, or to practise as, a nurse or midwife in the UK, or as a nursing associate in England, if you are not on the relevant part of our register.

It is also a criminal offence for anyone who, with intent to deceive, causes or permits someone else to falsely represent them as being on the register, or makes a false representation about them being on the NMC register.

Publication date: 29 January 2015

Effective from: 31 March 2015

Updated to reflect the regulation of nursing associates:
10 October 2018

A note on this version of the Code

All regulators review their Codes from time to time to make sure they continue to reflect public expectations. This new version of the Code is substantially similar to the 2015 version, but it has been updated to reflect our new responsibilities for the regulation of nursing associates. In joining the register, nursing associates will uphold the Code.

The current versions of our Code, standards and guidance can always be found on our website. Those on our register should make sure they are using the most up to date version of the Code.

For more information about the Code, please visit:

www.nmc.org.uk/code

Introduction

The Code contains the professional standards that registered nurses, midwives and nursing associates¹ must uphold. Nurses, midwives and nursing associates must act in line with the Code, whether they are providing direct care to individuals, groups or communities or bringing their professional knowledge to bear on nursing² and midwifery practice in other roles, such as leadership, education, or research. The values and principles set out in the Code can be applied in a range of different practice settings, but they are not negotiable or discretionary.

Our role is to set the standards in the Code, but these are not just our standards. They are the standards that patients and members of the public tell us they expect from health professionals. They are the standards shown every day by those on our register.

When joining our register, and then renewing their registration, nurses, midwives and nursing associates commit to upholding these standards. This commitment to professional standards is fundamental to being part of a profession. We can take action if those on our register fail to uphold the Code. In serious cases, this can include removing them from the register.

-
1. *Anyone practising as a registered nurse or midwife in the UK, or a nursing associate in England, has to be registered with us. The nursing associate role is being used only in England.*
 2. *We have used the word 'nursing' in this document to apply to the work of nurses and nursing associates. Nursing associates are a distinct profession with their own part of our register, but they are part of the nursing team.*
-

The Code sets out common standards of conduct and behaviour for those on our register. This provides a clear, consistent and positive message to patients, service users and colleagues about what they can expect of those who provide nursing or midwifery care.

The professions we regulate have different knowledge and skills, set out in three distinct standards of proficiency. They can work in diverse contexts and have different levels of autonomy and responsibility. However, all of the professions we regulate exercise professional judgement and are accountable for their work.

Nurses, midwives and nursing associates uphold the Code within the limits of their competence. This means, for example, that while a nurse and nursing associate will play different roles in an aspect of care, they will both uphold the standards in the Code within the contribution they make to overall care. The professional commitment to work within one's competence is a key underpinning principle of the Code (see section 13) which, given the significance of its impact on public protection, should be upheld at all times.

In addition, nurses, midwives and nursing associates are expected to work within the limits of their competence, which may extend beyond the standards they demonstrated in order to join the register.

The Code should be useful for everyone who cares about good nursing and midwifery.

- Patients and service users, and those who care for them, can use it to provide feedback to nurses, midwives and nursing associates about the care they receive.
- Those on our register can use it to promote safe and effective practice in their place of work.
- Employer organisations should support their staff in upholding the standards in their professional Code as part of providing the quality and safety expected by service users and regulators.
- Educators can use the Code to help students understand what it means to be a registered professional and how keeping to the Code helps to achieve that.

For the many committed and expert practitioners on our register, this Code should be seen as a way of reinforcing professionalism. Through revalidation, nurses, midwives and nursing associates provide evidence of their continued ability to practise safely and effectively. The Code is central to the revalidation process as a focus for professional reflection. This gives the Code significance in the professional life of those on our register, and raises its status and importance for employers.

The Code contains a series of statements that taken together signify what good practice by nurses, midwives and nursing associates looks like. It puts the interests of patients and service users first, is safe and effective, and promotes trust through professionalism.

Prioritise people

You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

- 1.1 treat people with kindness, respect and compassion
- 1.2 make sure you deliver the fundamentals of care effectively
- 1.3 avoid making assumptions and recognise diversity and individual choice
- 1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay
- 1.5 respect and uphold people's human rights

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

- 2.1 work in partnership with people to make sure you deliver care effectively
- 2.2 recognise and respect the contribution that people can make to their own health and wellbeing

The fundamentals of care include, but are not limited to, nutrition, hydration, bladder and bowel care, physical handling and making sure that those receiving care are kept in clean and hygienic conditions. It includes making sure that those receiving care have adequate access to nutrition and hydration, and making sure that you provide help to those who are not able to feed themselves or drink fluid unaided.

- 2.3 encourage and empower people to share in decisions about their treatment and care
- 2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care
- 2.5 respect, support and document a person's right to accept or refuse care and treatment
- 2.6 recognise when people are anxious or in distress and respond compassionately and politely

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

- 3.1 pay special attention to promoting wellbeing, preventing ill-health and meeting the changing health and care needs of people during all life stages
- 3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life
- 3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it
- 3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

4 Act in the best interests of people at all times

To achieve this, you must:

- 4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment
- 4.2 make sure that you get properly informed consent and document it before carrying out any action

- 4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process
- 4.4 tell colleagues, your manager and the person receiving care if you have a conscientious objection to a particular procedure and arrange for a suitably qualified colleague to take over responsibility for that person's care

5 Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you must:

- 5.1 respect a person's right to privacy in all aspects of their care
- 5.2 make sure that people are informed about how and why information is used and shared by those who will be providing care
- 5.3 respect that a person's right to privacy and confidentiality continues after they have died
- 5.4 share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality
- 5.5 share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand

You can only make a 'conscientious objection' in limited circumstances. For more information, please visit our website at www.nmc.org.uk/standards.

Practise effectively

You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay, to the best of your abilities, on the basis of best available evidence. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.

6 Always practise in line with the best available evidence

To achieve this, you must:

- 6.1 make sure that any information or advice given is evidence-based including information relating to using any health and care products or services
- 6.2 maintain the knowledge and skills you need for safe and effective practice

7 Communicate clearly

To achieve this, you must:

- 7.1 use terms that people in your care, colleagues and the public can understand
- 7.2 take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs
- 7.3 use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs
- 7.4 check people's understanding from time to time to keep misunderstanding or mistakes to a minimum
- 7.5 be able to communicate clearly and effectively in English

8 Work co-operatively

To achieve this, you must:

- 8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate
- 8.2 maintain effective communication with colleagues
- 8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff
- 8.4 work with colleagues to evaluate the quality of your work and that of the team
- 8.5 work with colleagues to preserve the safety of those receiving care
- 8.6 share information to identify and reduce risk
- 8.7 be supportive of colleagues who are encountering health or performance problems. However, this support must never compromise or be at the expense of patient or public safety

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

- 9.1 provide honest, accurate and constructive feedback to colleagues
- 9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance
- 9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times
- 9.4 support students' and colleagues' learning to help them develop their professional competence and confidence

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

- 10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event
- 10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
- 10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements
- 10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation
- 10.5 take all steps to make sure that records are kept securely
- 10.6 collect, treat and store all data and research findings appropriately

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

- 11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions
- 11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care
- 11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

12 Have in place an indemnity arrangement which provides appropriate cover for any practice you take on as a nurse, midwife or nursing associate in the United Kingdom

To achieve this, you must:

- 12.1 make sure that you have an appropriate indemnity arrangement in place relevant to your scope of practice

For more information, please visit our website at www.nmc.org.uk/indemnity.

Preserve safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

- 13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care
- 13.2 make a timely referral to another practitioner when any action, care or treatment is required
- 13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence
- 13.4 take account of your own personal safety as well as the safety of people in your care
- 13.5 complete the necessary training before carrying out a new role

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

- 14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm.

- 14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers
- 14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

- 15.1 only act in an emergency within the limits of your knowledge and competence
- 15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly
- 15.3 take account of your own safety, the safety of others and the availability of other options for providing care

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

- 16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices
- 16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

The professional duty of candour is about openness and honesty when things go wrong. "Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress." Joint statement from the Chief Executives of statutory regulators of healthcare professionals

- 16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can
- 16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so
- 16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern
- 16.6 protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised

For more information, please visit our website at www.nmc.org.uk/raisingconcerns.

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

- 17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse
- 17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information
- 17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

- 18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs
- 18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs
- 18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines
- 18.4 take all steps to keep medicines stored securely
- 18.5 wherever possible, avoid prescribing for yourself or for anyone with whom you have a close personal relationship

Prescribing is not within the scope of practice of everyone on our register. Nursing associates don't prescribe, but they may supply, dispense and administer medicines. Nurses and midwives who have successfully completed a further qualification in prescribing and recorded it on our register are the only people on our register that can prescribe.

For more information, please visit our website at www.nmc.org.uk/standards.

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

- 19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place
- 19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)
- 19.3 keep to and promote recommended practice in relation to controlling and preventing infection
- 19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

Human factors refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety – Health and Safety Executive. You can find more information at www.hse.gov.uk.

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

- 20.1 keep to and uphold the standards and values set out in the Code
- 20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment
- 20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
- 20.4 keep to the laws of the country in which you are practising
- 20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress
- 20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers
- 20.7 make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way

- 20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to
- 20.9 maintain the level of health you need to carry out your professional role
- 20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times

For more guidance on using social media and networking sites, please visit our website at www.nmc.org.uk/standards.

21 Uphold your position as a registered nurse, midwife or nursing associate

To achieve this, you must:

- 21.1 refuse all but the most trivial gifts, favours or hospitality as accepting them could be interpreted as an attempt to gain preferential treatment
- 21.2 never ask for or accept loans from anyone in your care or anyone close to them
- 21.3 act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care
- 21.4 make sure that any advertisements, publications or published material you produce or have produced for your professional services are accurate, responsible, ethical, do not mislead or exploit vulnerabilities and accurately reflect your relevant skills, experience and qualifications
- 21.5 never use your status as a registered professional to promote causes that are not related to health
- 21.6 cooperate with the media only when it is appropriate to do so, and then always protecting the confidentiality and dignity of people receiving treatment or care

22 Fulfil all registration requirements

To achieve this, you must:

- 22.1 keep to any reasonable requests so we can oversee the registration process
- 22.2 keep to our prescribed hours of practice and carry out continuing professional development activities
- 22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance

For more information, please visit our website at

www.nmc.org.uk/standards.

23 Cooperate with all investigations and audits

This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register.

To achieve this, you must:

- 23.1 cooperate with any audits of training records, registration records or other relevant audits that we may want to carry out to make sure you are still fit to practise
- 23.2 tell both us and any employers as soon as you can about any caution or charge against you, or if you have received a conditional discharge in relation to, or have been found guilty of, a criminal offence (other than a protected caution or conviction)
- 23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body.

- 23.4 tell us and your employers at the first reasonable opportunity if you are or have been disciplined by any regulatory or licensing organisation, including those who operate outside of the professional health and care environment
- 23.5 give your NMC Pin when any reasonable request for it is made

For more information, please visit our website at www.nmc.org.uk.

24 Respond to any complaints made against you professionally

To achieve this, you must:

- 24.1 never allow someone's complaint to affect the care that is provided to them
- 24.2 use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice

When telling your employers, this includes telling (i) any person, body or organisation you are employed by, or intend to be employed by, as a nurse, midwife or nursing associate; and (ii) any person, body or organisation with whom you have an arrangement to provide services as a nurse, midwife or nursing associate.

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

- 25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first
- 25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken

Throughout their career, all our registrants will have opportunities to demonstrate leadership qualities, regardless of whether or not they occupy formal leadership positions.

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The nursing and midwifery regulator for England,
Wales, Scotland and Northern Ireland

Registered charity in England and Wales (1091434)
and in Scotland (SC038362)

Policy Checklist

Name of Policy:	Nursing Supervision Policy
Purpose of Policy:	To ensure that a culture of Nursing Supervision is embedded in the Southern Health and Social Care Trust and that the processes through which Supervision is carried out are integral to the organisational arrangements for the delivery of safe and effective care.
Directorate responsible for Policy	Executive Director of Nursing
Name & Title of Author:	Margaret Marshall, Assistant Director of Nursing Governance Paula Fearon, Nursing Governance Co-ordinator
Does this meet criteria of a Policy?	Yes
Trade Union consultation?	Yes
Equality Screened by:	NA
Date Policy submitted to Policy Scrutiny Committee:	9 th July 2018
Members of Policy Scrutiny Committee in Attendance: Electronically by membership of Policy Scrutiny Committee	
Policy Approved/Rejected/Amended	19 th July 2018
Policy Implementation Plan included?	N/A – reviewed policy
Any other comments:	
Date presented to SMT	N/A – reviewed policy
Director Responsible	Director of Nursing and AHP's
SMT Approved/Rejected/Amended	N/A
SMT Comments	

POLICY DOCUMENT – VERSION CONTROL SHEET	
Title	Nursing Supervision Policy Version 3 July 2018
Supersedes	Version 2_0_August 2011
Originator	Margaret Marshall, Assistant Director of Nursing Governance
Scrutiny Committee & SMT approval	Referred for approval by: Margaret Marshall Date of Referral: 10 th July 2018 Scrutiny Policy Committee Approval 9 th July 2018 SMT approval (Date)
Circulation	Issue Date: 20 th July 2018 Circulated By: Assistant Director of Nursing Governance
Review	Review Date: September 2019 Responsibility Margaret Marshall, Assistant Director of Nursing Governance



Quality Care - for you, with you

POLICY TITLE:	Nursing Supervision Policy
ACCOUNTABLE DIRECTOR:	Heather Trouton, Interim Executive Director of Nursing
POLICY AUTHOR:	Margaret Marshall, Assistant Director of Nursing Governance
CO-ORDINATOR FOR IMPLEMENTATION PLAN:	Heather Trouton, Interim Executive Director of Nursing
DATE APPROVED BY POLICY SCRUTINY COMMITTEE:	9 th July 2018
DATE APPROVED BY SMT:	N/A – Policy Review

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1.0 Introduction

The importance of effective Supervision has been highlighted in regional critical incident inquiries such as the Lewis Review (2003)¹, Murtagh Review (2005)², and McCleery Report (2006)³. The Quality Standards for Health and Social Care (DHSSPS 2007)⁴ recommend an effective system for Supervision across Health and Social Care (HSC) to help organisations meet each of the Clinical and Social Care Governance Standards.

It is recognised that effective Supervision processes improve: recruitment and retention of nursing staff; job satisfaction; professional autonomy; and reduces absenteeism⁵.

- 1.1 This revised policy and “*Guidance on Nursing Supervision*” (Appendix 1) have been produced to support the continuing development and maintenance of a robust system of Supervision for nursing staff who work within the Southern Health and Social Care Trust (SHSCT).
- 1.2 The Review of Clinical Supervision for Nursing in the Health and Personal Social Services (Ireland and UK) (HPSS) (2007)⁶ recommended action to enhance and promote professional Supervision for Nursing in Trusts throughout Northern Ireland.

The report defined Supervision as:

‘a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety’.

Following this the Chief Nursing Officer (CNO) published Standards for Supervision for Nursing⁷ which contained 2 Regional Standards.

¹ Lewis, RJ, Cole, D, Williamson, A (2003). Review of Health and Social Services in the case of David and Samuel Briggs. Belfast, DHSSPS

² Regional Quality Improvement Authority (2005). Review of the lessons arising from the death of the Late Janine Murtagh, Belfast, RQIA

³ McCleery Inquiry Panel (2006). Executive Summary and Recommendations from the report of the Inquiry Panel (McCleery) to the Eastern Health and Social Services Board, Belfast, DHSSPS

⁴ Department of Health, Social Services and Public Safety (2007). The Quality Standards for Health and Social Care. Belfast, DHSSPS

⁵ Hyrkäs, K., Appelqvist-Schmidlechner, K. and Haataja, R. (2006). Efficacy of clinical Supervision: Influence on job satisfaction, burnout and quality of care. *Journal of Advanced Nursing*.55(4), 521-535

⁶ http://www.nipec.hscni.net/download/projects/current_work/highstandards_practice/framework_for_Supervision_in_nursing_and_miwifery/documents/Supervision-in-Nursing-in-NI-Review-of-Current-Processes.pdf

⁷ Chief Nursing Officer for Northern Ireland (2007) *Standards for Supervision for Nursing*. Belfast, DHSSPS

- 1.3 Other outcomes were : a Regional Policy and Procedure document, a [Frequently Asked Questions Leaflet](#) ; standardised record keeping resources including contracts for supervisors and supervisees; a regional approach to the preparation of supervisors and supervisees.

A Supervision Regional Forum was charged with directing and supporting the implementation of the Standards. This was facilitated by Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC). The Standard Statements were revised as follows:-

Standard Statement 1 *Supervision will contribute to the delivery of safe and effective care when practitioners have access to appropriate systems that facilitate the development of knowledge and competence through a culture of learning by reflection.*

Standard Statement 2 *An organisational framework supporting effective leadership and performance management will ensure that Supervision will become an effective tool to improve the safety and quality of care.*

- 1.4 NIPEC annually evaluates Supervision process and perceived impact on practice. Each Trust receives a confidential report. The Chief Nursing Officer (CNO) monitors Trust compliance with the Standards through annual reports from each HSC Trust's Executive Director of Nursing (EDoN).

- 1.5 In June 2016 the CNO and Central Nursing and Midwifery Advisory Committee (CNMAC) agreed to the development of a single regional overarching Nursing and Midwifery Supervision Framework. The new model must provide professional accountability assurances to the CNO, Executive Directors of Nursing and the public. NIPEC is facilitating this development and has reviewed the current Supervision processes. It had been hoped the Framework would be completed by 2017, however work, although near completion, is ongoing. Progress can be tracked via the following link:

http://www.nipec.hscni.net/download/projects/current_work/highstandards_practice/framework_for_Supervision_in_nursing_and_miwifery/documents/Supervision-in-Nursing-in-NI-Review-of-Current-Processes.pdf

As an interim measure, the previously agreed Regional Nursing Supervision Policy (SHSCT) has been reviewed and revised here-in.

2.0 Aim of the Policy

This policy identifies Supervision in Nursing as a key organisational objective for all Health and Social Care (HCS) Trusts in Northern Ireland. The aim of this policy is to ensure that a culture of Nursing Supervision is embedded in the SHSCT and that the processes through which Supervision is carried out are integral to the organisational

- 2.1** The implementation of an effective system of Supervision for Nursing will help ensure:-
- The promotion and maintenance of Nursing Care Standards,
 - A competent and skilled workforce,
 - Delivery of safe and effective care; and
 - A supportive professional environment for nursing staff.

- 2.2** Senior management teams in the SHSCT must ensure that appropriate measures are in place to enable Supervision activities for both clinical and non-clinical teams.

3.0 Policy Statement

The SHSCT acknowledges the importance of Nursing Supervision in ensuring the delivery of safe and effective nursing care and the essential role it plays in protecting the public.

The SHSCT stipulates that all nurses it employs should have access to and avail of, a minimum of two Supervision sessions per year. The Trust must ensure there are effective systems in place to support Supervision processes. All supervisors must be supported to acquire the appropriate knowledge and skills to competently undertake this role.

4.0 Definition and Scope of the Policy

The Department of Health, Social Services and Public Safety (DHSSPS) adopted the following definition of Supervision for Nursing following *The Review of Clinical Supervision for Nursing in the HPSS* undertaken by NIPEC in 2006:

'Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety', NIPEC 2006⁸

- 4.1** The SHSCT requires all registered nurses to have a minimum of two formal Supervision sessions per year. Registrants are likely to engage in other activities which could also support the Supervision process. The Regional Forum acknowledged that a variety of diverse approaches and activities could be employed in implementing Supervision. Some examples are included in Appendix 2.

⁸ Northern Ireland Practice and Education Council (2007) *The Review of Clinical Supervision for Nursing in the HPSS 2006* on Behalf of the DHSSPS. Belfast, NIPEC.

4.2 It should be noted that the scope of Safeguarding Children Supervision differs from Supervision referred to in this Policy. Safeguarding Children is separate from, but complimentary to, other forms of Supervision. Safeguarding Children Supervision provides specialist professional advice, case management and support to staff in their safeguarding of children. This includes children in need of protection; children in need; looked after children and families of concern.

The **Safeguarding Children Nursing Supervision** process includes the assessment of staff performance, professional development in relation to safeguarding children and families and quality assurance of practice to ensure compliance with best practice guidelines.

Further information is available via:

- DHSSPS Safeguarding Children Supervision Policy for Nurses (2011).
- <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/safeguarding-children-supervision-policy.pdf>
- *The SHSCT Policy, Procedures and Guidance for Registered Nurses, Midwives and Specialist Community Public Health Nurses on Safeguarding Children and Young People (Revised May 2018)*. This is available on the Trust Intranet and SharePoint
<http://sharepoint.gov/home/Policies%20and%20Procedures/Forms/AllItems.aspx?RootFolder=%2Fgov%2Fhome%2FPolicies%20and%20Procedures%2FPolicies&FolderCTID=0x0120002BE1109E37E47349B3DE6A07F51171ED&View=%7B39B022B7%2DEAF5%2D4CE3%2D8BC9%2D6EE55B567DC4%7D>

4.3 Midwifery Supervision in Northern Ireland

The awaited Framework for the overarching Supervision of Midwifery, Nursing and Safeguarding Children will be introduced on the completion of the CNO-commissioned NIPEC work. Whilst this work is ongoing, Midwifery (as well as Nursing and Safeguarding) Supervision will continue in Northern Ireland.

Northern Ireland has taken forward legislative changes to the Nursing and Midwifery Order 2001 effective from 31st March 2017. Northern Ireland has taken forward legislative changes to the Nursing and Midwifery Order 2001 effective from 31st March 2017. This removed Supervision from its statutory regulation components. Until the review of supervision is completed by NIPEC midwifery supervision will continue in the agreed format as determined by the Midwifery Working group September 2016.

Details of the arrangements from April 2017 until the overarching Supervision of Midwifery, Nursing and Safeguarding Children can be found via the following link:

<https://www.health-ni.gov.uk/articles/changes-midwife-Supervision-uk>

5.0 Supervision and Appraisal

It is important that Supervisors and Supervisees in the SHSCT recognise and differentiate Supervision activity from other processes such as appraisal. Whilst Supervision activity informs and is informed by the Agenda for Change Knowledge and Skills Framework Annual Review Process, neither activity should be substituted for the other, each activity having a different purpose.

6.0 Responsibilities

In the SHSCT there are key individuals in posts with responsibility for ensuring Nursing Supervision is implemented. They are: -

6.1 Chief Executive

The Chief Executive of the SHSCT accepts responsibility and accountability for quality service provision at Trust Board level which includes systems, such as Supervision in Nursing, which support clinical and social care governance.

6.2 Executive Director of Nursing

The Executive Director of Nursing, in conjunction with the Operational Directors in the SHSCT is accountable to the Chief Executive for the implementation and maintenance of Supervision in Nursing. The Executive Director of Nursing presents the Trust Report to both the Trust Board and the Chief Nursing Officer for Northern Ireland on an annual basis. In addition, s/he may act as a supervisor for Assistant Directors and other senior professional roles when appropriate.

6.3 Directors

All Directors have responsibility for ensuring that arrangements are in place within their directorate to evidence compliance with this policy and that resources are available to support Nursing Supervision, monitoring and reporting processes.

6.4 Assistant Director of Nursing Governance

The Assistant Director of Nursing Governance has responsibility to co-ordinate, facilitate, evaluate and maintain a system of Supervision in the Nursing workforce. S/he is accountable to the Executive Director of Nursing and for presenting information relevant to the quantity and quality of SHSCT Supervision activity in governance reports or accountability reviews.

6.5 Operational Assistant Directors

Operational Assistant Directors have responsibility to co-ordinate and facilitate

implementation and maintenance of Supervision for nurses within their individual directorates. They are responsible for agreeing the models of Supervision to be employed within the division/directorate and must ensure appropriate resources are in place to enable nurses to undertake at least two formalised sessions of Supervision annually. They are responsible for monitoring the ongoing level of Supervision activity within individual directorates and will facilitate the Assistant Director of Nursing Governance in collation of reports

6.6 Heads of Service/Nurse Managers/Lead Nurses

Heads of Service/Nurse Managers/Lead Nurses have a responsibility to promote, co-ordinate and facilitate implementation and maintenance of Supervision for nurses within their individual directorates/divisions. They are accountable to the Operational Assistant Director and can act as supervisors for Ward Managers/Team Leaders within their own division/directorate.

6.7 Ward Managers/Team Leaders

Ward Managers/Team Leaders have a responsibility to role-model and facilitate implementation and maintenance of Supervision for nurses within their staff teams. They are accountable to the Heads of Service. They can act as supervisors for other members of staff, either within or outside their own team.

6.8 Supervisors

Supervisors have a responsibility to maintain and develop their own skills and competencies relative to Supervision activity, contribute to the models of learning and to the approaches used. They must seek and undertake Supervision themselves, maintaining records for both their personal Supervision and professional Supervision of others. They must provide at least two formal sessions of Supervision annually for each supervisee, whether group or individual. They must adhere to ground rules identified and conduct Supervision sessions within the principles and process identified in these procedures. They are accountable to their line managers for this activity.

6.9 Supervisees

Supervisees have a responsibility to engage fully in the nursing supervision process, adhering to identified ground rules. They have a responsibility to prepare for, and participate in, a minimum of two formal Supervision sessions per year, keeping accurate records of relevant actions. Activities undertaken between sessions should be used to inform formal Supervision sessions. Supervisees are accountable to their line manager to engage in a minimum of two formal supervision sessions annually.

7.0 Legislative Compliance, Relevant Policies, Procedures

This policy should be read in conjunction with the:-

- Southern Trust Policy, Procedure and Guidance on Record Keeping as outlined in the content and appendices of this document.
- Safeguarding Board for Northern Ireland (SBNI) Regional Core Child Protection Policy and Procedures (2017).
- DHSSPS Safeguarding Children Supervision Policy for Nurses and Midwives (2011) - currently under Regional review

http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/RecordsManagementProcedures_001.pdf

<https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf>

<http://sharepoint.gov/home/NMC1/NMC%20Standards%20for%20Competence/NMC%20Standards%20for%20competence%20for%20Registered%20Nurses.pdf>

<http://sharepoint.gov/home/NMC1/NMC%20Standards%20for%20Competence/NMC%20Standards%20for%20Competence%20for%20Registered%20Midwives.pdf>

<http://revalidation.nmc.org.uk/>

<https://www.health-ni.gov.uk/articles/changes-midwife-Supervision-uk>

<https://www.ombudsman.org.uk/publications/midwifery-Supervision-and-regulation-recommendations-change/current-midwifery-Supervision-and-regulation-nursing-and-midwifery-councils-role>

8.0 Equality and Human Rights Considerations

This policy has been screened for equality implications as required by Section 75, Schedule 9, of the Northern Ireland Act, 1998. Equality Commission for Northern Ireland Guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be targeted at them.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. This policy will therefore not be subject to an Equality Impact Assessment.

This policy has been considered under the terms of the Human Rights Act 1998, and was deemed to be compatible with the European Convention Rights contained in that Act.

- 9.0** This policy will be included in the Trust's Register of Screening Documentation and maintained for inspection whilst it remains in force.

This document can be made available on request in alternative formats, e.g. Braille, disc, audio cassette, and in other languages to meet the needs of those who are not fluent in English.

The SHSCT audit this Policy every two years and make appropriate changes where necessary.

GUIDANCE ON NURSING SUPERVISION

Purpose of Nursing Supervision

The main purpose of Nursing Supervision is to support: -

- Nurses to develop the necessary knowledge, competencies and skills within a role or clinical area, to enhance safe and effective practice and person centeredness;
- Nurses in both clinical and non-clinical roles by providing an opportunity to discuss issues pertinent to the delivery of safe and effective care and / or professional issues;
- Nurses through difficult circumstances such as challenging patient caseloads or difficult interpersonal contact with other team members;
- Nurses to realise personal and professional growth through reflection and facilitation.

Supervision Processes

Frequency of Supervision

Formalised Supervision sessions for nursing staff should take place at least twice per year.

Nursing and Midwifery Mandatory Requirements

The Nursing and Midwifery Council (NMC) has recognised the importance of reflection and subsequent discussion as integral to professional development of nurses and midwives. It has included reflective discussion as a mandatory requirement for Revalidation.

<http://revalidation.nmc.org.uk/>

Nurses can access guidance on reflection and keeping a portfolio with corresponding templates:-

<https://www.nmc.org.uk/globalassets/sitedocuments/revalidation/reflective-discussion-guidance.pdf>

The pre-requisite Reflective Template can be completed by staff in preparation for Supervision:-

<http://revalidation.nmc.org.uk/download-resources/forms-and-templates/>

Preparation for Supervision

Registered nurses should reflect on their own practices as they engage in ongoing learning and development activities in their working environment. This experience should be used to inform the Supervision sessions. There are many ways to reflect on practice and approach supervision-some examples are included in Appendix 2.

In order to benefit from Supervision, nurses should prepare appropriately. Preparation will include becoming familiar with and agreeing to, the Ground Rules for the Supervision session. (Appendix 3) Preparation will also include a review of the current Supervision action plan and reflection on the learning activities that have been undertaken between sessions. A Supervision Preparation template to help structure this process can be found at Appendix 4.

General information and guidance on Nursing Supervision is available in the Health and Social Care Trust (HSC) 'Nursing Supervision Information Leaflet - Frequently Asked Questions (updated 2016).

Issues of Concern

Where an issue of unsafe, unethical or illegal practice is identified, it should be dealt with supportively via appropriate procedures. All parties must be informed of the intention to disclose, before revealing confidential information.

Use of Patient /Client Records

If necessary, patient/client records maybe used for the purposes of Supervision activity. The NMC states that where this happens, principles of access and confidentiality apply, namely:-

- Patients'/clients' health records should only be accessed where necessary;
- The patient/client reserves the right to refuse access to, or limit the information from his/her records; this should be respected.

The SHSCT Records Management Policy¹⁰ and associate procedures should be adhered to.

http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/RecordsManagementProcedures_001.pdf

The NMC no longer have standalone guidance on record keeping, this has been incorporated into the NMC Code.

<https://www.nmc.org.uk/standards/code/record-keeping>

Recording Supervision

It is essential that written notes of individual sessions are taken, remain confidential and record clearly any agreed actions. Individual sessional notes are the responsibility of the supervisee. The supervisor should, however, keep brief notes and maintain quarterly Sessional Records information which is submitted to the Ward Manager/Team Leader or the appropriate line manager. Copies of the Record of Supervision form can be found in Appendix 5.

Each formalised Supervision session must have a written record signed by both supervisor and supervisee(s).

Storage of Records

The SHSCT Policy for the safe storage of records must be adhered to however, each registrant should also be mindful of his/her professional accountability with regard to the principle of confidentiality of information. Nurses must, therefore, take responsibility for making sure that the system used is managed in such a way that it is appropriately protected to ensure the security of confidential information.

Monitoring and Evaluation

Monitoring and evaluation of Supervision activity are essential to ensure that resources required for professional Supervision are managed effectively. It is also necessary to

monitor the benefit to individual registrants, as the quality of Supervision activities can influence professional and clinical effectiveness.

The SHSCT may seek qualitative information periodically from individual registrants to assist in the ongoing evaluation of Supervision processes.

Individual supervisors must record quarterly the number of sessions they engage in and make these returns available to line managers for collation. This information will, in turn, be collated by directorate managers and communicated to the Assistant Director of Nursing Governance, who is responsible for monitoring Nursing Supervision within the Trust.

Formal Supervision sessions (2 per year) must be recorded on the “*KSF Form for use by NMC Registrants – Part B*” and forwarded to the SHSCT Nursing Revalidation Team at the time of yearly appraisal

Part B of the Annual Personal Development Plan can be found on the Trust Intranet under Knowledge and Skills Framework section – *KSF Form for use of NMC Registrants Only*
http://vsrintranet.southerntrust.local/SHSCT/HTML/KSF/documents/KSFFormforNMCRegistrants_001.docx

Range of Supportive Activities

A range of activities can support Supervision in the Nursing workforce. Whichever activity is used each registrant must ensure he/she has the appropriate skills and competencies required to engage in the activity.

Nurses should use the many learning opportunities within their work environments to reflect on their own practice. These *informal* experiences can be used to inform *formal* Supervision sessions.

Examples of activities which support Supervision can be found in Table 1 – overleaf.

Many activities inform Supervision processes; it should, therefore, be noted that this is not a definitive list of activities, merely examples to guide professional teams.

Table 1: Range of Supportive Activities

<p>Reflective Practice</p> <p>Reflective practice is the process of thinking about your own practice and that of others in a structured way; this leads to new and better ways of working and helps you develop new levels of knowledge and competence. You will learn to think critically about your practice and about what you need to do to improve it and the care you provide. Reflection allows you to describe your experience, think about it, and evaluate the outcomes. This should help you to have new understandings and insights. Reflection is what turns experience into meaningful learning, making sense of the world around you, and building on what is happening. You may also find it helpful to use one of the many reflective tools that have been developed.</p>	<p>Work-Based Learning</p> <p>A work-based learning programme is provided by an education institution, using a negotiated, project-led approach; this is managed by you and provides the best opportunities for learning and professional development in the workplace. Work-based learning acknowledges that everyone learns in different ways. It gives you control over how and when you learn and takes learning out of the classroom into the workplace. The learning is gained through work-related projects. Work-based learning opens your eyes to the fact that you can learn from anything. Work-based learning in multi-professional teams, making full use of modern technology, can produce benefits to you, the organisation and the profession. Successful completion of the programme will provide you with accredited learning and lead to an academic qualification. It is concerned with helping you to bridge the practice/theory gap.</p>	<p>Post Incident Review</p> <p>This happens when an incident has occurred in the workplace that has caused you and/or other members of the healthcare team a level of distress. The incident has usually resulted in a miss or near-miss, where there has or could have been damage to a patient or client. A post-incident review involves the reviewing of specific incidents, either individually or as a team, within a setting that provides emotional support to each person. The incident is analysed with your involvement and the involvement of all team members, using reflection, self-evaluation and/or facilitated learning to establish how the incident happened and how it could be avoided in the future. If you are involved in a post-incident review, it should result in good support from your team members and outcomes and actions for yourself and the team, with possible organisational implications. The final outcome must provide a clear description of risk factors and required action. You should also use the review process to identify personal action plans and required development. This is a learning event for all involved, with the objective of learning to improve practice.</p>
<p>Learning Sets</p> <p>The term refers to a group of people who meet regularly to work and learn together, using a structured format. The learning set can comprise of uni- or multi-professional groups and the focus is on self-directed learning; the participants decide the particular issues to be addressed. This provides you with a confidential forum in which to test issues that concern you, discuss new ideas and help you and the others to challenge working practices in new and creative ways. It is important to set ground rules to deal with issues such as confidentiality. Each member of the group is facilitated and supported by the others in the solving of issues and problems.</p>	<p>Critical Incident Review</p> <p>A critical incident is a significant event or experience that has occurred in your workplace and that you feel has had an impact on you or the people you work with. This could be negative or positive; it could be a personal experience or it could result from observing how other people work. You need to examine the incident through a process of reflection, using an evidence-based approach, to identify lessons to be learned. This could also take place with a group of practitioners working together. This should result in new learning for you and/or the group you are working with and result in a short action plan to bring about improvement in practice.</p>	<p>Group Supervision</p> <p>This is a valuable learning activity as it helps to develop critical thinking and collaborative working and brings about improvements in Nursing practice. Group Supervision needs to be set up within a structured format to ensure that nurses have the required skills and are supported by experienced colleagues.</p>
<p>Supervised Practice for Competency Development</p> <p>This is a negotiated period of supervised practice, with agreed learning and competency outcomes and may be provided for you if you require to develop specific, identified competencies. It is also likely to be arranged for you if you have poor or failing clinical competence in an area of practice. This is a period of practice where you are supervised and monitored by an experienced practitioner. The length of the supervised practice and the required outcome are set before the exercise begins. You are required to work closely with your supervisor throughout the entire period of practice. You will also be assessed at the end of the supervised practice to demonstrate that you have the necessary knowledge and competence.</p>	<p>Preceptorship / Mentoring</p> <p>A mentor is someone who has skills of working with individuals who can provide guidance and support to help you achieve your potential. Your mentor may not be from your own field of practice but should be a person with mentoring experience. Mentoring is achieved through a process of relationship building between yourself and your mentor and takes place over a period of time. The purpose of the mentoring process is to enable you to recognise your own skills and capabilities and maximise the development opportunities available to you.</p>	<p>Opportunistic Experiences</p> <p>Often in the course of a working day there is the opportunity to learn from other people or situations in which you might find yourself participating. These experiences are not planned but provide us with a rich learning ground. Examples of these could be: a medicine round where you learn about a new drug regimen; a community patient visit with a tissue viability nurse; discussing the difficulties a palliative patient in your care is experiencing with a colleague; supporting a colleague who has experienced challenging behaviour from a client. All of these situations provide learning which we often reflect on without recording. It is important to make a brief note of the learning provided by these experiences as it can inform other more formal processes in the future.</p>

GROUND RULES FOR 1:1 SUPERVISION	
Prior to Supervision session the SUPERVISEE will have: -	
<ul style="list-style-type: none"> • Read all relevant/associated policies, procedures and guidance • Prepared for the session and will have considered and identified practice areas for open discussion • Undertaken relevant action(s) as agreed at previous Supervision session(s) 	
During each Supervision session both SUPERVISOR and SUPERVISEE will: -	
<ul style="list-style-type: none"> • Maintain mutual respect • Have an attitude of open learning • Maintain strict confidentiality • Be open to constructive feedback • Engage in reflective practice • Deal appropriately with areas of disagreement according to the Ground Rules • Ensure that identified unsafe, unethical or illegal practice is dealt with supportively via appropriate procedures • All parties must be informed of the intention to disclose, before revealing confidential information • Explore the supervisee's expectations appropriately using appropriate knowledge, skills and experience 	
At the end of the Supervision session both SUPERVISOR and SUPERVISEE will: -	
Agree a suitable time and venue for the next session	
After the session the SUPERVISEE will: -	
<ul style="list-style-type: none"> • Engage in learning and development activities that will inform subsequent Supervision sessions • Record and reflect on significant activities using a portfolio approach • Evaluate the perceived benefit of the session • Maintain and store records in line with Trust Policy 	
After the session the SUPERVISOR will: -	
<ul style="list-style-type: none"> • Complete the Trust's Sessional form(s) • Maintain and store records in line with Trust policy • Provide the supervisee with a copy of the session if not already provided • Evaluate the perceived benefit of the session to the supervisee 	

GROUND RULES FOR GROUP SUPERVISION

Prior to Supervision session the SUPERVISEES will have: -

- Read all relevant/associated policies, procedures and guidance
- Prepared for the session and will have considered and identified practice areas for open discussion
- Undertaken relevant action(s) as agreed at previous Supervision session(s)

During each Supervision session both SUPERVISOR and SUPERVISEES will: -

- Be sensitive to the needs of individuals and the overall dynamics within the group
- Maintain strict confidentiality by not disclosing or discussing information provided by any other members of a group
- Be supportive of other members of the group
- Listen to and allow other members of the group to speak
- Maintain mutual respect
- Have an attitude of open learning
- Be open to constructive feedback
- Engage in reflective practice
- Deal appropriately with areas of disagreement according to the ground rules
- Ensure that identified unsafe, unethical or illegal practice is dealt with supportively via appropriate procedures
- All parties must be informed of the intention to disclose, before revealing confidential information
- Explore the supervisee's expectations appropriately using appropriate knowledge, skills and experience

At the end of the Supervision session both SUPERVISOR and SUPERVISEES will: -

Agree a suitable time and venue for the next session

After the session the SUPERVISEES will: -

- Engage in learning and development activities that will inform subsequent Supervision sessions
- Record and reflect on significant activities using a portfolio approach
- Evaluate the perceived benefit of the session
- Maintain and store records in line with Trust policy

After the session the SUPERVISOR will: -

- Complete the Trust's Sessional form(s)
- Maintain and store records in line with Trust policy
- Provide the supervisees with a copy of the session if not already provided
- Evaluate the perceived benefit of the session to the supervisees

PREPARATION FOR SUPERVISION

NAME _____

DATE ____ / ____ / ____ VENUE _____ TIME from ____ to ____

Agreed actions from previous session	Progress on action points
Reflection on Learning from previous session	
Issues to be brought forward and discussed at the next meeting	

RECORD OF 1:1 SUPERVISION

Date ____/____/____

Venue _____

Time from ____ to ____

SUPERVISEE	
PRINT NAME:	
SIGNATURE	
SUPERVISOR	
PRINT NAME:	
SIGNATURE	
Review of Action Points from Previous Supervision Session	
Issues / Topics for Discussion	
Key Points from Discussion	
Agreed Action Plan for Supervisee	
Actions	Timescale

RECORD OF GROUP SUPERVISION

Date ____ / ____ / ____

Venue _____

Time from ____ to ____

SUPERVISEES	SIGNATURE
SUPERVISOR(S)	SIGNATURE

Review of Action Points from Previous Supervision Session

Issue / Topic for Discussion

Agreed Action Plan for Supervisor (if applicable)		
Actions	Timescale	
If a significant issue requires onward reporting, record below outline of issues for onward reporting, to who and when it will be reported		
Issue	Report to	Timescale
Issues / areas of disagreement		
Date and Time of Next Session		
Date		Time
Session Evaluation		

Copy to supervisee

☐

Date ____/____/____

Agreed Action Plan for Supervisees		
Actions	Timescale	
Agreed Action Plan for Supervisor (if applicable)		
Actions	Timescale	
If a significant issue requires onward reporting, record below outline of issues for onward reporting, to who and when it will be reported Issues / area of disagreement		
Issue		Timescale
Issues / areas of disagreement		
Date and Time of Next Session		
Date		Time
Session Evaluation		

Copy to supervisees ☐ Date ____/____/____

Appendix 19-

[Code of conduct - GMC \(gmc-uk.org\)](http://gmc-uk.org)

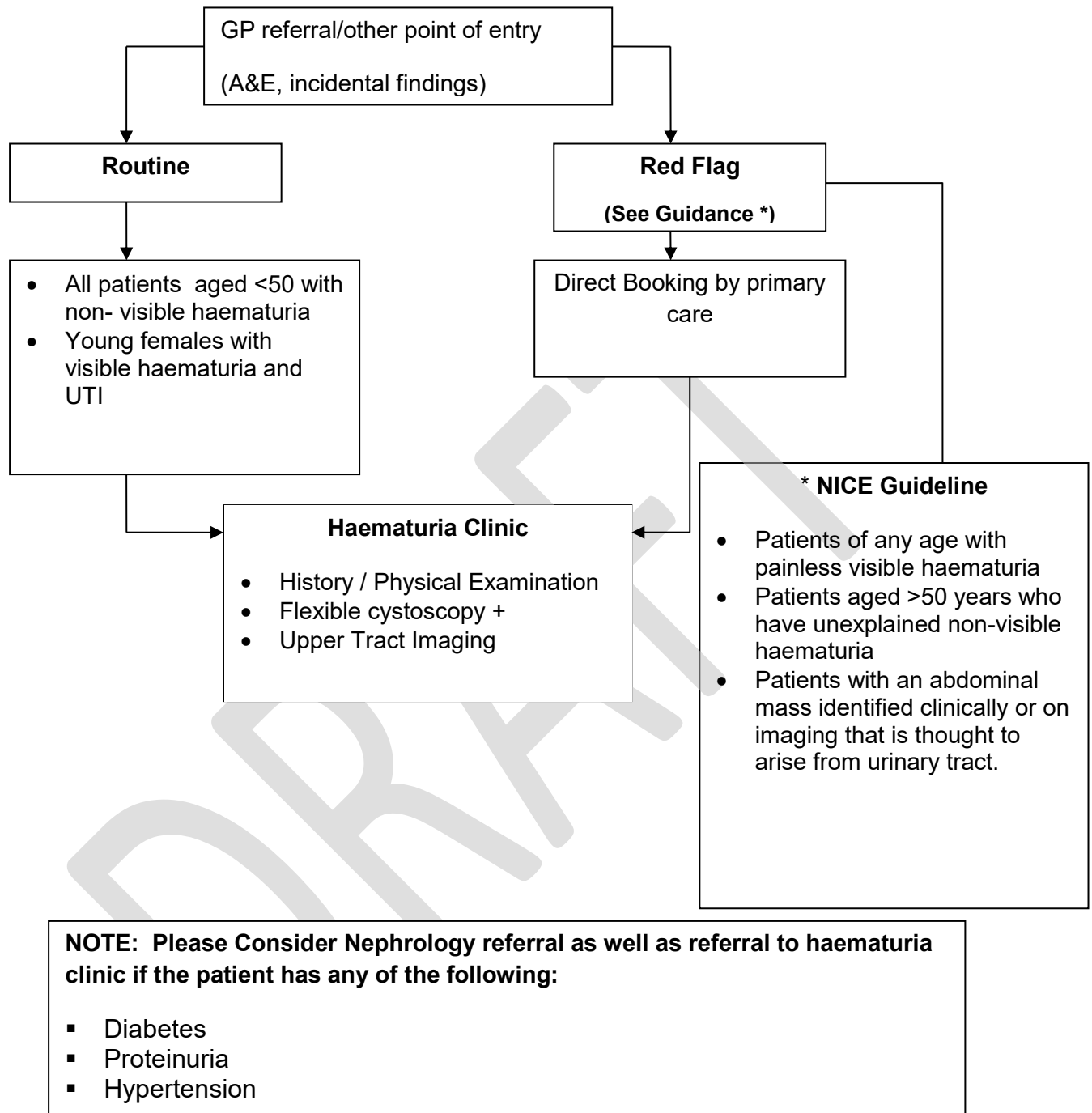


Urology Care Pathways

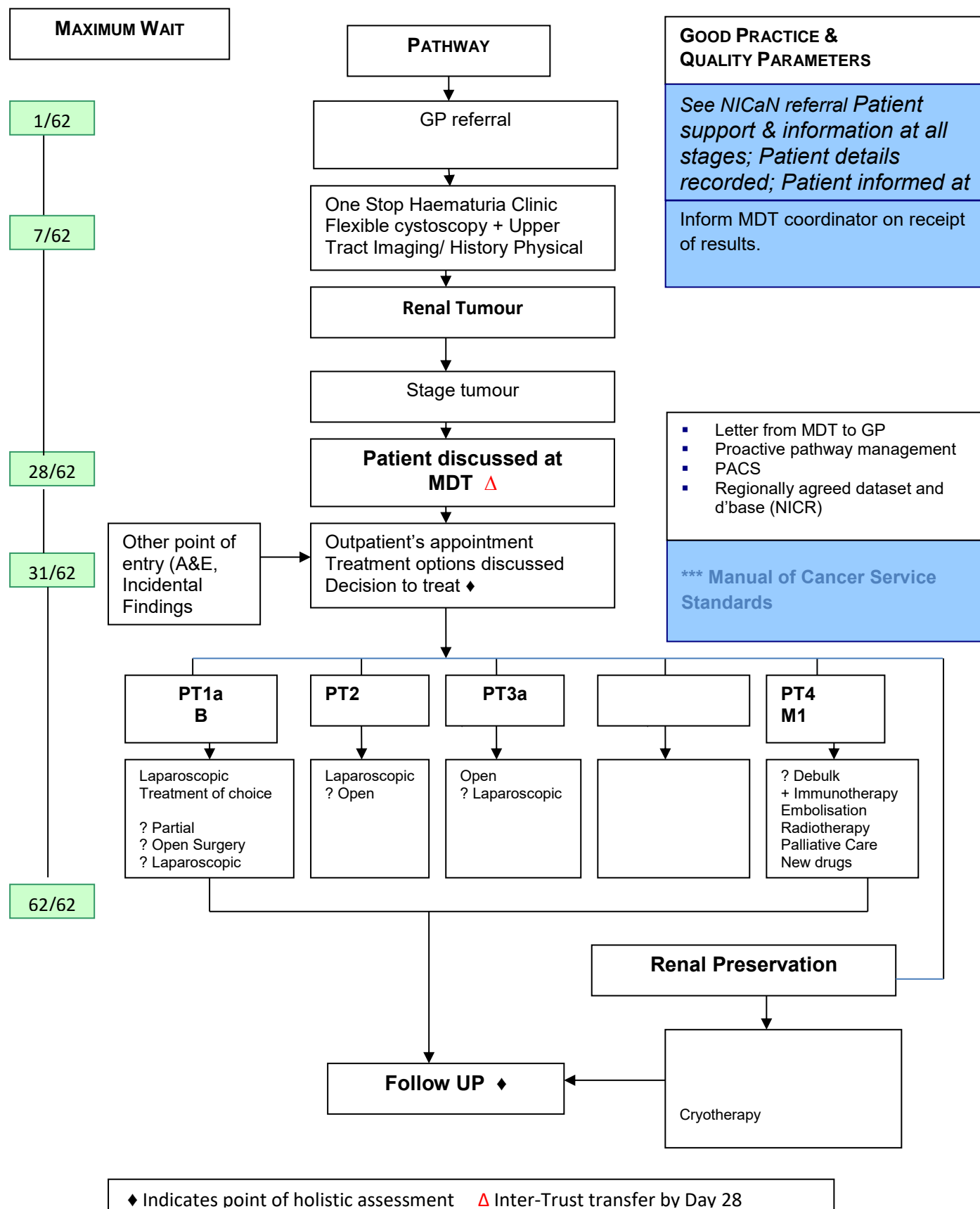
Cancer Care Pathways outline the steps and stages in the patient journey from referral through to diagnostics, staging, treatment, follow up, rehabilitation and if applicable onto palliative care.

Timed effective care pathways are central to delivering quality and timely care to patients throughout their cancer journey and to the delivery of an equitable service. These pathways have been developed following with reference to available best practice guidance. They represent an 'ideal' pathway that can be adapted for local use. The timelines on the pathway are intended to facilitate the proactive management of patients within the access standards and it is to be noted that for some urological tumours, the patient will move much quicker through the pathway (e.g. testicular cancer).

Haematuria Referral Guideline

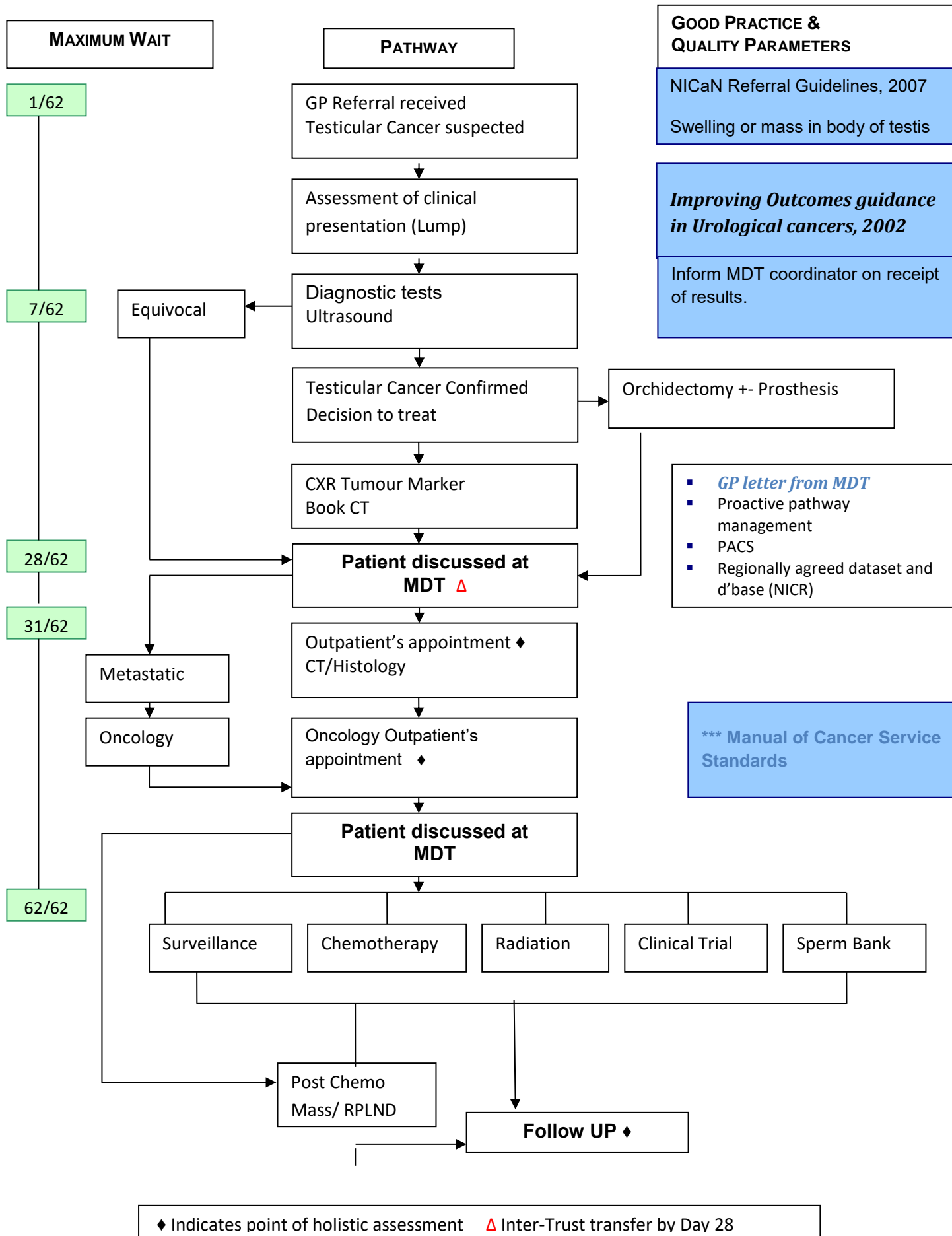


Renal Tumour



Testicular Cancer Pathway

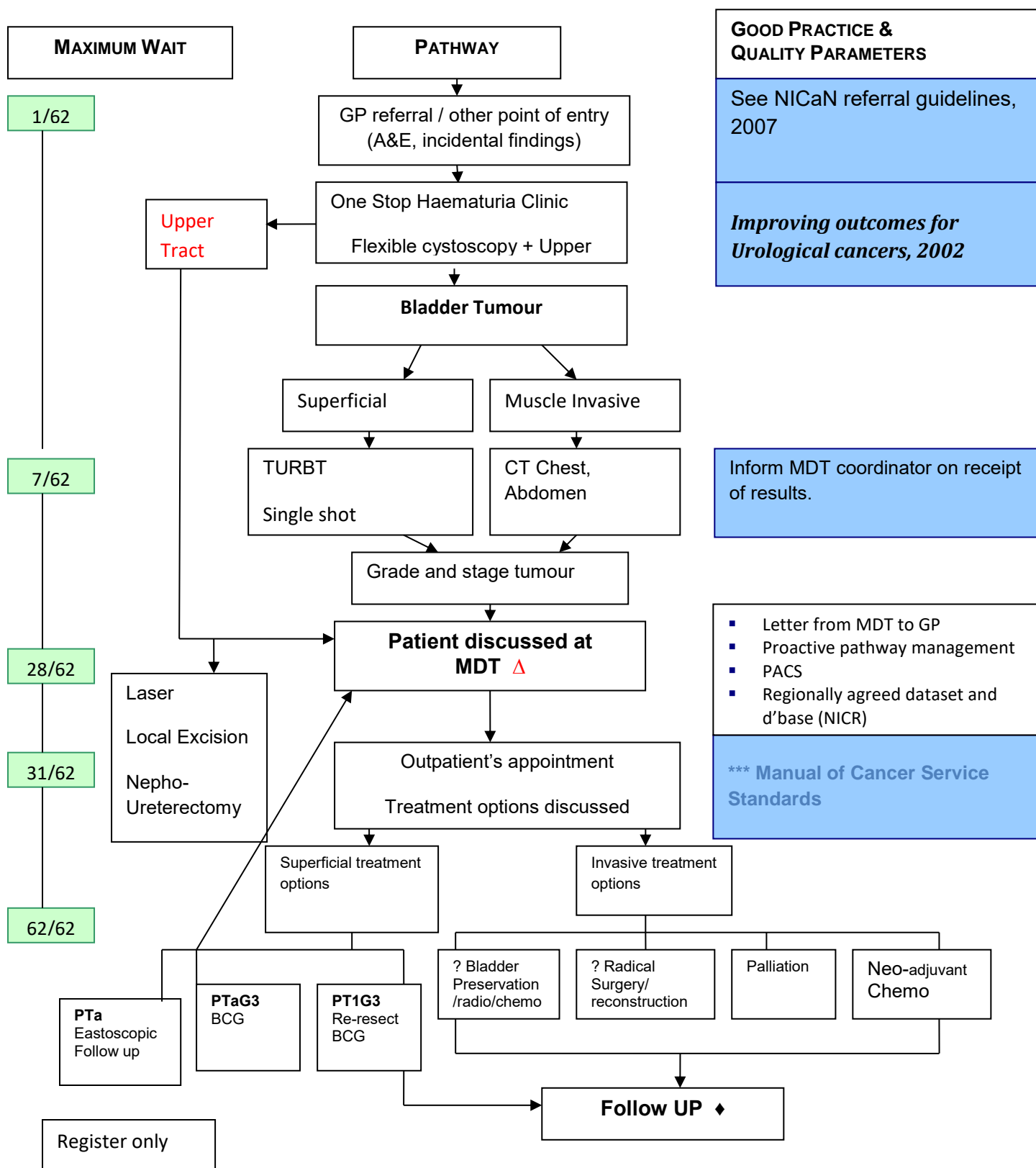
Patient support & information at all stages; Patient details recorded; Patient informed at appropriate points *****NICE



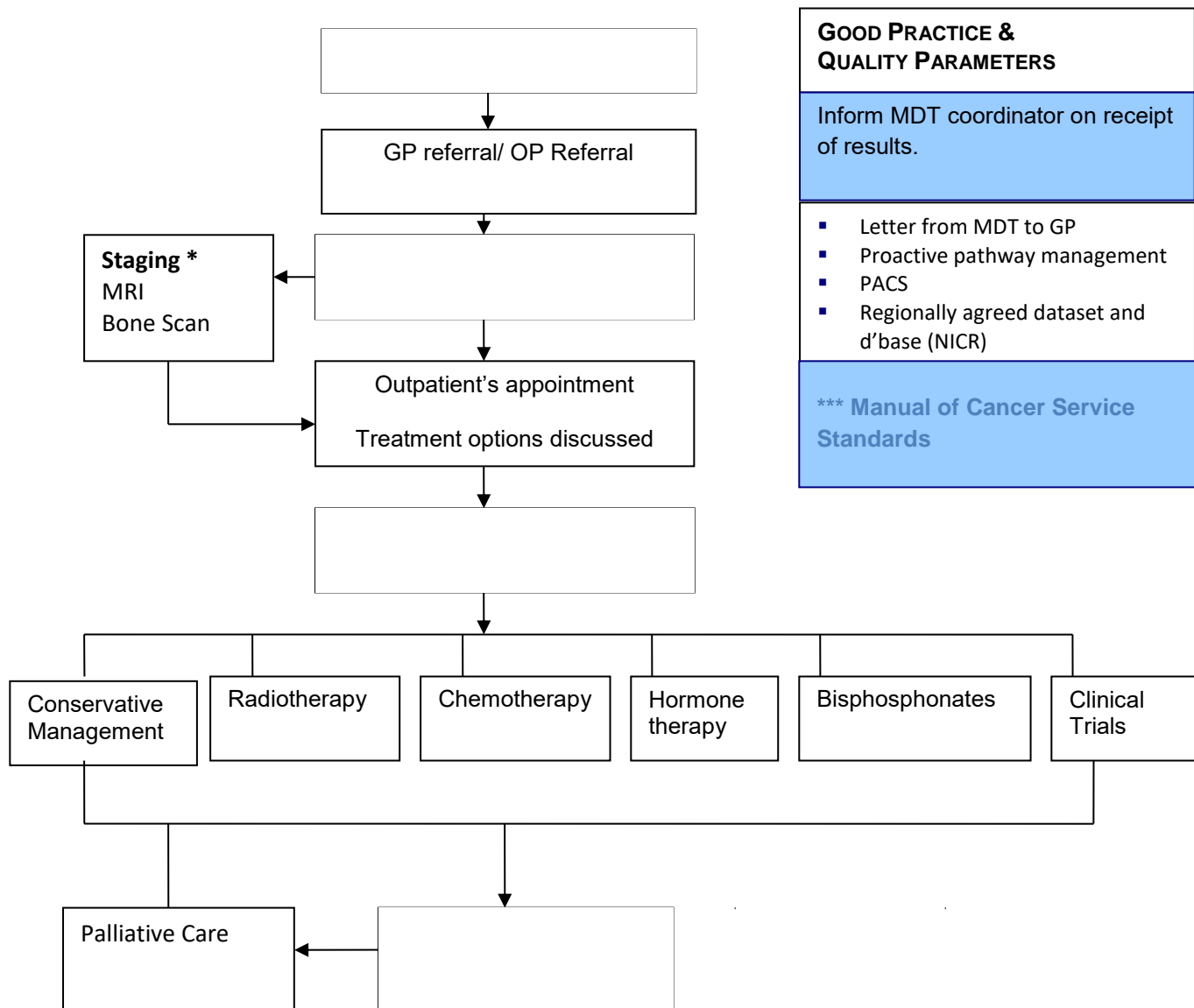
Appendix 3 of NICA Urology Cancer Clinical Guidelines

◆ Indicates point of holistic assessment ▲ Inter-Trust transfer by Day 28

Patient support & information at all stages; Patient details recorded; Patient informed at appropriate points *****NICE



Castration Resistant Prostate Cancer

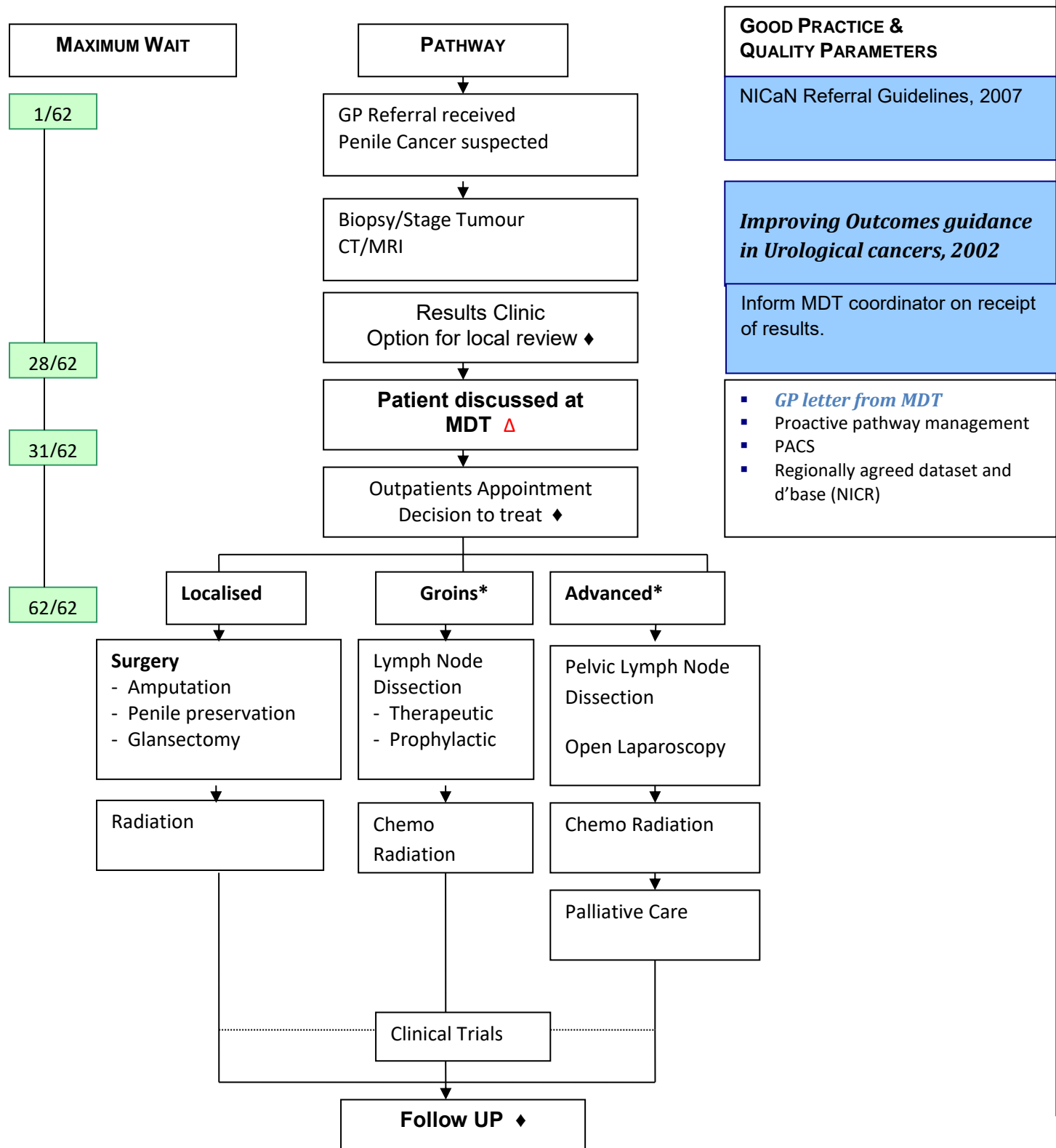


Patient support & information at all stages; Patient details recorded; Patient informed at appropriate points *****NICE

* MRI/Bone Scan as clinically indicated

Penile Cancer Pathway (Currently Under Review as part of development of local penile service 2019)

Patient support & information at all stages; Patient details recorded; Patient informed at appropriate points *****NICE



♦ Indicates point of holistic assessment ▲ Inter-Trust transfer by Day 28

Appendix 3 of NICE Urology Cancer Clinical Guidelines

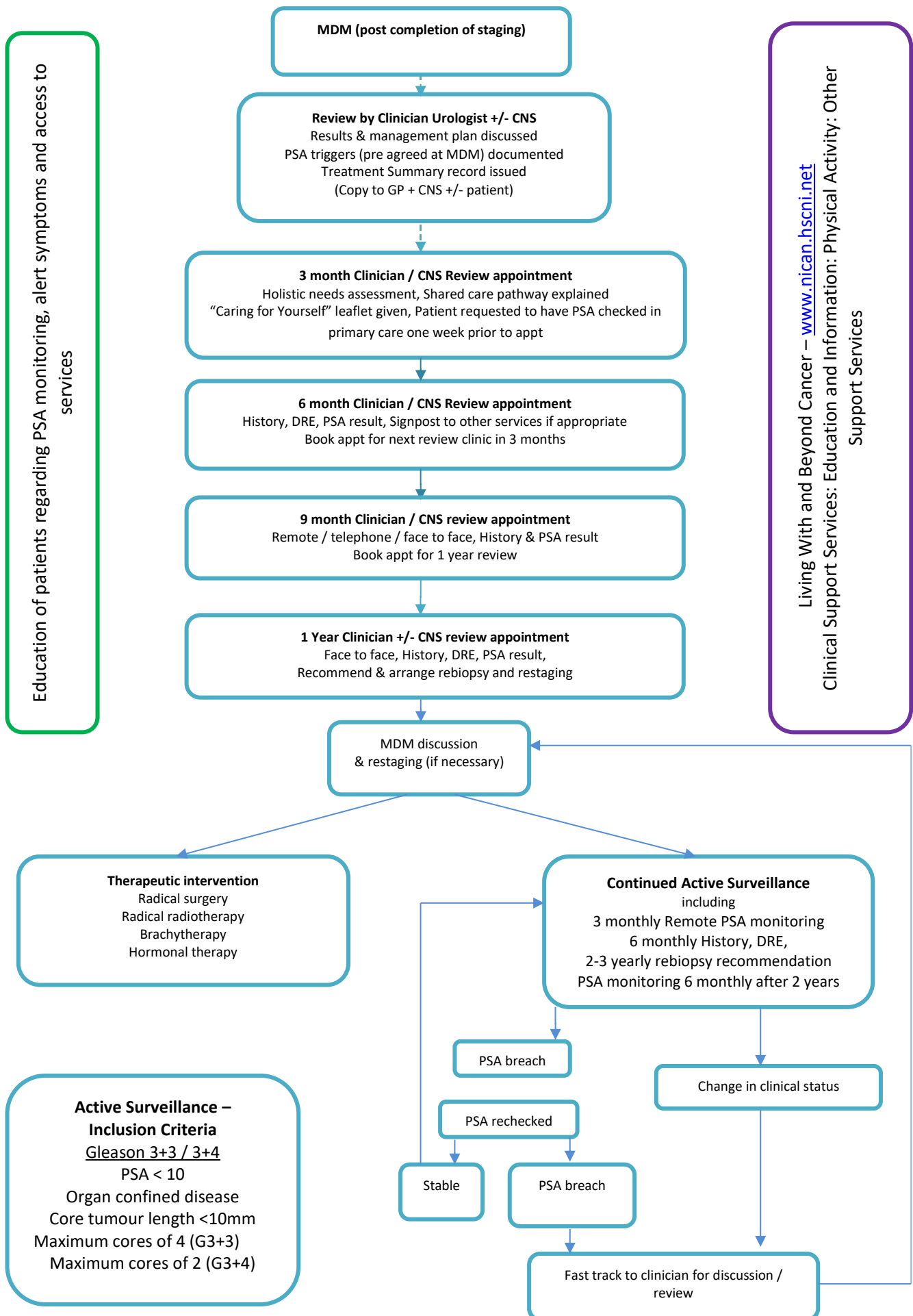
Trust Logo

Policy Code / Reference No:

Appendix 3 of NICA Urology Cancer Clinical Guidelines

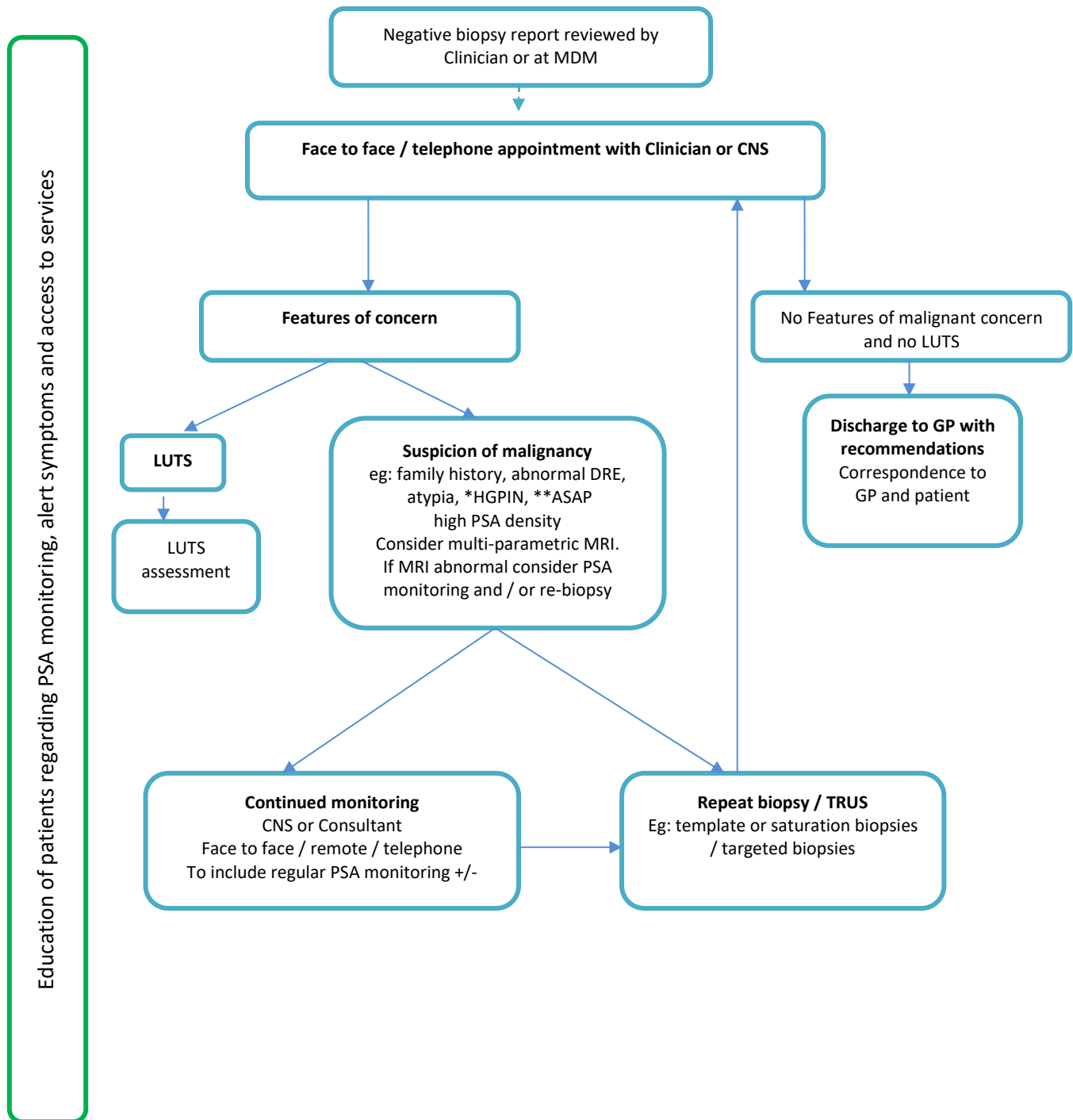
Pathway 2

Prostate Cancer: Active Surveillance



Pathway 3

Raised PSA & Negative Biopsy

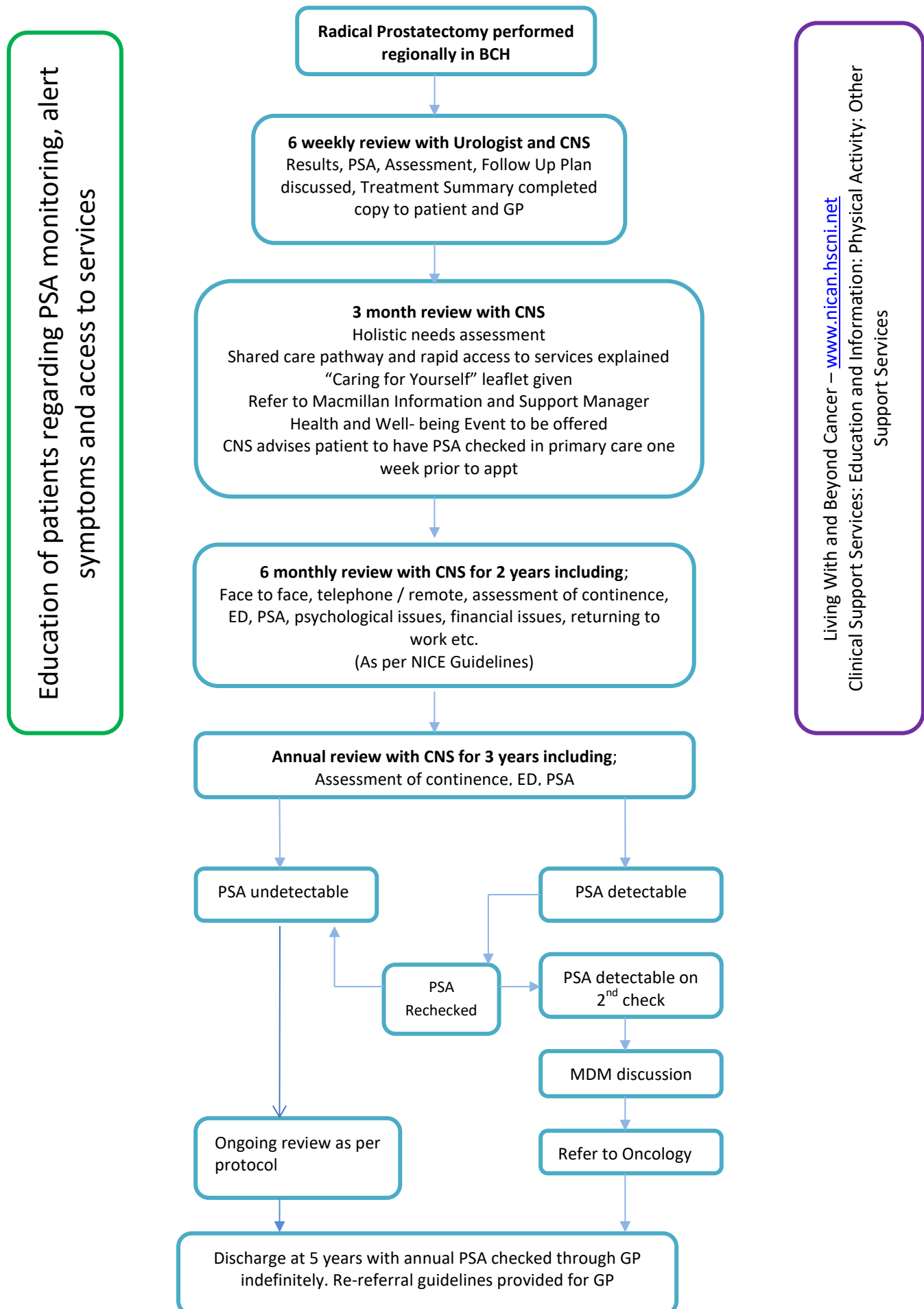


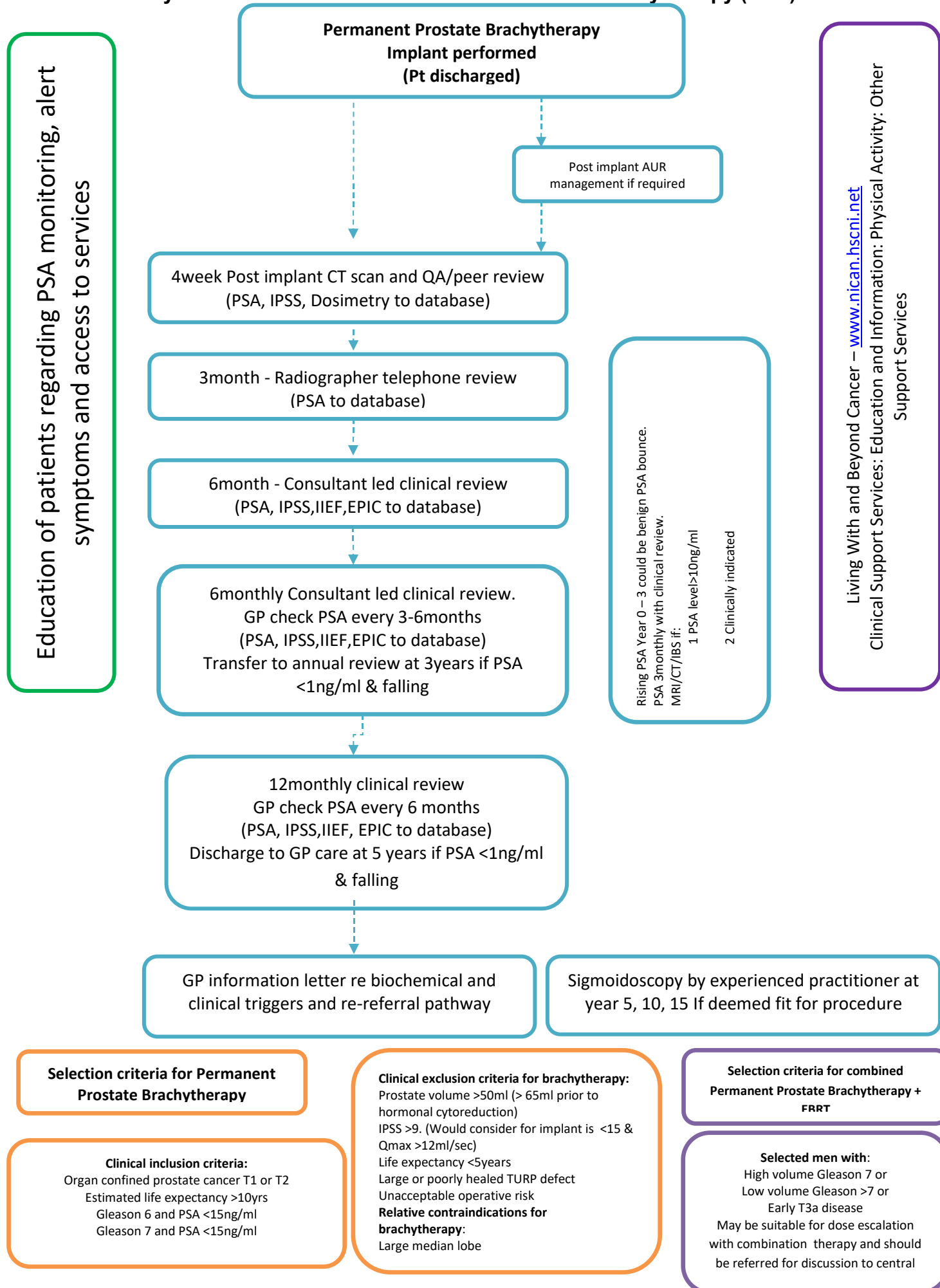
*HGPIN – High grade prostatic intra-epithelial neoplasia

**ASAP – Atypical small acinar proliferation

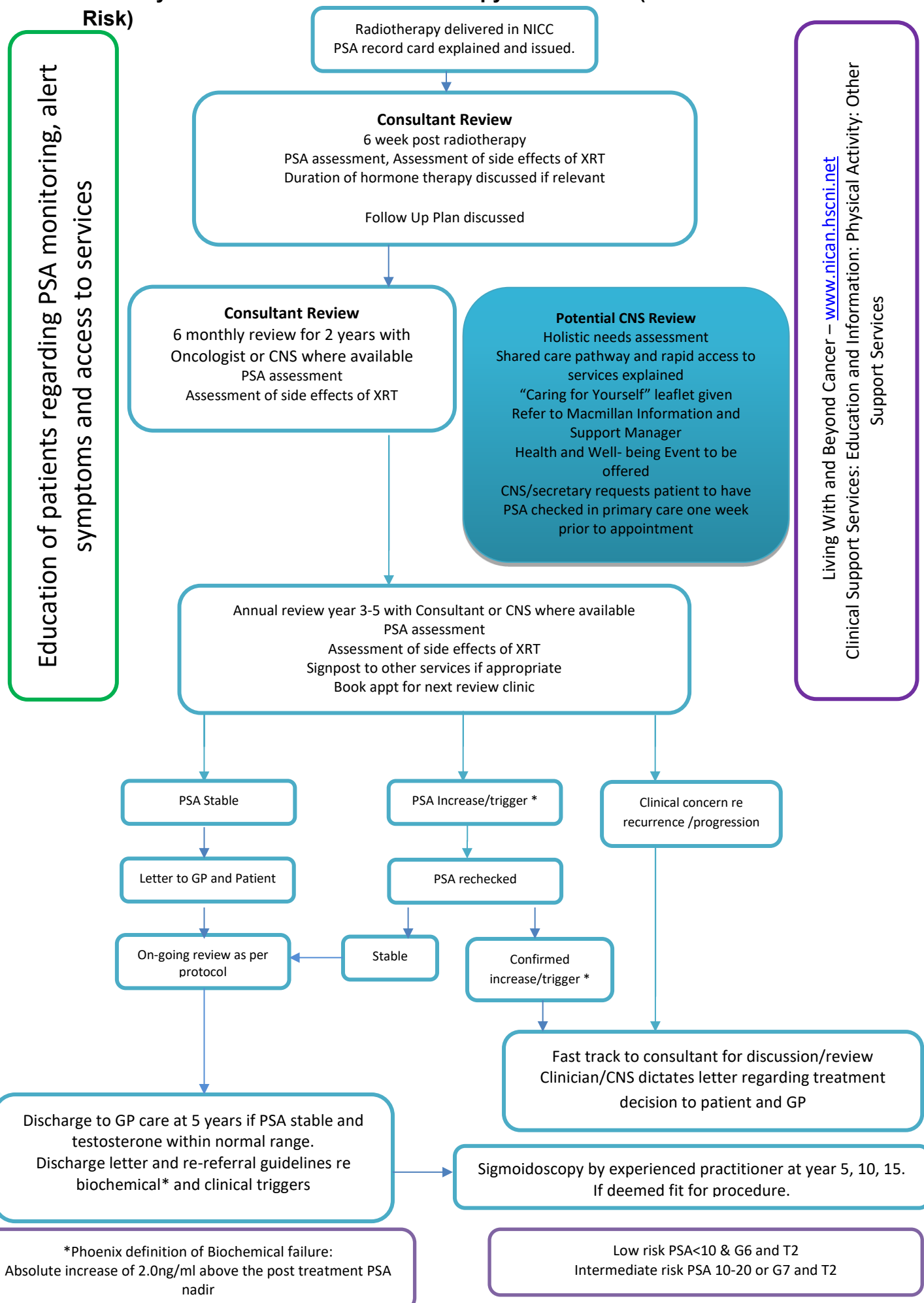
Pathway 4

Prostate Cancer: Radical Surgery – Negative margins



Pathway 5 Prostate Cancer: Permanent Prostate Brachytherapy (LDR)

Appendix 3 of NICA Urology Cancer Clinical Guidelines

Pathway 6: Prostate Cancer: Radiotherapy+/-Hormones (Low Intermediate Risk)

Terms of Reference- Agreed by Group ***Feb 2022**

Service User Urology Task & Finish Group (SUUTFG) SHSCT

Terms of Reference for Service User Urology Task and Finish Group (SUUTFG)

1. Purpose and Role of SUUTFG

The purpose of Urology Task and Finish Group is for service users to work in partnership with Trust staff and contribute to the implementation of Urology SAI recommendations 2020. The SUUTFG will bring together a breadth of experience, expertise and perspective. The role of the SUUTFG is to share experiences, suggestions and to bring a lived perspective to guide and help the Trust to implement the recommendations focused on patient safety and improved assurance for all the patients referred into the Trust. All whilst ensuring the actions taken to implement the recommendations are based on evidence and reflect the demands of the service.

The Trust members will provide updates to the Service Users on the recommendations work plan on a monthly basis. Service Users will also feedback on actions in which they have contributed to and collectively ensure patient centred focus to all the recommendations. The discussion and actions from the SUUTFG will be shared with the external Urology Assurance Group (UAG) and HSCB meeting monthly to advise them of service user feedback, input and progress on implementation. Service User Group will be updated on the information shared with HSCB, decisions made at the Urology Assurance Group with regards to the SAI implementations and regional work that evolves throughout this process.

Membership of Service User Task and Finish Group

Consultant	Nurse	Manager/Admin	Service User/ Family Representative
Shahid Tariq, DivMed Director for Cancer & Clinical Services	Clair, Quin, Acting HOS Cancer Services Sarah Ward, Head of Service Janet Johnstone, Family Liaison Officer Fiona Sloan, Family Liaison Officer Lisa Polland-O'Hare, Service User Officer	Ronan Carroll Assistant Director Mary Haughey, Cancer Service Improvement Lead	Irrelevant redacted

The group has 3 key responsibilities:

1. To utilise the service user's feedback and expertise to provide a patient centred focus now and for the future service to the actions required to implement the SAI recommendations.
2. To ensure achievable and sustainable delivery of all the SAI recommendations with consideration of the quality and safety impact on Urology services and all cancer multidisciplinary teams within Timeframes to be established and reflective of the priority of the recommendation.

- 3. To ensure that Service Users are fully informed of the actions taken to ensure a safe service and feel supported throughout the process of Urology recommendations implementation.

4.

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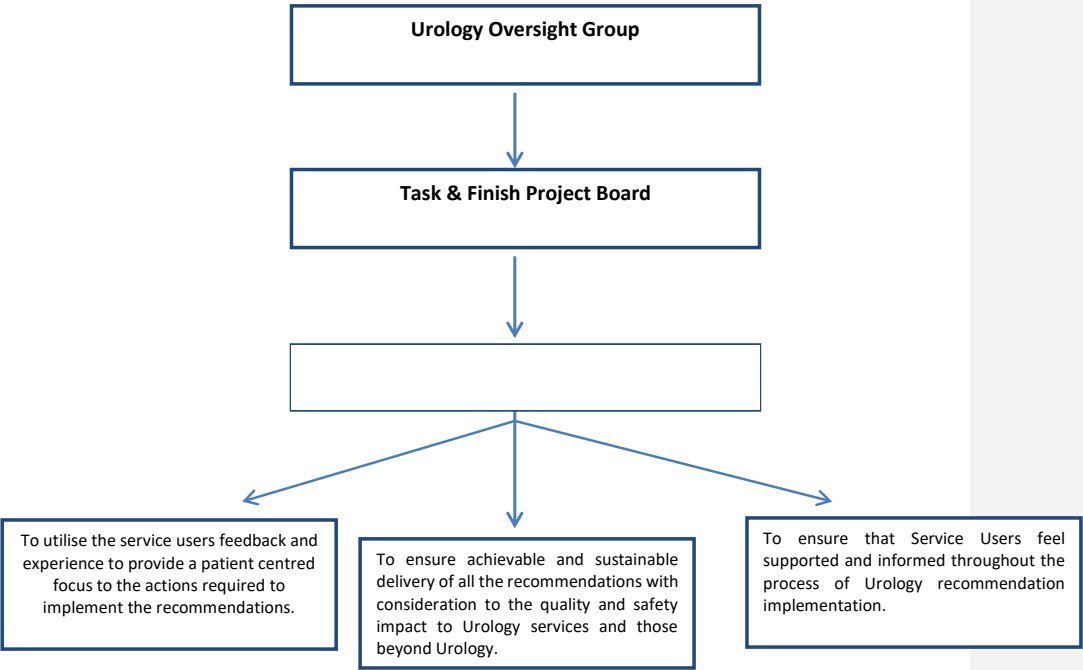
Life span of Task and Finish Group

The anticipated timescales for completion of all the recommendations will be 12 months. It is anticipated that the implementation of recommendations will exceed this time frame as the group is standardising the practice across all cancer sites, not just Urology and the actions required may evolve through time.

Reporting and Communications

- 1. SUUTFG meeting zoom link & agenda will be sent via the Liaison Officers to the service users in advance of the meeting.
- 2. SUUTFG meeting minutes (discussions & actions) from each meeting will be prepared and circulated to members in advance of next meeting and will be a standing agenda item for comments. Once agreed the notes can be shared with other parties as directed by the Chairs.
- 3. Chairs of the SUUTFG Group will report to the Urology Oversight Group Meeting and regular updates will be provided to the HSCB, DoH and written updates to those affected by the SAI's. The patients, families or carers will receive communication at 4 monthly intervals (Sept 21, Jan 22 and May 22)

Governance and Accountability



Frequency of Meetings

Monthly. At each meeting the next meeting will be agreed. Date for the next meeting decided at the end of the meeting

Terms of Reference- Agreed by Group 11 October 2021**Trust's Task and Finish Group into Urology SAI Recommendations*****Terms of Reference of Task and Finish Group***

The Task and Finish group is charged with implementing all the recommendations and providing assurance/evidence to the Urology Oversight Group

Membership of Task and Finish Group

Consultant	Nurse	Manager/Admin
Philip Murphy, Deputy Med Director Shahid Tariq, Deputy Med Director Mark Haynes – Deputy Med Director David McCaul Clinical Director Ted McNaboe Clinical Director Manos Epanomeritakis, Gen Surgery Kevin McElvanna General Surgery Art OHagan Dermatology Geoff McCracken, Gynae Helen Mathers Breast Rory Convery Lung Christina Bradford, Hematology Anthony Glackin, Urology Marian Korda, ENT	Clair, Quin, Cancer Lead Tracey McGuigan, Lead Nurse Kate O'Neil, Clinical Nurse Specialist Leanne McCourt Clinical Nurse Specialist Patricia Thompson, Clinical Nurse Specialist Sarah Walker, Clinical Nurse Specialist Catherine English, Clinical Nurse Specialist Fiona Keegan, Clinical Nurse Specialist Matthew Kelly, Clinical Nurse Specialist Nicola Shannon, Clinical Nurse Specialist Stephanie Reid, Clinical Nurse Specialist Janet Johnstone, Family Liaison Officer Lisa Polland-O'Hare, Service User Officer	Ronan Carroll Assistant Director Martina Corrigan, Assistant Director Anne McVey, Assistant Director Barry Conway Assistant Director Helen Walker, Assistant Director Stephen Wallace, Assistant Director Mary Haughey, Service Improvement Lead Sharon Glenny, performance manager Jane Scott performance manager Wendy Clarke, Head of Service Amie Nelson Head of Service Wendy Clayton, Head of Service Patricia Loughan, Head of Service Chris Wamsley, Head of Service Kay Carroll, Head of Service Sarah Ward, Head of Service Clinical Assurance

Role of Task and Finish Group

The Task and Finish Group will bring together a breadth of experience, expertise and perspective from across all cancer Multi-disciplinary teams to enable the recommendations to be achieved within the given time frames through

1. overseeing the delivery of all the recommendations
2. ensuring sustainable delivery of all the recommendations;
3. oversee and action quality, safety and governance risks as a result of implementing all, the recommendations

Life span of Task and Finish Group

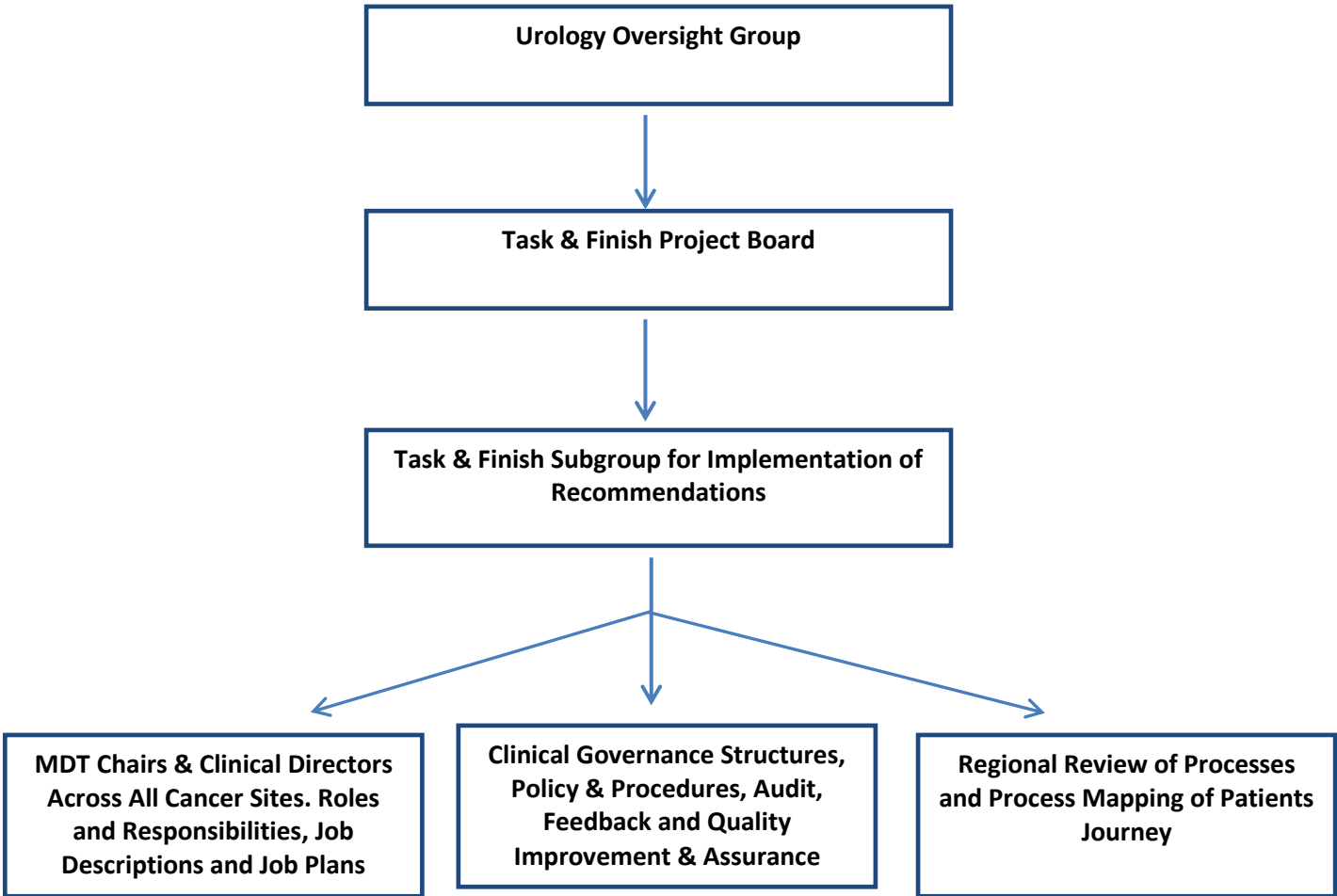
The group is a task and finish group and the anticipated timescales for completion and this work will be 12 months

Reporting and Communications

1. Task and Finish Group meeting minutes (decisions & actions) from each meeting will be prepared and circulated to members and once agreed the notes can be shared with other parties as directed by the Chairs.

- 2. Task and Finish Group will report to the Urology Oversight Group Meeting and regular updates will be provided to the HSCB, DoH and families involved in the SAI's.

Governance and Accountability



Frequency of Meetings

Monthly






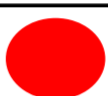

Title	
	Cancer MDT Improvement Plan
Version control date	1st November 2021
Executive Leads	Barry Conway, Assistant Director Cancer & Clinical Services; Dr Shahid Tariq, AMD Cancer; David McCaul Clinical Lead for Cancer Services
Report Author	Mary Haughey; Macmillan Cancer Service Improvement Lead
Timeframe	1st November 2021 - 31st March 2022




Introduction

The Southern Trust is undertaking work to strengthen approaches to cancer multidisciplinary team (MDT) processes. This improvement work will include a review of how MDTs currently function and consider any potential additional assurance measures that may be required. The NCAT tool - Characteristics of an Effective Multidisciplinary Team (MDT), self-assessment and feedback questionnaire (Feb 2010) was adapted by the Trust and amended into a fillable audit proforma to assist with obtaining a baseline of the holistic MDT attributes and help form the basis for quality improvement. The MDT audit is designed to target and drive patient safety and quality improvement by identifying areas for strengthening systems and processes. Between June-August 2021, the x8 local MDTs completed the NCAT self-assessment tool to reflect the views of their own MDT, these were then circulated to the wider MDTs for review and comment. During September-October 2021, the Cancer Services Management Team met with all of the MDT Leads to review the baselines, identify common areas/themes, identify tumour-site specific areas and prioritise areas for improvement. This action plan is a product from those meetings to capture all of the issues identified and agree actions to address. The action plan has been cross-referenced against the Urology SAI recommendations. The initial time frame for this action plan is from 1st November 2021 - 31st March 2022.

NCAT Section / Characteristic	Generic issue	Action/s to address	Action Product	Action owner	Action End date	Status update	RAG rating	Evidence when completed	Cross-reference to Urology SAI recommendation/s
Section 1: The Multidisciplinary Team									
1.1.1 / 1.1.3	All relevant specialities are represented in the team, cross cover for some specialities	Audits of attendance at MDM should be more regular (?quarterly) rather than review at annual business meeting - this will also assure on quoracy and allow for issues to be addressed earlier	Audit of MDT Attendance on regular basis	MDT Administrator / Projects Officer & MDT Leads	Will be on-going quarterly	Dr Tariq has written to all MDT Leads to ensure that attendance is being accurately recorded at MDT meetings. Audits of attendance to take place on a monthly basis starting from Feb 2022. Quorarcy to be shared with MDT Leads and Cancer Management Team		Monthly report of all MDT attendances available from Feb 2022 and circulated to the MDT Leads and Cancer Management Team for review and further escalation as required	Recommendation 1
1.2.1	Dedicated time in job plans for preparation & attendance at MDT	Ensure job plans of all MDT members has dedicated time included to prepare and attend the MDT meeting	Review of MDT Job plans	Dr Tariq / C.Quin	Dec-21	Dr Tariq has written to the surgical & medical directors to clarify that MDT time is included in the job plans of all MDT members. Attendance at the MDT meeting has been confirmed for all tumour sites. Preparation time is not included and falls under the time allocated for general patient admin time. C.Quin has checked with all CNS's - they all attend MDTs as required though not all have formal job plans. C.Quin to link with J.Davenport to confirm oncology input to the local MDTs.		Confirmation received per speciality that all core MDT members have dedicated time to prepare and attend MDT. Awaiting confirmation by BT in relation to oncology input to local MDTs.	Recommendation 1; Recommendation 4
1.2.6	Extended members / non-members attend for cases relevant to them	To be agreed by the MDT and detailed in the MDT operational policy	MDT Operational Policy	MDT Leads / SIL / MDT Administrator	30th Jan 2022	Discuss with MDT Leads and include agreed process in each MDT operational policy. MDT Administrator / SIL to ensure this is documented in the Operational policies.		Detailed in MDT Operational Policies. Reference 1.6 Principle Doc re. quality indicator required to audit/monitor.	Recommendation 1
1.3.5	MDT Leader has a broader remit not confined to MDT meetings	Develop role description of the MDT Lead and ensure adequate time is allocated in their job plan	Job description for MDT Lead role	Dr Tariq; Stephen Wallace	Jan-22	Dr Tariq has liaised with Stephen Wallace in relation to MDT Lead role description. A draft has been circulated to all MDT Leads for review / comment.		MDT Lead role description agreed and signed off	Recommendation 7
1.4.1	Each member has clearly defined roles / responsibilities in the team which they have signed up and included in their job plans	Define and detail the roles and responsibilities of all members involved in the MDM meetings	Review of MDT operational policies to ensure all MDT members roles are clearly defined; Review of MDT job plans	MDT Leads; MDT Administrator & Projects Officer; Medical & Surgical Speciality;AMD	Mar-22	MDT Administrator & SIL to review all MDT Operational policies with MDT Lead to ensure roles and responsibilities are included. To date LGI, UGI policies have been reviewed / updated.		Clearly detailed in each MDT Operational policy.	Recommendation 1
1.5.2	Networking opportunities to share learning & experiences with other MDTs locally	Provide opportunity for MDTs to meet locally, at least once per year, to share learning and experiences	Set up an Annual networking meeting for all MDTs	Dr Tariq; CD for Cancer; AD for Cancer services	Mar-22	Dr Tariq to contact MDTs Leads for feedback on the format and content of an annual networking event and to seek a date early 2022		An annual networking event is arranged if agreed by MDT Leads	Recommendation 6
Section 2: Infrastructure for meetings	0								
3.2.5	Locally agreed minimum dataset of information about patients for discussion collated and summarised prior to meeting (pathology, radiology, clinical, co-morbidities, psychosocial & spec palliative care needs	To develop MDT Proforma per tumour site with locally agreed minimum dataset	MDT Proforma	MDT Administrator / Projects Officer & MDT Leads	Mar-22	MDT proforma for Urology MDT agreed and will be rolled out from 4 Jan 22. Proformas for Lung, UGI and LGI to be considered next.		Each MDT has a proforma implemented for referrals to the MDM	Recommendation 1
3.2.6	Members know what info from locally agreed minimum dataset of info they will be expected to present	To be detailed in the MDT Proforma	MDT Proforma	MDT Administrator / Projects Officer & MDT Leads	Mar-22	To be developed in a phased approach for all MDTs, beginning with Urology MDT (Jan 22)		Each MDT has a proforma implemented for referrals to the MDM	Recommendation 1
3.3.1/3.3.2	It is clear who wants to discuss a patient & why being discussed / a locally agreed dataset of information is presented on each patient including diagnostic information	To develop MDT Proforma per tumour site with locally agreed minimum dataset, clear reason for discussion and sign off from the presenting clinician	MDT Proforma	MDT Administrator / Projects Officer & MDT Leads	Mar-22	To be developed in a phased approach for all MDTs, beginning with Urology MDT		Each MDT has a proforma implemented for referrals to the MDM	Recommendation 5
3.3.5	Core data items are collected during meetings and datasets completed in real time	Review and agreement of which data fields should be completed during MDT discussion and by whom, this should be detailed in MDT Principles/Protocol	Audit process agreed to review and monitor	MDT Leads; MDT Administrator / Projects Officer & MDT Co-ordinators; OSL	Mar-22	To start review with Breast & Gynae MDTs as they have more experienced trackers		Completion of core data fields during MDT meeting & process implemented to check compliance (ref 2.1 Principle doc)	Recommendation 5
3.4.1	Processes in place to ensure patients info needs are assessed and met; to ensure actions agreed are implemented;	CNS to use the Cancer Information Recording form to record the information provided by the clinical team to the patient and file in the patient notes. Holistic needs assessment offered to all newly diagnosed patients and a care plan developed to address concerns raised. All patients offered a written record of their management plan with diagnosis and contact details before they leave clinic.	Audits to check completion of Cancer information recording form & permanent record of consultation. Roll out of electronic health needs assessment by CNS's across all tumour sites.	HOS Cancer, Lead Nurse for Cancer and MDT Administrator / Projects Officer	Feb-22	Audits to take place when MDT Administrator is in post		Roll out of audits to check compliance	Recommendation 2
3.4.2	ensure MDT is notified of significant changes made to recommended treatment/care-plan	Any variation from recommended treatment/careplan should be documented at a MDT meeting. Develop an SOP with a clear pathway on whose role it is to capture , record and document and how this will be done per MDT for any patients that have declined further treatment.	Develop SOP; Include in MDT Principle's document (ref 2.6); agree audit process to check compliance	MDT Leads; MDT Administrator & Project Officer	Mar-22	Principles document developed and agreed. SOP to be developed and audit process to be agreed (ref 2.6 Principles Doc)		Roll out of audits to check compliance	Recommendation 5
Section 4: Patient Centred Clinical Decision-making									

4.1.1	Local mechanisms to identify all patients where discussion at MDT is needed	Define and detail what failsafe mechanisms are in place to ensure that there is a safety net to identify all patients who require MDT discussion	Failsafe mechanism agreed with Pathology	Pathology Clinical Lead; MDT Administrator & Project Officer	Mar-22	A report has been developed by Cellular Pathology & Lab service in Belfast and is currently being reviewed and tested.		Process in place to run a report to enable a cross-check across all the MDTs	Recommendation 5
4.1.3	Local agreement about if/when patients with advanced/recurrent disease should be discussed	MDT site specific agreement if/when patients with advanced or recurrent disease are listed for discussion and this is detailed in operational policy. Audit process to monitor this to be detailed in MDT Principles doc and rolled out.	To be guided by what is agreed and funded regionally. MDT Principles details audit process to be carried out.	MDT Leads; OSL; HOS Cancer; MDT Administrator & Projects Officer	Mar-22	Regional discussion required to agree enhanced tracking definitions and funding secured to implement . Reference 2.6 MDT Principles Doc in relation to audit mechanism		To be guided by what is agreed and funded regionally. Audit process agreed and rolled out.	Recommendation 4
4.2.3	Named individual at MDT has responsibility for identifying a key worker for the patient	To be detailed in MDT Principles doc and audit process required; additional field to be added to CAPPs to identify key worker	MDT Principles document; CAPPs	MDT Leads; HOS Cancer; SIL; MDT Administrator & Project Officer	Feb-22	Principles doc agreed, audit process to be set up once the additional field is added to CAPPs		Audit process agreed and implemented across all MDTs	Recommendation 5 & Recommendation 2
4.2.4	Named individual at MDT ensures patients information needs are assessed and addressed	To be detailed in MDT Principles doc and key worker identified on CAPPs	MDT Principles document - audit of compliance to be agreed	MDT Leads; HOS Cancer; SIL; MDT Administrator & Project Officer	Feb-22	Principles document agreed. Meetings ongoing with CNS's to ensure that patient info needs are assessed and documented appropriately.		Audit proces in place to monitor compliance (ref. 2.8 Principles Doc)	Recommendation 2
4.3.1	A locally agreed minimum dataset of info is provided at the MDT meeting	To develop MDT Proforma per tumour site with locally agreed minimum dataset	MDT Proforma	MDT Leads; MDT Administrator & Project Officer	Mar-22	Proforma for Urology MDT developed and agreed, this will be used from 4 Jan 2022. Next tumour sites for consideration are Lung, LGI and UGI.		Audit process agreed and implemented across all MDTs	Recommendation 1; Recommendation 5; Recommendation 8
4.3.3	MDTs have access to all current clinical trials, consider patients suitability, relevant research nurses attends MDT where feasible	Ensure that all MDTs have access to clinical trials and recruitment is considered as appropriate	MDT Principles document (ref 2.11)	MDT Leads,Clinical research nurses; Peter Sharpe; Irene Knox;	Ongoing	When Principles doc is agreed by MDT Leads, process will be agreed to ensure that MDTs are aware of clinical trials and consider patients suitability		Audit process agreed and implemented across all MDTs	Recommendation 1;
4.3.12	MDTs collect social demographic data (age, ethnicity & gender) & consider data periodically to reflect on equality of access to active treatments	To review systems to identify how this information can be collected and agree a clear process on how this info is captured, whose role it is to do this and when this will be considered by the MDTs	Data collection	OSL/ MDT Administrator & Project Officer / SIL	Feb-22	MDT Administrator to raise at next regional CAPPs meeting. Meeting held with NICR and info request to be submitted in Spring 2022.		Data is collected and reviewed by MDT Leads	Recommendation 6
Section 5: Team Governance									
5.1.1	Organisational support demonstrated via adequate funding/resources in terms of people, time, equipment for MDT meetings to operate effectively	Review of MDT Leads job plans, clear process in place to escalate any issues that may impact negatively on the effectiveness of the MDT meeting, new MDT room suitable equipped for meetings	MDT job plans; MDT room for meetings; process in place to escalate issues of concern, monthly Cancer checkpoint meetings, attendance at MDT AGMs	Cancer Services Management Team	Jan-22	MDT Leads job plans all reviewed; room allocated for MDT meetings; MDT Administrator post; regular meetings set up to escalate issues / concerns		MDT job plans reviewed and adequate time allocated; new MDT room operational for MDMs; clear process in place to escalate concerns; monthly checkpoint meetings; Cancer management attendance at MDT AGMs	Recommendation 9
5.1.2	Trusts consider their MDTs annual assessments and act on issues of concern	Cancer Services team attend MDT annual meetings and process in place to enable escalation of MDT areas of concern	Clear process in place and communicated to all MDT Leads to escalate issues of concern; Representation from Cancer Management Team at MDT annual business meetings	Cancer Services Management Team	Feb-22	Escalation Process agreed and circulated to all MDT Leads; Schedule of MDT business meetings to be agreed at start of each year and communicated to management team to ensure		MDT annual meetings to be agreed for 2022 and Cancer services management representation agreed for all meetings; escalation of other issues of concern as per agreed	Recommendation 3
5.2.1	Data collection resource is available to the MDT	Identify what data support is required by MDTs and explore funding sources with Trust SMT and commisioners	Data resource allocated	AD / HOS Cancer / OSL /	Feb-21	The MDT Administrator took up post on 04/01 and additional data support will be considered		Adequate data support is available to all the MDTs	Recommendation 6
5.2.2	Key info that directly affects treatment decisions is collected by MDT (staging, performance status, co-morbidity)	To ensure this info is captured in the MDT Proforma	Sytems review / MDT Proforma	MDT Administrator / Projects Officer; OSL; MDT Leads	Feb-22	This has started with the Urology MDT and will be rolled out across all of the MDTs in a phased approach		Key info is collected and considered by the MDT in relation to treatment options	Recommendation 5
5.2.3	Mandated national datasets are populated prior to or during MDT meetings or shortly afterwards	Detailed in MDT Principles doc and clear process detailed on what info is collected and by whom	MDT Principles document	MDT Co-ordinator / OSL / MDT Administrator	30th Nov	Draft presented to MDT Leads at Cancer checkpoint meeting and to the Urology Task & Finish Group meeting. Document is now finalised. Audit process to be implemented.	 	Monitoring process is undertaken as defined in the MDT Principles Doc (ref 2.1) and results shared with MDTs	Recommendation 6
5.2.4	Data collected during MDT meetings (including social demographic data) is analysed and fed back to MDT to support learning	Agree what data is collected, who will collect & analyse it and when this will be shared with the MDTs for consideration	Data collection process agreed per MDT	MDT Leads; MDT Co-ordinator; OSL; SIL	Mar-22	Liaise with HSCB to get a regional steer on social demographic collected. Meeting held with NICR and info request to be submitted in Spring 2022.		Data collected is analysed and fed back to the MDT for review and learning	Recommendation 6
5.2.5	MDT takes part in internal and external audits of processes & outcomes, reviews audit data and takes action to change practice where necessary	MDTs to identify and agree their audits at the annual business meeting including whi will lead and what support is required	Completion and and log of audits per MDT	MDT Leads / Dr Tariq / AD / Clinical audit team	Mar-22	Dr Tariq to write to MDT Leads to seek input on completion and review of future audits and the process for this to be discussed and agreed. Additional audit resource to be secured from the Clinical Audit Team		MDTs to take part in audits, both internal and external, and takes action as appropriate. All audits are logged.	Recommendation 6
5.2.7	Patient experience surveys include questions relevant to MDT working and action is taken to implement improvements in response to pt feedback	Local patient experience surveys per MDT should be rolled out at least once every two years.	Patient experience surveys	CNS's / SIL / MDT Leads	Mar-22	Scope what patient experience surveys have been undertaken and identify any gaps across MDT teams		All MDTs undertake patient experience surveys and action plans developed in response to findings	Recommendation 6
5.3.1	Data collection resource is available to the MDT	Identify what data is required for the MDTs and by whom and how often	Data resource calculated	OSL / MDT Administrator / HOS Cancer / MDT Leads	Feb-21	This will be considered further once the MDT Administrator has had to time to settle into the post		Data support is available to all MDTs	Recommendation 6

5.3.3	User Partnership Groups are given the opportunity to advise on the development of MDT policy and practice	Re-establish the Cancer Service User Group and agree the process for involvement in MDT policy and practice	Establishment of Cancer Service User Group	HOS Cancer; SIL ; Macmillan HWB Manager	Feb-22	Terms of reference developed; recruitment process underway; Group is re-established. Further discussion required to agree process for MDT involvement.		Trust cancer service user group is involved in the development of MDT policy and practice	Recommendation 6
5.3.5	Mechanisms in place to record MDT recommendation v actual treatment given and alert MDT if these are not adopted and reason for this; ensure MDT is alerted to serious treatment complications and adverse/unexpected events/death in treatment	To be detailed in MDT Principles document including quality indicator to audit; additional resource to support this needs to be identified and secured.	MDT Principles Document; Additional resource secured	AD; DMD; OSL; MDT Administrator & Projects Officer	Mar-22	Principles document is agreed. BT audit process to be reviewed and implemented intially for the Urology MDT to test and ascertain resource required.		Mechanisms and audit process are in place	Recommendation 8
5.3.6	Strategies in place to monitor: proportion of pts discussed without sufficient information to make recommendations & proportion of patients offered and/or receiving information recommended by MDT	Agree how this data is collected & analysed for MDTs, by whom and when this will be shared with the MDTs for consideration	Data collection & analysis - AUDITS	MDT Leads; MDT Administrator & Project Officer;	Jan-22	To be agreed with MDT Leads once MDT Administrator & Projects Officer is settled into post		Agreed mechanism and audit process in place	Recommendation 1; Recommendation 2
5.3.7	MDT shares good practice & discusses local problem areas with MDTs in own trust/network	Provide opportunity for MDTs to meet locally to share learning and experiences (see 1.5.2)	MDT networking event	Cancer Services Management Team	Feb-22	Dr Tariq has contacted MDT Leads to seek feedback on whether an event is required or to agree other mechanisms to share learning		Agreed mechanism in place between MDTs to share learning	Recommendation 3
5.3.9	Significant discrepancies in pathology, radiology or clinical findings between local and specialist MDTs should be recorded and subject to audit	This is currently done on a one-to-one basis, a process needs to be developed and implemented	To develop an MDT Communications Protocol	MDT Administrator / MDT Leads /	Mar-22	Dr Tariq to liaise with MDT Leads to discuss process. M.Haughey and A.Muldreu to review BT communications protocol in relation to communication back to local MDTs and advise accordingly.		Agreed process and audit in place	Recommendation 6
5.3.10	MDTs reflect annually on equality issues	Data to be agreed and collected for MDT annual reports for review & reflection by the MDT members	Data collection	MDT Leads / MDT Administrator & Projects Officer	Mar-22	Data and process for collection to be agreed when MDT Administrator & Projects Officer is settled into post. M.Haughey to check with NICR.		Process agreed to collect data which are reviewed by MDTs	Recommendation 1; Recommendation 6
Additional areas	Overall governance of MDT and decisions arising from MDTs	Review of JDs for ADs, CDs and AMDs – both for cancer and specialties.	Process set up to review JDs	AMD / Medical Directorate / Specialities	Mar-22	This is ongoing via the Medical Directorate		Clear governance structure and process in place	Recommendation 6; Recommendation 7

RAG Rated Scale for Actions	
	Action not progressed
	Process in progress
	Process complete and action implemented

MDT	NCAT Characteristic	Issue/s	Action/s to address	Action Product	Action owner	Action Start Date	Action End Date	Status update	Sign Off
GYNAE	1.2.2 Core members are present for the discussion of all cases where their input is needed	Pathology input at times	Review MDT attendance on quarterly basis	MDT attendance audit	MDT Administrator	1st Nov-21	Mar-22	Regular reports to be run when MDT Administrator is in post	Y
	1.2.3 Clinician who has met the patient whose case is being discussed is present at the meeting	Patient may be seen by different HCP until confirmation of cancer & management plan agreed	Following confirmation of diagnosis, it will be the same clinician who sees the patient	MDT Principles Document	SIL / MDT Leads	1st Nov-21	30th nov	This is detailed in the Principles document which has now been agreed	Y
	1.5.4 MDTs have a teaching & training role within team and beyond	Due to COVID, there have been less medical students / clinicians-in-training at the MDT	Include in MDT Principles document	MDT Principles dcoument	SIL / MDT Leads	1st Nov-21	30th Nov	This is detailed in the Principles document	Y
	3.2.3 Cases are organised in a way that is logical for tumour area being considered and sufficient time given to more complex cases	Cases are alphabetical for main part of meeting. Small number are set aside for regional meeting	Review of case listing	MDT List	MDT Lead / MDT Tracker / MDT Administrator	1st Nov-21	Mar-22	To be reviewed when MDT Administrator is in post	N
LUNG	1.2.7 Anyone observing should be introduced to team members and their details included on the attendance list	Medical student/registrars are not always recorded. SAS Drs would like their attendance recorded	To consider this going forward	MDT attendance list	MDT Tracker / MDT Lead	1st Nov-21	Dec-21	To be agreed with MDT Leads / MDT Co-ordinator	N
	1.5.3 Access to training opportunities as required to support an individuals role in the MDT	Consideration of MDT training for new consultants/nurses/other specialities through their training route/professional bodies	MDT Principles document shared with all new members	MDT Principles document	SIL / MDT Lead	1st Nov-21	30th Nov	Document is agreed	Y
	4.3.11 It is clear who will communicate the MDT recommendations to the patient, GP and clinical team, how and by when and this is minuted	This is not minuted but each consultant is responsible for communicating with other clinical teams, the patient and their GP	To develop MDT Communication doc	MDT Communication doc	OSL / MDT Co-ordinator	1st Nov-21	Dec-21	Review / amend BT Communication protocol	Ongoing
BREAST	1.4.2 Team has agreed what is acceptable team behaviour/etiquette	Not in place	Include in MDT Principles document; consider 360 questionnaire to audit / measure	MDT Principles document	SIL /MDT Leads	1st Nov-21	30th Nov	Detailed in MDT Principles document	Y
	1.5.3 Access to training opportunities as required to support an individuals role in the MDT	Consideration of MDT training for new consultants/nurses/other specialities through their training route/professional bodies	Consider bespoke course for MDTs - mandatory training for new appointees to MDT	MDT Principles Document	Dr Tariq / SIL / MDT Leads	1st Nov-21	30th Dec	Dr Tariq has written to colleagues in Liverpool and they will share their training course with us for consideration	Ongoing
	4.1.2 There are referral criteria in place so it is clear when to send a case to MDT for consideration	Some patients are added and at times it is not clear what the question is for the MDT	MDT Proforma would help to standardise this	MDT Proforma	Cancer Services Co-ordinator / OSL / mdt Administrator	1st Nov-21	Dec-21	MDT Proforma developed for Urology and this will be rolled out in a phased approach	Ongoing
	4.3.11 It is clear who will communicate the MDT recommendations to the patient, GP and clinical team, how and by when and this is minuted	This is not minuted but each consultant is responsible for communicating with other clinical teams, the patient and their GP	Develop a MDT communications doc	MDT Communication document	OSL /MDT Administrator / MDT Leads	1st Nov-21	30th Jan 22	BT Communications document to be reviewed and adopted	Ongoing
	5.3.2 There are agreed policies, guidelines or protocols how changes in clinical practice are to be managed; communications post meetings	Not sure of process for other modalities / specialities. For Surgery, this is agreed and disseminated through the Breast CRG	To be clearly documented for all specialities	MDT Communications Document	OSL / MDT ADMINISTRATOR/MDT Leads	1st Nov-21	30th Jan-22	BT Communications document to be reviewed and adopted	Ongoing
SKIN	1.4.2 Team has agreed what is acceptable team behaviour/etiquette	Not in place	Include in MDT Principles document	MDT Principles document	SIL /MDT Leads	1ST Nov	30th Nov	Document is now agreed	Y
	1.5.3 Access to training opportunities as required to support an individuals role in the MDT	Through different routes: appraisals, revalidation, training courses completed by members	No specifc training course in relation to the MDT	Explore what training is available	Dr Tariq / MDT Leads	1st Dec	Jan-22	Dr Tariq has written to colleagues in Liverpool and they will share their training course with us for consideration	Ongoing
	3.2.2 Locally agreed cut-off time for inclusion of a case on the MDT list	Not in place - there is no cut-off time for cases to be brought back	Potential to filter out cases that are not suitable and to ensure availability of MDT list earlier in week.	Agree cut-off time for cases	MDT / MDT Co-ordinator	1st Nov-21	Dec-21	MDT Lead to take forward with Pathology	Y

UROLOGY	1.2.7 Anyone observing should be introduced to team members and their details included on the attendance list	Medical student attendees are not recorded	Consider recording all attendees for future MDT meetings	MDT attendance list	MDT Tracker / MDT Lead	1st Nov-21	Dec-21	Ensure all attendees are recorded - this will be picked up through the quarterly attendance audits	
	3.2.3 Cases are organised in a way that is logical for tumour area being considered and sufficient time given to more complex cases		This could be improved by implementing protocolised pathways for more straight forward cases which are registered and signed off by the MDT Chair. The more complex cases would be listed for discussion.	MDT Proforma	Cancer Services Co-ordinator / MDT Lead	1st Nov-21	Dec-21	MDT Proforma developed for Urology and this will be rolled out in a phased approach	Y
	4.1.4 A clinician can bring the case of a private patient to the MDT for discussion provided there is time on the agenda	Not in place	Process to be detailed in MDT Principles document	MDT Principles document	SIL / MDT Leads / Cancer Management team	1st-Nov	Dec-21	MDT Principles document developed and shared with MDT Lead for sign off	Y
	5.2.6 MDTs consider and act on clinical outcomes data as they become available e.g. through peer review	Clinical outcomes not available through peer review	Agree what clinical data will be collected, by whom, & when this will be reviewed by the MDT	Data collection	MDT Administrator / MDT Lead	1st Nov	Mar-22	To be considered with MDT Leads when MDT Administrator is in post	Y
	5.3.11 The MDT assesses at least annually its own effectiveness/performance & benchmarks against similar MDTs	The MDT was peer reviewed in 2015, and submitted self-assessments in 2016 and 2017	Set up a process / ensure mechanism is in place for this to happen outside of peer review programme	Annual business meeting	MDT Administrator / MDT Lead	1st Nov	Mar-22	To be part of all future business meetings	N
LGI	1.2.2 Core members are present for discussion of all cases where their input is needed	Issue with pathology input at times	Review MDT attendance on quarterly basis	MDT Attendance list	MDT Co-ordinator	1st Nov	Mar-22	Attendance audit to be conducted on a quarterly basis when MDT Administrator is in post	Y
	1.2.5 A register of attendance is maintained, members sign in and out with times	Untimed weekly register is maintained by MDT Co-ordinator	To be documented in MDT Principles document	MDT Principles document	SIL / MDT Leads	1st Nov	Dec-21	MDT Principles document developed and shared with MDT Lead for sign off	Y
	1.2.7 Anyone observing should be introduced to team members and their details included on the attendance list	Medical students are introduced but not listed on the attendance sheet	MDT Attendance sheet	MDT Attendance sheet	MDT Tracker / MDT Lead	1st Nov	Mar-22	Attendance audit to be conducted on a quarterly basis when MDT Administrator is in post	Y
	1.5.3 Access to training opportunities as required to support an individual's role in the MDT	More access to ACST is required	Need an update in relation to future ACST courses	ACST Courses provided	HOS Cancer / SIL	1st Nov	Dec-21	Regional meeting convened Dec 21 to discuss a virtual course	Ongoing
UGI	5.3.4 MDT policies, guidelines and protocols are reviewed at least annually	MDT operational policy reviewed, and annual report and workplan updated. This has fallen behind over past couple of years.	To review all MDT docs and arrange a MDT meeting to sign off	MDT Docs updated for 2019	SIL /MDT Lead/ MDT Co-ordinator	1st Nov	Mar-22	All MDT documents to be updated on an annual basis	y
THYROID	5.3.4 MDT policies, guidelines and protocols are reviewed at least annually	MDT operational policy reviewed, and annual report and workplan updated. This has fallen behind over past couple of years.	To review all MDT docs and arrange a MDT meeting to sign off	MDT Docs updated for 2019	SIL / MDT Lead /MDT Co-ordinator	1st Nov	Mar-22	All MDT documents to be updated on an annual basis	Y
	5.3.11 the MDT assesses at least annually its own effectiveness/performance & benchmarks against similar MDTs	The MDT was peer reviewed in 2016, and submitted a self-assessment in 2017	Set up a process / ensure a mechanism is in place for this to happen outside of peer review	Annual business meeting	MDT Lead / MDT Co-ordinator	1st Nov	Mar-22	All MDT documents to be updated on an annual basis and presented for review at an annual MDT meeting	Y



Southern Health
and Social Care Trust

WIT-11517

Characteristics of an Effective Multidisciplinary Team (MDT)

Self Assessment and Feedback Questionnaire

Version 2 – 12th April 2021

*Based on National Cancer Action Team (NCAT)
Guidance (February 2010)*

1. The Multidisciplinary Team

Membership

No.	Effective MDT Characteristic	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
1.1.1	All relevant professions/disciplines – core & extended members - are represented in the team in line with the Manual of Cancer Services.			
1.1.2	The MDT co-ordinator is recognised as a core member of the team – they sit where they can hear and see everything.			
1.1.3	Cross cover/deputies with authority to support recommendations are in place to cover planned (and where possible unplanned) absences - advanced notice is given of core member absence so that this cover (or alternative management) can be organised if possible.			
1.1.4	Members have the level of expertise and specialization required by the MDT in question – where there are no relevant peer review measures or accreditation for these roles the issue of clinical competence is for the relevant professional body or the Trust to determine.			

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
1.2.1.	MDT members (core and extended) have dedicated time included in their job plans to prepare for, travel to (if necessary) and attend MDT meetings – the amount of time is negotiated locally to reflect their workload and varies according to discipline and cancer type.			
1.2.2	Core members are present for the discussion of all cases where their input is needed – it is for the chair to decide (in consultation with others as he/she sees fit) whether there is adequate representation at a single meeting to make safe recommendations about any/all patients and the action to take if not.			
1.2.3	Every effort should be made to ensure that a clinician who has met the patient whose case is being discussed is present at the meeting.			
1.2.4	The chair is responsible for raising concerns about non-attendance of particular members (or their deputies) and escalating these concerns if regular non-attendance is impacting on the quality of MDT working/recommendations. Frequent non-			

	attendance is addressed during appraisal processes & job plan reviews.			
1.2.5	A register of attendance is maintained – members signing in and out (with times) supports assessment of attendance.			
1.2.6	Extended members and non-members attend for the cases that are relevant to them.			
1.2.7	Anyone observing MDT meetings should be introduced to team members and their details included on the attendance list.			

Leadership

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
1.3.1	There is an identified leader/chair of the MDT and a deputy to cover when necessary – the leader and the chair do not have to be the same person			
1.3.2.	The MDT chair is responsible for the organisation and the running of the MDT meetings.			
1.3.3.	The chair has skills in the following areas: <ul style="list-style-type: none"> • meeting management; • listening & communication; • interpersonal relations; • managing disruptive 			

	personalities & conflict; • negotiations; • facilitating effective consensual clinical decision making; • time-management.			
1.3.4.	The chair: • prepares and/or agrees the agenda with the MDT coordinator; • ensures the meeting is quorate and takes action if not; • ensures all relevant cases are discussed and prioritized as necessary; • ensures all relevant team members are included in discussions; • ensures discussions are focused and relevant; • ensures good communications/a pro-discussion environment; • promotes evidence-based and patient-centered recommendations and ensures that eligibility for relevant clinical trial recruitment is considered; • ensures the current patient discussion and treatment/care plan recommendations are complete before the next patient discussion starts; • ensures relevant demographic and clinical data items are recorded; • ensures recommendations are clearly summarised, recorded and fed back to the patient, GP and			



	<p>clinical team within a locally agreed timeframe;</p> <ul style="list-style-type: none"> ensures that it is clear who is going to take any resulting actions post meeting and that this is minuted. 			
1.3.5.	<p>The MDT leader (who may also be the chair) has a broader remit not confined to the MDT meetings. They are responsible for:</p> <ul style="list-style-type: none"> issues of governance e.g. setting clear objectives/purpose for the team/what is expected of members etc; ensuring that others in the organisation have an understanding of the role of the MDT and why it is important in cancer care; negotiating locally for funding/resources needed for the MDT to be effective; escalating issues of concern that may impact on safety of MDT Recommendations etc. 			

Team working & culture

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
1.4.1.	Each MDT member has clearly defined roles and responsibilities within the team which they have signed up to and which are included in their job plans.			
1.4.2.	<p>The team has agreed what is acceptable team behavior/etiquette including:</p> <ul style="list-style-type: none"> • mutual respect & trust between team members; • an equal voice for all members - different opinions valued; • resolution of conflict between team members; • encouragement of constructive discussion/debate; • absence of personal agendas; • Ability to request and provide clarification if anything is unclear. 			
1.4.3.	MDT members play a role in sharing learning and best practice with peers.			

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
1.5.1.	Team members recognise the need for continued learning and individual members are supported to gain the necessary knowledge and skills for their roles and responsibilities within the MDT and for their respective professional role – support is available from the team, the organisation and nationally as appropriate and members take up relevant CPD opportunities.			
1.5.2.	There are networking opportunities to share learning and experiences with other MDTs in the same Trust and potentially in other Trusts in the Network or beyond.			
1.5.3.	<p>There is access to training opportunities as required to support an individual's role in the MDT in areas such as:</p> <ul style="list-style-type: none"> • leadership skills; • chairing skills; • advanced communication skills including listening, presenting and, where relevant, writing; • time management; 			

	<ul style="list-style-type: none"> • confidence & assertiveness; • use of IT equipment e.g. video-conferencing; • knowledge of anatomy, oncology, radiology & pathology (for members not expert in these areas). 			
1.5.4.	There is a teaching & training role for MDTs both within the team itself (eg. bringing patient cases back) and beyond (eg. for clinicians in training).			

2. Infrastructure for Meetings

Physical environment of meeting venue

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
2.1.1.	There is a dedicated MDT room in a suitable (quiet) location with sound proofing if necessary to ensure confidential discussions.			
2.1.2.	The room is environmentally appropriate in size and layout ie. All team members have a seat and are able to see and hear each other and view all presented data (eg. diagnostics) within and across hospital trusts.			

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
2.2.1.	<p>Rooms where MDT meetings take place have:</p> <ul style="list-style-type: none"> • access to equipment for projecting and viewing radiology images including retrospective images; • facilities for projecting and viewing specimen biopsies/resections and accessing retrospective pathology reports; • connection to relevant IT systems; • access to a database or proforma to enable documentation of recommendations in real-time; • projection facilities so members can view and validate the recommendations being recorded; • facilities (when needed) to see and speak to members who are off site (eg. video-conferencing) and share all information that will be viewed (eg. images and reports) with 			



	them.			
2.2.2.	<p>There is commitment/buy-in from all sites to provide technology and equipment (including video-conferencing) that is good quality and reliable, up to at least a minimum network wide specification, which takes into account issues such as:</p> <ul style="list-style-type: none"> • standards of data transfer; • image quality; • bandwidth - speed for loading images, time delay for discussions; • inter-hospital compatibility / cross-site co-ordination etc. <p>This specification is kept under review and updated in light of technological advances.</p>			
2.2.3	<p>There is technical support for MDT meetings so that assistance can be provided in a timely fashion (ie. during the meetings) if there are problems with any IT systems or video-conferencing links during the meeting – the quality of MDT decision making can be seriously affected when equipment fails.</p>			

3. Meeting Organisation & Logistics

Scheduling of MDT meetings

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
3.1.1.	MDT meetings take place regularly (as set out in Manual of Cancer Services).			
3.1.2.	MDT meetings are held during core hours where possible - ('core hours' are defined locally and included in staff job plans) and are set up so as not to clash with related clinics that core members need to attend – such clinics follow MDT meetings where feasible.			

Preparation prior to MDT meetings

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
3.2.1.	Processes are in place to ensure that all patients diagnosed with a primary cancer have their case considered by the relevant MDT and it is clear when patient cases can be taken back to MDTs including when discussion of patients with			



	metastatic disease/recurrence should take place.			
3.2.2.	There is a locally agreed cut-off time for inclusion of a case on the MDT list/agenda and team members abide by these deadlines – there is flexibility for cases that may need to be added at the last minute due to clinical urgency..			
3.2.3.	Cases are organised on the agenda in a way that is logical for the tumour area being considered and sufficient time is given to more complex cases – the structure of the agenda allows, for example, the pathologist to leave if all cases requiring their input have been discussed.			
3.2.4.	The structured agenda/patient list is circulated prior to the meeting if members agree this would be useful.			
3.2.5.	A locally agreed minimum dataset of information about patients to be discussed should be collated and summarised prior to MDT meetings wherever possible – this should include diagnostic information (pathology and radiology), clinical information (including co-morbidities, psychosocial and			

	specialist palliative care needs) and patient history, views and preferences where known. It is important that any data items collected locally that are in existing national datasets or are within the NHS Data Dictionary are in line with these data definitions and codes when collected.			
3.2.6.	Members know what information from the locally agreed minimum dataset of information they will be expected to present on each patient so that they can prepare and be ready to share this information (or have delegated this to another member if they cannot attend) prior to and/or at the meeting.			

Organisation/administration during MDT meetings

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
3.3.1.	It is clear who wants to discuss a particular patient and why they are being discussed.			
3.3.2.	A locally agreed minimum dataset of information is presented on each patient including diagnostic information (pathology and radiology), clinical information			



	(including co-morbidities, psychosocial and specialist palliative care needs) and patient history, views and preferences – the focus is on what the team need to hear to make appropriate recommendations on the patient in question. It may not, for example, be necessary to show/discuss the pathological or radiological findings in all cases.			
3.3.3.	There is access to all relevant information at the meeting including patient notes, test results/images/samples (past and present) and appointment dates (or a proforma /summary record with the necessary information) along with access to PAS, radiology & pathology systems etc – relevant past material should be reviewed prior to the meeting if it is not accessible during the meeting.			
3.3.4.	Electronic databases are used to capture recommendations during the meeting (including the rationale for the decision and any uncertainties or disagreements about the recommendations) – a standard pro-forma is used where			



	such a database is not available.			
3.3.5.	Core data items are collected during the meeting and cancer datasets completed in real time (where feasible) – training may be required to ensure accurate recording of real-time information to minimise the impact on (i.e. slowing down) the MDT discussion. Some MDTs will wish to collect as much of the core data items before the meeting to save time – the function of the MDT is then to check these are correct. It is important that any data items collected locally that are in existing national datasets or are within the NHS Data Dictionary are in line with these data definitions and codes when collected.			
3.3.6.	Mobile phones are off or on silent during the meeting and if phone calls have to be taken during the meeting the person taking the call leaves the room.			
3.3.7.	There is effective chairing and co-ordination throughout the meeting.			

Post MDT meeting/co-ordination of services

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
3.4.1.	<p>Processes are in place:</p> <ul style="list-style-type: none"> • for communicating MDT recommendations to patients, GPs and clinical teams within locally agreed timeframes e.g. patient clinics on the same or next day as MDT meetings where feasible; • for ensuring that patients' information needs are assessed and met; • to ensure actions agreed at the meeting are implemented; • to ensure the MDT is notified of significant changes made to their recommended treatment/care plan; • to manage referral of patient cases between MDTs (including to MDTs in a different Provider); • to track patients through the system to ensure that any tests, appointments, treatments are carried out in a timely manner e.g. Within cancer waits standards where applicable. 			
3.4.2.	Relevant items from cancer datasets are completed (if this has			

	not been done in real time at the meeting).			
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4. Patient Centered Clinical Decision-Making

Who to discuss?

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
4.1.1.	There are local mechanisms in place to identify all patients where discussion at MDT is needed.			
4.1.2	There are referral criteria in place so it is clear when to send a case to the MDT for consideration i.e. clarity on: <ul style="list-style-type: none"> • which patients should be discussed by the MDT; • the clinical questions that need to be addressed by the MDT; • what information has to be available for the MDT discussion to be productive; • when to refer a patient on to another MDT (e.g. from a local to a specialist MDT). 			
4.1.3	There is local agreement about if/when patients with advanced/recurrent disease should be discussed at MDT meetings.			



4.1.4	A clinician can bring the case of a private patient to the MDT for discussion provided there is time on the agenda - any reimbursement arrangements are for local determination.			
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Patient-centered care

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
4.2.1.	Patients are aware of the MDT, its purpose, membership, when it meets and that their case is being/has been discussed and are given the outcome within a locally agreed timeframe.			
4.2.2	A patient's views/preferences/holistic needs are presented by someone who has met the patient whenever possible.			
4.2.3	A named individual at the MDT has responsibility for identifying a key worker for the patient.			
4.2.4	A named individual at the MDT has responsibility for ensuring that the patient's information needs have been (or will be) assessed and addressed.			



4.2.5	Patients are given information consistent with their wishes, on their cancer, their diagnosis and treatment options including therapies which may be available by referral to other MDTs, sufficient to make a well informed choice/decision on their treatment and care.			
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Clinical Decision-Making Process

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
4.3.1	A locally agreed minimum dataset of information is provided at the meeting i.e. the information the MDT needs to make informed recommendations including diagnostic information (pathology and radiology), clinical information (including co-morbidities, psychosocial and specialist palliative care needs) and patient history, views and preferences. It is important that any data items collected locally that are in existing national datasets or are within the NHS Data Dictionary are in line with these data definitions and codes			



	when collected.			
4.3.2	MDTs consider all clinically appropriate treatment options for a patient even those they cannot offer/provide locally.			
4.3.3.	MDTs have access to a list of all current and relevant clinical trials (including eligibility criteria) particularly those in the NCRN portfolio and consider patients' suitability for appropriate clinical trials as part of the decision-making process - the relevant trial coordinator/ research nurse attends MDT meetings where feasible.			
4.3.4.	Standard treatment protocols are in place and used whenever appropriate			
4.3.5	A patient's demographic profile and co-morbidities are always considered - age does not in itself act as a barrier to active treatment.			
4.3.6	A patient's psychosocial and supportive & palliative care issues are always considered (e.g. via holistic needs assessment).			
4.3.7	A patient's views, preferences and needs inform the decision-making			

	process when relevant/possible			
4.3.8	<p>The clinical–decision making process results in clear recommendations on the treatment/care plan resulting from the meeting. These recommendations are:</p> <ul style="list-style-type: none"> • evidence-based (eg. in line with NICE and/or cancer network guidelines); • patient-centered (in line with patient views & preferences when known and taking into account co-morbidities); • in line with standard treatment protocols unless there is a good reason against this, which should then be documented. 			
4.3.9	MDT recommendations are only as good as the information they are based on – if there are concerns that key data is missing this should be documented.			
4.3.10	Where a recommendation cannot be made because of incomplete data or where new data becomes available at a later stage it should be possible to bring the patient case back to the MDT for further discussion.			
4.3.11	It is clear who will communicate the MDT recommendation(s) to the patient, GP and clinical team, how and by when and this is minuted.			



4.3.12	MDTs collect social demographic data (on age, ethnicity and gender as a minimum) and consider that data periodically to reflect on equality of access to active treatments and to other aspects of treatment, care and experience – Information relating to these issues will/should be on PAS / NIECR / CAPPS (based on NHS Data Dictionary definitions) and MDTs should link up to the source of these data rather than create separate data capture processes.			
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5. Team Governance

Organisational support

5.1.1.	<p>There is Organisational (employer) support for MDT meetings and MDT membership demonstrated via:</p> <ul style="list-style-type: none"> • recognition that MDTs are the accepted model by which to deliver safe and high quality cancer care; • adequate funding/resources in terms of people, time, equipment and facilities for MDT meetings to operate effectively (as set out in this document). 			
5.1.2.	Trusts consider their MDTs' annual assessments and act on issues of concern (see 5.3.10).			

Data collection, analysis and audit of outcomes

No.	Statement	Embedded (Fully, Partially, Not in	Evidence	Comments / Action Required to Improve?
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		Place)		
5.2.1.	Data collection resource (i.e. the ability to capture relevant information in a timely manner etc) is available to the MDT.			
5.2.2.	Key information that directly affects treatment decisions (e.g. staging, performance status and co-morbidity) is collected by the MDT.			
5.2.3.	Mandated national datasets are populated prior to or during MDT meetings where possible and appropriate – if this is not possible this takes place shortly after the meetings.			
5.2.4.	Data collected during MDT meetings (including social demographic data extracted from PAS) is analyzed and fed back to MDTs to support learning.			
5.2.5.	The MDT takes part in internal and external audits of processes and outcomes and reviews audit data (eg. to confirm that treatment recommendations match current best practice and to consider trial recruitment) taking action to change practice etc where necessary.			
5.2.6.	MDTs consider and act on clinical outcomes data as they become available eg. through peer review, NCIN clinical reference groups etc.			



5.2.7.	Patient experience surveys include questions relevant to MDT working and action is taken by MDTs to implement improvements needed in response to patient feedback.			
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Clinical governance

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
5.3.1	Data collection resource (i.e. the ability to capture relevant information in a timely manner etc) is available to the MDT.			
5.3.2	There are agreed policies, guidelines or protocols for: <ul style="list-style-type: none"> • how the MDT operates; • who the core and extended members are; • the roles of members; • how members should work together; • how changes in clinical practice are to be managed; • communications post meetings eg. To patients, GPs and other clinical colleagues. 			
5.3.3	User Partnership Groups are given the opportunity to advise on the development of MDT policy and practice			



	– they are given feedback in response to their advice including actions taken in response to their recommendations.			
5.3.4	MDT policies, guidelines and protocols are reviewed at least annually			
5.3.5	<p>There are mechanisms in place to:</p> <ul style="list-style-type: none"> record the MDT recommendation(s) versus the actual treatment given and to alert the MDT if their treatment recommendation(s) are not adopted and the reason for this – the MDT has regular opportunities to review and act on learning from such cases; ensure that the MDT is alerted to serious treatment complications and adverse or unexpected events/death in treatment - the MDT has regular opportunities to review and act on learning from such cases. 			
5.3.6	<p>There are strategies in place to monitor:</p> <ul style="list-style-type: none"> the proportion of patients discussed without sufficient information to make recommendations/ take action at that meeting; the proportion of patients offered 			

	and/or receiving information recommended by the MDT.			
5.3.7	The MDT shares good practice and discusses local problem areas with MDTs within its own trust/Network.			
5.3.8	The MDT has representation on the Clinical Reference Group (CRG) for its cancer site and that representative attends the meetings or sends a deputy.			
5.3.9	Significant discrepancies in pathology, radiology or clinical findings between local and specialist MDTs should be recorded and be subject to audit.			
5.3.10	MDTs reflect, at least annually, on equality issues, for example, that there is equality of access to active treatments and other aspects of treatment, care and experience for all patients.			
5.3.11	The MDT assesses (at least annually) its own effectiveness/performance and where possible benchmarks itself against similar MDTs making use of cancer peer review processes and other national tools as they become available – results of the assessment are acted on by the MDT or employing organisation.			



Characteristics of an Effective Multidisciplinary Team (MDT)

Self Assessment and Feedback Questionnaire

Urology MDT, May 2021

Version 2 – 12th April 2021

*Based on National Cancer Action Team
(NCAT) Guidance (February 2010)*

1. The Multidisciplinary Team

Membership

No.	Effective MDT Characteristic	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
1.1.1	All relevant professions/disciplines – core & extended members - are represented in the team in line with the Manual of Cancer Services.	Partial	Annual report	Issue re. cover for radiology and oncology at the MDT Additional radiologist has been recruited by the Trust and following a period of absence for a sabbatical will be able to provide cover Oncology representation has been raised at a regional level
1.1.2	The MDT co-ordinator is recognised as a core member of the team – they sit where they can hear and see everything.	Fully	Operational Policy	
1.1.3	Cross cover/deputies with authority to support recommendations are in place to cover planned (and where possible unplanned) absences - advanced notice is given of core member absence so that this cover (or alternative management) can be organised if possible.	Partially	Operational Policy	See 1.1.1 in relation to cover for radiology and oncology
1.1.4	Members have the level of expertise and specialization required by the MDT in question	Fully	Professional registration Ongoing professional development	

	– where there are no relevant peer review measures or accreditation for these roles the issue of clinical competence is for the relevant professional body or the Trust to determine.		Organisational policy sets out individual roles / specialties of the MDT members	
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Attendance

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
1.2.1.	MDT members (core and extended) have dedicated time included in their job plans to prepare for, travel to (if necessary) and attend MDT meetings – the amount of time is negotiated locally to reflect their workload and varies according to discipline and cancer type.	Partially	Job plans for members which include prep time and attendance at MDT meetings	Spec palliative CNS attends MDT when is able but has no protected time to prepare and attend
1.2.2	Core members are present for the discussion of all cases where their input is needed – it is for the chair to decide (in consultation with others as he/she sees fit) whether there is adequate representation at a single meeting to make safe recommendations about any/all patients and the action to take if not.	Fully	Operational Policy Attendance / Minutes of the MDT meetings	
1.2.3	Every effort should be made to ensure that a clinician who has met the patient whose case is being discussed is present at the meeting.	Fully	Operational Policy Minutes / outcomes of the MDT meeting	

1.2.4	The chair is responsible for raising concerns about non-attendance of particular members (or their deputies) and escalating these concerns if regular non-attendance is impacting on the quality of MDT working/recommendations. Frequent non-attendance is addressed during appraisal processes & job plan reviews.	Fully	Staff appraisal Review of Job plans Action plan from peer review	Usually only an issue if core members leave or change Regular review of individual core/cover attendance and MDT quoracy to flag attendance issues Operational policy (page 9) states that attendance records will be calculated on a quarterly basis and fed back to individual core members
1.2.5	A register of attendance is maintained – members signing in and out (with times) supports assessment of attendance.	Partially	MDT minutes	Attendance is recorded by MDT Co-coordinator, sign in/out is not used as some members video-link
1.2.6	Extended members and non-members attend for the cases that are relevant to them.	Fully	MDT minutes	
1.2.7	Anyone observing MDT meetings should be introduced to team members and their details included on the attendance list.	Partially		Medical student attendees are not recorded

Leadership

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
1.3.1	There is an identified leader/chair of the MDT and a deputy to cover when necessary – the leader and the chair do not have to be the same person	Fully	Operational Policy details the MDT Lead clinician / cover and the arrangements for chairing the MDT meetings	The Urology Consultants rotate the chair / deputy roles for the MDT



1.3.2.	The MDT chair is responsible for the organisation and the running of the MDT meetings.	Fully	Operational Policy details the role of the MDT	
1.3.3.	<p>The chair has skills in the following areas:</p> <ul style="list-style-type: none"> • meeting management; • listening & communication; • interpersonal relations; • managing disruptive personalities & conflict; • negotiations; • facilitating effective consensual clinical decision making; • Time-management. 	Fully	Advanced Communication Skills Training	<p>As there are different chairs of the MDT, how do we ensure they have all the relevant skills?</p> <p>Consideration of a bespoke MDT training course for chairs and members..?</p>
1.3.4.	<p>The chair:</p> <ul style="list-style-type: none"> • prepares and/or agrees the agenda with the MDT coordinator; • ensures the meeting is quorate and takes action if not; • ensures all relevant cases are discussed and prioritized as necessary; • ensures all relevant team members are included in discussions; • ensures discussions are focused and relevant; • ensures good communications/a pro-discussion environment; • promotes evidence-based and patient-centered recommendations and ensures that eligibility for relevant clinical trial recruitment is 	Fully	<p>Minutes of MDT meeting:</p> <ul style="list-style-type: none"> -List of cases discussed -Outcomes of discussion recorded -Identified actions and by whom <p>MDM report</p> <p>CAPPs / NIECR</p>	



	<p>considered;</p> <ul style="list-style-type: none"> • ensures the current patient discussion and treatment/care plan recommendations are complete before the next patient discussion starts; • ensures relevant demographic and clinical data items are recorded; • ensures recommendations are clearly summarised, recorded and fed back to the patient, GP and clinical team within a locally agreed timeframe; • ensures that it is clear who is going to take any resulting actions post meeting and that this is minuted. 			
1.3.5.	<p>The MDT leader (who may also be the chair) has a broader remit not confined to the MDT meetings. They are responsible for:</p> <ul style="list-style-type: none"> • issues of governance e.g. setting clear objectives/purpose for the team/what is expected of members etc; • ensuring that others in the organisation have an understanding of the role of the MDT and why it is important in cancer care; • negotiating locally for funding/resources needed for the MDT to be effective; • escalating issues of concern that may impact on safety of MDT 	Fully	<p>Adhering to role of MDT Lead Clinician as set out in the Operational Policy</p> <p>Annual General Meeting</p> <p>X2 Business Meetings per annum with Service Managers / senior personnel to escalate concerns as required</p> <p>Attendance / participation in relevant meetings as required</p>	<p>Delivery of action points can be challenging. It is important to ensure that recurrent issues / themes do not continue to drift from one meeting to another</p>

	Recommendations etc.			
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Team working & culture

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
1.4.1.	Each MDT member has clearly defined roles and responsibilities within the team which they have signed up to and which are included in their job plans.	Fully	MDT members job plans	
1.4.2.	<p>The team has agreed what is acceptable team behavior/etiquette including:</p> <ul style="list-style-type: none"> • mutual respect & trust between team members; • an equal voice for all members - different opinions valued; • resolution of conflict between team members; • encouragement of constructive discussion/debate; • absence of personal agendas; • Ability to request and provide clarification if anything is unclear. 	Fully	Completed once in every 5 years for appraisal – patient and colleague feedback	Maybe consider a 360 questionnaire regarding MDT Behaviours/etiquette..?
1.4.3.	MDT members play a role in sharing learning and best practice with peers.	Fully	Participation and presentation of audits, both at a local and regional level	<p>A log of audits is held centrally in the trust.</p> <p>In the main, it is up to clinicians to do their own</p>

				<p>audits. There can be a degree of bias in relation to what audits are completed compared to what may be required.</p> <p>Quality improvement initiatives are ad-hoc – need to capture evidence to measure improvement</p> <p>Does the MDT need to consider developing a log of completed and planned audits / service improvement initiatives..?</p>
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Personal development & training

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
1.5.1.	Team members recognise the need for continued learning and individual members are supported to gain the necessary knowledge and skills for their roles and responsibilities within the MDT and for their respective professional role – support is available from the team, the organisation and nationally as	Fully	<p>Annual appraisal of medical team members</p> <p>Revalidation process – present evidence of CPD</p> <p>Training / education register of attendance at CPD events</p>	<p>Annual appraisal runs outside of MDT – self relying on members to undertake appropriate CPD</p> <p>Does this need to be collated centrally for the MDT members and updated on an annual basis..?</p>

	appropriate and members take up relevant CPD opportunities.			Consider developing a bespoke MDT training course, it would help to consolidate the Trust's expectations of MDTs
1.5.2.	There are networking opportunities to share learning and experiences with other MDTs in the same Trust and potentially in other Trusts in the Network or beyond.	Not in place		Set up a bi-annual meeting of MDT leads to share learning and experiences Provide opportunity for MDT Leads to sit-in in other MDT meetings to review practice / share learning and support opportunity for developing
1.5.3.	There is access to training opportunities as required to support an individual's role in the MDT in areas such as: <ul style="list-style-type: none"> • leadership skills; • chairing skills; • advanced communication skills including listening, presenting and, where relevant, writing; • time management; • confidence & assertiveness; • use of IT equipment e.g. video-conferencing; • knowledge of anatomy, oncology, radiology & pathology (for members not expert in these areas). 	Fully	Appraisal ACST register Details of training completed	Bespoke course for MDT's – mandatory training for new appointees for MDT core members, including CNS's and other specialities
1.5.4.	There is a teaching & training role for	Fully	Attendance of medical	Junior staff – could be more

	MDTs both within the team itself (eg. bringing patient cases back) and beyond (eg. for clinicians in training).		students / clinicians-in-training at the MDT	actively involved in the MDT
			Appraisal documentation..?	

2. Infrastructure for Meetings

Physical environment of meeting venue

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
2.1.1.	There is a dedicated MDT room in a suitable (quiet) location with sound proofing if necessary to ensure confidential discussions.	Fully	The MDT takes place in the tutorial room, MEC, each week with video-conferencing facilities to enable communication via video to Daisy Hill Hospital and the Specialist MDT	
2.1.2.	The room is environmentally appropriate in size and layout ie. All team members have a seat and are able to see and hear each other and view all presented data (eg. diagnostics) within and across hospital trusts.	Fully		

Technology & equipment (availability & use)

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
2.2.1.	Rooms where MDT meetings take place	Fully	As per 2.1.1	

	<p>have:</p> <ul style="list-style-type: none"> • access to equipment for projecting and viewing radiology images including retrospective images; • facilities for projecting and viewing specimen biopsies/resections and accessing retrospective pathology reports; • connection to relevant IT systems; • access to a database or proforma to enable documentation of recommendations in real-time; • projection facilities so members can view and validate the recommendations being recorded; • facilities (when needed) to see and speak to members who are off site (eg. video-conferencing) and share all information that will be viewed (eg. images and reports) with them. 			
2.2.2.	<p>There is commitment/buy-in from all sites to provide technology and equipment (including video-conferencing) that is good quality and reliable, up to at least a minimum network wide specification, which takes into account issues such as:</p>	Fully		<p>Is the technology / equipment spec kept under review and by whom..?</p>

	<ul style="list-style-type: none"> standards of data transfer; image quality; bandwidth - speed for loading images, time delay for discussions; inter-hospital compatibility / cross-site co-ordination etc. <p>This specification is kept under review and updated in light of technological advances.</p>			
2.2.3	There is technical support for MDT meetings so that assistance can be provided in a timely fashion (ie. during the meetings) if there are problems with any IT systems or video-conferencing links during the meeting – the quality of MDT decision making can be seriously affected when equipment fails.	Fully	The trust has a contract with HSL who manage pexip, video-conferencing systems, desktop client. There is support available for staff via email or a helpline telephone number	

3. Meeting Organisation & Logistics

Scheduling of MDT meetings

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
3.1.1.	MDT meetings take place regularly (as set out in Manual of Cancer Services).	Fully	Annual report – details the MDT meetings & attendance / quoracy	
3.1.2.	MDT meetings are held during core	Fully	MDT is held each Thursday at 2.15pm, with video-link to the	

	hours where possible - ('core hours' are defined locally and included in staff job plans) and are set up so as not to clash with related clinics that core members need to attend – such clinics follow MDT meetings where feasible.		Specialist MDT at 3.30pm and finishes by 5pm. Core members have time allocated in job plans to attend the MDT outside of clinics.	
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Preparation prior to MDT meetings

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
3.2.1.	Processes are in place to ensure that all patients diagnosed with a primary cancer have their case considered by the relevant MDT and it is clear when patient cases can be taken back to MDTs including when discussion of patients with metastatic disease/recurrence should take place.	Fully	Operational Policy details purpose of MDT, patients discussed and the process to re-discuss patients if required	
3.2.2.	There is a locally agreed cut-off time for inclusion of a case on the MDT list/agenda and team members abide by these deadlines – there is flexibility for cases that may need to be added at the last minute due to clinical urgency..	Fully	Operational Policy details the cut-off day/time for patients to be added to the MDT list and there is flexibility to add cases due to clinical urgency if required	
3.2.3.	Cases are organised on the agenda in a way that is logical for the	Partially	Cases are alphabetical for main body of the meeting	This could be improved by implementing protocolised pathways for more straight

	tumour area being considered and sufficient time is given to more complex cases – the structure of the agenda allows, for example, the pathologist to leave if all cases requiring their input have been discussed.		A small number of cases are set aside for regional meeting	forward cases which just need to be registered and signed off by the MDT Chair. The other more complex cases would be listed for discussion.
3.2.4.	The structured agenda/patient list is circulated prior to the meeting if members agree this would be useful.	Fully	The MDT list is circulated to all members prior to the MDM	
3.2.5.	A locally agreed minimum dataset of information about patients to be discussed should be collated and summarised prior to MDT meetings wherever possible – this should include diagnostic information (pathology and radiology), clinical information (including co-morbidities, psychosocial and specialist palliative care needs) and patient history, views and preferences where known. It is important that any data items collected locally that are in existing national datasets or are within the NHS Data Dictionary are in line with these data definitions and codes when collected.	Partially		Use of a MDT proforma would help to ensure a minimum dataset is completed for each patient being presented – reviewed by chair re. which goes to protocol and what requires discussion
3.2.6.	Members know what information	Not in place		Use of a MDT proforma would help to ensure a minimum

	from the locally agreed minimum dataset of information they will be expected to present on each patient so that they can prepare and be ready to share this information (or have delegated this to another member if they cannot attend) prior to and/or at the meeting.			dataset is completed for each patient being presented
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Organisation/administration during MDT meetings

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
3.3.1.	It is clear who wants to discuss a particular patient and why they are being discussed.	Partially	MDT list and referring consultant	Use of MDT proforma would help to improve this
3.3.2.	A locally agreed minimum dataset of information is presented on each patient including diagnostic information (pathology and radiology), clinical information (including co-morbidities, psychosocial and specialist palliative care needs) and patient history, views and preferences – the focus is on what the team need to hear to make appropriate recommendations on the patient in question. It may not, for example, be necessary to show/discuss the pathological or radiological findings	Partially		Improve listing of patients by indicating which aspects need to be reviewed e.g. pathology, radiology

	in all cases.			
3.3.3.	There is access to all relevant information at the meeting including patient notes, test results/images/samples (past and present) and appointment dates (or a proforma /summary record with the necessary information) along with access to PAS, radiology & pathology systems etc – relevant past material should be reviewed prior to the meeting if it is not accessible during the meeting.	Fully	<p>Access to patient notes & test results through NIECR available during the MDM if required</p> <p>Access to PAS, radiology & pathology systems is available as required though material is usually reviewed prior to the meeting</p>	
3.3.4.	Electronic databases are used to capture recommendations during the meeting (including the rationale for the decision and any uncertainties or disagreements about the recommendations) – a standard pro-forma is used where such a database is not available.	Partially	<p>CAPPs system is an electronic database which is used to collect data on patients and document MDT decisions.</p> <p>Investigation plans and treatment recommendations are formulated during the meeting and recorded in narrative format by the MDT Co-ordinator.</p>	
3.3.5.	Core data items are collected during the meeting and cancer datasets completed in real time (where feasible) – training may be required to ensure accurate recording of real-time information to minimise the impact on (i.e. slowing down) the	Not in place	<p>The CAPPs system is not populated in real time during the MDT meeting. The MDT Co-ordinator will populate the patient data after the meeting and will be quality assured by the Chair</p> <p>Summaries agreed at meeting,</p>	Further discussion/work required to explore how to streamline process.

	MDT discussion. Some MDTs will wish to collect as much of the core data items before the meeting to save time – the function of the MDT is then to check these are correct. It is important that any data items collected locally that are in existing national datasets or are within the NHS Data Dictionary are in line with these data definitions and codes when collected.		paper notes, circulate to chair, read, approve, circulate final version to all members of team. Data fields on CAPPs are regionally agreed.	
3.3.6.	Mobile phones are off or on silent during the meeting and if phone calls have to be taken during the meeting the person taking the call leaves the room.	Fully		
3.3.7.	There is effective chairing and co-ordination throughout the meeting.	Fully	MDT lists and outcomes are completed during the allocated time	

Post MDT meeting/co-ordination of services

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
3.4.1.	Processes are in place: <ul style="list-style-type: none"> for communicating MDT recommendations to patients, GPs and clinical teams within locally agreed timeframes e.g. patient clinics on the same or next day as MDT meetings 	Partial	Some of the consultant clinics take place the week after the MDT All patients are offered a core	



	<p>where feasible;</p> <ul style="list-style-type: none"> for ensuring that patients' information needs are assessed and met; to ensure actions agreed at the meeting are implemented; to ensure the MDT is notified of significant changes made to their recommended treatment/care plan; to manage referral of patient cases between MDTs (including to MDTs in a different Provider); to track patients through the system to ensure that any tests, appointments, treatments are carried out in a timely manner e.g. Within cancer waits standards where applicable. 	<p>Fully</p> <p>Not in place</p> <p>Not in place</p> <p>Fully</p> <p>Partial</p>	<p>information pack and additional info as required. All patients are provided with a permanent record of consultation detailing their diagnosis and treatment plan.</p> <p>Operational Policy outlines process for referrals between MDTs</p> <p>Patients are tracked from diagnosis up until the 1st definitive treatment (31 day & 62 day pathways).</p>	<p>All pathway breaches are discussed at the monthly SHSCT Cancer Performance meetings with presentation from the Assistant Director, Head of Service and Operational Service Leads from each the clinical specialities. Report outcomes are shared and learning is identified for onward sharing / implementation within the clinical specialty.</p>
3.4.2.	Relevant items from cancer datasets are completed (if this has not been done in real time at the meeting).	Fully	This is completed by the MDT Co-ordinator post-MDT	

4. Patient Centered Clinical Decision-Making

Who to discuss?

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
4.1.1.	There are local mechanisms in place to identify all patients where discussion at MDT is needed.	? Not sure		Red flag referrals from GPs and other consultants are triaged and depending on outcome are put on 31 day and 62 day pathways which are tracked.
4.1.2	There are referral criteria in place so it is clear when to send a case to the MDT for consideration i.e. clarity on: <ul style="list-style-type: none"> • which patients should be discussed by the MDT; • the clinical questions that need to be addressed by the MDT; • what information has to be available for the MDT discussion to be productive; • when to refer a patient on to another MDT (e.g. from a local to a specialist MDT). 	Fully	Operational policy	
4.1.3	There is local agreement about if/when patients with advanced/recurrent disease should be discussed at MDT meetings.	Partial		<p>Patients are not necessarily brought back to the MDT and is based on the consultant's decision</p> <p>Review and update the operational policy in relation to this</p>

4.1.4	A clinician can bring the case of a private patient to the MDT for discussion provided there is time on the agenda - any reimbursement arrangements are for local determination.	Not in place		
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Patient-centered care

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
4.2.1.	Patients are aware of the MDT, its purpose, membership, when it meets and that their case is being/has been discussed and are given the outcome within a locally agreed timeframe.	Fully	MDT Patient Leaflet provided to patients detailing purpose of the MDT and the roles of the health care professionals Consultant meets with patient following MDT to discuss diagnosis and agree treatment plan	
4.2.2	A patient's views/preferences/holistic needs are presented by someone who has met the patient whenever possible.	Fully	Patient's holistic needs are considered as part of the MDT discussion. This is documented and the outcomes are recorded in the MDT Proforma.	
4.2.3	A named individual at the MDT has responsibility for identifying a key worker for the patient.	No	Key worker not identified at the MDT meeting – this may happen afterwards	
4.2.4	A named individual at the MDT has responsibility for ensuring that the patient's information needs have been (or will be) assessed and	Fully	This is usually the Consultant responsible for patient's care	

	addressed.			
4.2.5	Patients are given information consistent with their wishes, on their cancer, their diagnosis and treatment options including therapies which may be available by referral to other MDTs, sufficient to make a well informed choice/decision on their treatment and care.	Fully	<p>Core information is available to all patients depending on their wishes, along with additional information in relation to their specific cancer</p> <p>All patients are provided with a permanent record of consultation detailing their diagnosis and treatment plan.</p>	

Clinical Decision-Making Process

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
4.3.1	A locally agreed minimum dataset of information is provided at the meeting i.e. the information the MDT needs to make informed recommendations including diagnostic information (pathology and radiology), clinical information (including co-morbidities, psychosocial and specialist palliative care needs) and patient history, views and preferences. It is important that any data items collected locally that are in existing national datasets or are within the NHS Data Dictionary are in line with	Not in place		An MDT Proforma would help with this

	these data definitions and codes when collected.			
4.3.2	MDTs consider all clinically appropriate treatment options for a patient even those they cannot offer/provide locally.	Fully	Forms part of MDT discussion and is recorded on MDT outcomes proforma	
4.3.3.	MDTs have access to a list of all current and relevant clinical trials (including eligibility criteria) particularly those in the NCRN portfolio and consider patients' suitability for appropriate clinical trials as part of the decision-making process - the relevant trial coordinator/ research nurse attends MDT meetings where feasible.	Partial		Patients who are referred to the Specialist MDT will have access to clinical trials as they are usually regional trials
4.3.4.	Standard treatment protocols are in place and used whenever appropriate	Fully	Operational policy Adherence to NICAN clinical management guidelines	
4.3.5	A patient's demographic profile and co-morbidities are always considered - age does not in itself act as a barrier to active treatment.	Fully	Forms part of MDT discussion and outcome for treatment	
4.3.6	A patient's psychosocial and supportive & palliative care issues are always considered (e.g. via holistic needs assessment).	Fully	As above	
4.3.7	A patient's views, preferences and	Fully	Patient's views are considered and help to inform decision in	

	needs inform the decision-making process when relevant/possible		relation to treatment plan	
4.3.8	<p>The clinical–decision making process results in clear recommendations on the treatment/care plan resulting from the meeting. These recommendations are:</p> <ul style="list-style-type: none"> • evidence-based (eg. in line with NICE and/or cancer network guidelines); • patient-centered (in line with patient views & preferences when known and taking into account co-morbidities); • in line with standard treatment protocols unless there is a good reason against this, which should then be documented. 	Fully	Adherence to NICAN Clinical management guidelines, NICE Guidance and the MDT Operational Policy	
4.3.9	MDT recommendations are only as good as the information they are based on – if there are concerns that key data is missing this should be documented.	Fully	This is recorded in MDT outcomes proforma. A Patient maybe deferred to the next MDT meeting.	
4.3.10	Where a recommendation cannot be made because of incomplete data or where new data becomes available at a later stage it should be possible to bring the patient case back to the MDT for further discussion.	Fully		
4.3.11	It is clear who will communicate the MDT recommendation(s) to the patient, GP and clinical team, how	Fully	Detailed in the Operational Policy	

	and by when and this is minuted.			
4.3.12	MDTs collect social demographic data (on age, ethnicity and gender as a minimum) and consider that data periodically to reflect on equality of access to active treatments and to other aspects of treatment, care and experience – Information relating to these issues will/should be on PAS / NIECR / CAPPS (based on NHS Data Dictionary definitions) and MDTs should link up to the source of these data rather than create separate data capture processes.	Partial	Not sure if ethnicity is collected?	

5. Team Governance

Organisational support

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
5.1.1.	<p>There is Organisational (employer) support for MDT meetings and MDT membership demonstrated via:</p> <ul style="list-style-type: none"> recognition that MDTs are the accepted model by which to deliver safe and high quality 	Fully	Through MDT members job plans	

	cancer care; • adequate funding/resources in terms of people, time, equipment and facilities for MDT meetings to operate effectively (as set out in this document).	Partial	Issues with cover for Radiology and Oncology	Need more resource for audit and tracking
5.1.2.	Trusts consider their MDTs' annual assessments and act on issues of concern (see 5.3.10).	Not in place		

Data collection, analysis and audit of outcomes

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
5.2.1.	Data collection resource (i.e. the ability to capture relevant information in a timely manner etc) is available to the MDT.	Partial	Histology, stage and grade are captured Radiological info All treatment options captured – free text is used to generate an outcome	Due to volume of cases presented, the MDT Co-ordinator populates data after the meeting. This is sent to the Chair for approval before it is available. There may be a delay in availability of data on CAPPs.
5.2.2.	Key information that directly affects treatment decisions (e.g. staging, performance status and co-morbidity) is collected by the MDT.	Partial	Performance & co-morbidity is recorded in the free text box, there is no structured data fields to capture this	

5.2.3.	Mandated national datasets are populated prior to or during MDT meetings where possible and appropriate – if this is not possible this takes place shortly after the meetings.	Partial		CAPPs datasets are populated after MDT Under current legislation regarding the use of secondary data, the MDT is not able to provide data for national datasets
5.2.4.	Data collected during MDT meetings (including social demographic data extracted from PAS) is analyzed and fed back to MDTs to support learning.	Not in place		This is not currently happening and would require further resource to support this. It would be useful to support the MDT with forward planning, and provide assurance in relation to meeting standards / guidelines by providing a systematic review of MDT activity
5.2.5.	The MDT takes part in internal and external audits of processes and outcomes and reviews audit data (eg. to confirm that treatment recommendations match current best practice and to consider trial recruitment) taking action to change practice etc where necessary.	Partial		Limited audits due to lack of resource available to support
5.2.6.	MDTs consider and act on clinical outcomes data as they become available eg. through peer review, NCIN clinical reference groups etc.	Not in place		Clinical outcomes data not available through peer review
5.2.7.	Patient experience surveys include questions relevant to MDT working and action is taken by MDTs to implement improvements needed in response to	Partial	NI Cancer Patient Experience Survey Local patient surveys	Don't ask specific questions on MDT working

	patient feedback.			
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Clinical governance

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
5.3.1	Data collection resource (i.e. the ability to capture relevant information in a timely manner etc) is available to the MDT.	Partial		Very limited due to lack of support available
5.3.2	<p>There are agreed policies, guidelines or protocols for:</p> <ul style="list-style-type: none"> • how the MDT operates; • who the core and extended members are; • the roles of members; • how members should work together; • how changes in clinical practice are to be managed; • communications post meetings eg. To patients, GPs and other clinical colleagues. 	Fully	Operational Policy	
5.3.3	User Partnership Groups are given the opportunity to advise on the development of MDT policy and practice – they are given feedback in response to their advice including actions taken in response to their recommendations.	Not in place		<p>There is a Trust Cancer Service User Group who have acted as a readers panel in relation to the MDT patient information leaflet.</p> <p>This group is currently being re-established and the terms of reference reviewed. There is</p>

				scope to explore how the group can support the development of the MDT.
5.3.4	MDT policies, guidelines and protocols are reviewed at least annually	Fully	MDT operational policy is reviewed annually. An annual report and work plan is produced in relation to previous year MDT activity.	
5.3.5	<p>There are mechanisms in place to:</p> <ul style="list-style-type: none"> record the MDT recommendation(s) versus the actual treatment given and to alert the MDT if their treatment recommendation(s) are not adopted and the reason for this – the MDT has regular opportunities to review and act on learning from such cases; ensure that the MDT is alerted to serious treatment complications and adverse or unexpected events/death in treatment - the MDT has regular opportunities to review and act on learning from such cases. 	Not in place		<p>Needs to be considered but will require dedicated support in relation to ongoing audit of MDT outcomes Reinforces importance of role of CNS at clinics</p> <p>Department of Health Patient Safety regulations does not overlap with cancer services</p>
5.3.6	<p>There are strategies in place to monitor:</p> <ul style="list-style-type: none"> the proportion of patients discussed without sufficient information to make recommendations/ take action at 	Not in place		Needs to be considered but will require dedicated support to ensure regular auditing

	that meeting; <ul style="list-style-type: none"> the proportion of patients offered and/or receiving information recommended by the MDT. 			
5.3.7	The MDT shares good practice and discusses local problem areas with MDTs within its own trust/Network.	Partial	There is an opportunity through the regional Clinical Reference Group to share good practice and highlight areas of concern	There is no formal mechanism locally for MDTs to do this but should be considered. Would be useful to sit in on other MDTs to review practice.
5.3.8	The MDT has representation on the Clinical Reference Group (CRG) for its cancer site and that representative attends the meetings or sends a deputy.	Fully	Annual report details MDT attendance at the CRG	
5.3.9	Significant discrepancies in pathology, radiology or clinical findings between local and specialist MDTs should be recorded and be subject to audit.	Not in place	Discrepancies may be recorded but are not audited	
5.3.10	MDTs reflect, at least annually, on equality issues, for example, that there is equality of access to active treatments and other aspects of treatment, care and experience for all patients.	Not in place		Needs to be considered but will require dedicated support
5.3.11	The MDT assesses (at least annually) its own effectiveness/performance and where possible benchmarks itself against similar MDTs making use of cancer peer review processes and other national tools as they become available – results of the assessment are acted on by the MDT or employing	Partially	The MDT was peer reviewed in September 2015 and submitted self-assessments in 2016 and 2017	

	organisation.			
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Characteristics of an Effective Multidisciplinary Team (MDT)

Self Assessment and Feedback Questionnaire

Overview of results

Version 2 – 12th April 2021

*Based on National Cancer Action Team (NCAT)
Guidance (February 2010)*



1. The Multidisciplinary Team

KEY: F – Fully **Yellow** – partially **Blue** – Not in place

Membership

No.	Effective MDT Characteristic	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
1.1.1	All relevant professions/disciplines – core & extended members – are represented in the team in line with the Manual of Cancer Services.	P Issue re. cover for radiology and oncology at the MDT	F	P Specialist Palliative input to the MDM is through the regional MDT	F	F	F	F	P Oncology input is through the regional MDT No dedicated CNS
1.1.2	The MDT co-ordinator is recognised as a core member of the team – they sit where they can hear and see everything.	F	F	F	F	F	F	F	F
1.1.3	Cross cover/deputies with authority to support recommendations are in place to cover planned (and where possible unplanned) absences - advanced notice is given of core member absence so that this cover (or alternative	P Cover for radiology & oncology	F	P Need designated pathology cover	F	F	F	F	P No cover for radiology



	management) can be organised if possible.								
1.1.4	Members have the level of expertise and specialization Prequired by the MDT in qPuestion – where there are no relFevant peer review measures or Paccreditation for these roles the issue of clinical competence is for the relevant professional body or the Trust to determine.	F	F	F	F	F	F	F	F



Attendance

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
1.2.1	MDT members (core and extended) have dedicated time included in their job plans to prepare for, travel to (if necessary) and attend MDT meetings – the amount of time is negotiated locally to reflect their workload and varies according to discipline and cancer type.	P Spec palliative CNS attends MDT when is able but has no protected time to prepare and attend	P No preparation time included	P No additional time allocated for MDT Lead role Gynae CNS has time allocated to attend the MDT but there is no preparation time allocated	P Some specialties include prep time e.g. radiology and pathology	P Need to clarify if all specialty members are job-planned	P Specialist nurses don't have dedicated time allocated	P X 2 GPs do not attend the MDT	F
1.2.2	Core members are present for the discussion of all cases where their input is needed – it is for the chair to decide (in consultation with others as he/she sees fit) whether there is adequate representation at a single meeting to make safe recommendations about any/all patients and the	F	F	P Pathology input at times	F	P Further Histopathology representation / cover	F	P Some cases may be presented on behalf of a GP	F



	action to take if not.								
1.2.3	Every effort should be made to ensure that a clinician who has met the patient whose case is being discussed is present at the meeting.	F	F	P The patient may have been seen by different staff until the confirmation of cancer and a management plan is agreed. Following this it will be the same clinician who will see the patient.	F	F	F	F	F
1.2.4	The chair is responsible for raising concerns about non-attendance of particular members (or their deputies) and escalating these concerns if regular non-attendance is impacting on the quality of MDT working/recommendations. Frequent non-attendance is addressed during appraisal processes & job	F	F	F	F	P Attendance register is reviewed annually	F	F	F



	plan reviews.								
1.2.5	A register of attendance is maintained – members signing in and out (with times) supports assessment of attendance.	P Attendance is recorded by MDT Co-coordinator, sign in/out is not used as some members video-link	F	F	F	P Untimed weekly register maintained by Coordinator	F	P Attendance is recorded by MDT Co-coordinator, sign in/out is not used as some members video-link	F
1.2.6	Extended members and non-members attend for the cases that are relevant to them.	F	NIP MDT protocol for referral to the Breast MDT is not fully implemented	P Pathology input at times	F	F	F	F	NIP
1.2.7	Anyone observing MDT meetings should be introduced to team members and their details included on the attendance list.	P Medical student attendees are not recorded	F	F	P Medical student/registrar attendees are not always recorded. SAS drs would like attendance to be recorded at the	P Medical students are introduced but not listed on the attendance sheet	F	F	F



					meetings				
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Leadership

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
1.3.1	There is an identified leader/chair of the MDT and a deputy to cover when necessary – the leader and the chair do not have to be the same person	F	F	F	F	F	F	F	F
1.3.2.	The MDT chair is responsible for the organisation and the running of the MDT meetings.	F	F	F	F	F	F	F	F
1.3.3.	The chair has skills in the following areas: <ul style="list-style-type: none"> • meeting management; • listening & communication; • interpersonal relations; • managing disruptive personalities & conflict; • negotiations; • facilitating effective consensual clinical decision making; • time-management. 	F	F	F	F	F	F	F	F
1.3.4.	The chair: <ul style="list-style-type: none"> • prepares and/or agrees the agenda with the MDT coordinator; • ensures the meeting is 	F	F	P Partial - due	F	F	F	F	F



	<p>quorate and takes action if not;</p> <ul style="list-style-type: none">• ensures all relevant cases are discussed and prioritized as necessary;• ensures all relevant team members are included in discussions;• ensures discussions are focused and relevant;• ensures good communications/a pro-discussion environment;• promotes evidence-based and patient-centered recommendations and ensures that eligibility for relevant clinical trial recruitment is considered;• ensures the current patient discussion and treatment/care plan recommendations are complete before the next patient discussion starts;• ensures relevant demographic and clinical data items are recorded;• ensures recommendations are clearly summarised, recorded and fed back to the patient, GP and clinical team within a locally agreed timeframe;• ensures that it is clear who is going to take any resulting actions post meeting and that this is minuted.			<p>to COVID</p> <p>Clinical trial recruitment is through regional MDT</p>					
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1.3.5.	<p>The MDT leader (who may also be the chair) has a broader remit not confined to the MDT meetings. They are responsible for:</p> <ul style="list-style-type: none"> • issues of governance e.g. setting clear objectives/purpose for the team/what is expected of members etc; • ensuring that others in the organisation have an understanding of the role of the MDT and why it is important in cancer care; • negotiating locally for funding/resources needed for the MDT to be effective; • escalating issues of concern that may impact on safety of MDT Recommendations etc. 	F	<p>P</p> <p>Pre-COVID, there were regular 2 weekly meetings with Senior Managers to discuss / highlight areas of concern.</p> <p>These need to be re-established.</p>	F	<p>P</p> <p>Bi-weekly cancer checkpoint meetings take place with service managers and SMT members to discuss / highlight areas of concern.</p>	F	F	<p>P</p> <p>Bi-weekly cancer checkpoint meetings take place with service managers and SMT members to discuss / highlight areas of concern</p>	F
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Team working & culture

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
1.4.1.	Each MDT member has clearly defined roles and responsibilities within the team which they have signed up to and which are included in their job plans.	F	<p>P</p> <p>Prep time for MDT not included</p>	<p>P</p> <p>There is no reimbursement for the MDT Lead role</p>	<p>P</p> <p>Prep time for MDT not included for some members</p>	<p>P</p> <p>Core surgical members have job-planned</p>	F	<p>P</p> <p>Prep time for MDT not included for all members</p>	F



						MDM time. Don't have evidence for the wider membership			
1.4.2.	<p>The team has agreed what is acceptable team behavior/etiquette including:</p> <ul style="list-style-type: none"> • mutual respect & trust between team members; • an equal voice for all members - different opinions valued; • resolution of conflict between team members; • encouragement of constructive discussion/debate; • absence of personal agendas; • Ability to request and provide clarification if anything is unclear. 	F	<p>NIP</p> <p>Develop a memorandum of understanding in relation to MDT etiquette</p> <p>Maybe consider a 360 questionnaire to audit / measure?</p>	F	F	F	F	<p>NIP</p> <p>Develop a memorandum of understanding in relation to MDT etiquette</p>	F
1.4.3.	MDT members play a role in sharing learning and best practice with peers.	F	F	F	F	F	F	F	F

Personal development & training



No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
1.5.1.	Team members recognise the need for continued learning and individual members are supported to gain the necessary knowledge and skills for their roles and responsibilities within the MDT and for their respective professional role – support is available from the team, the organisation and nationally as appropriate and members take up relevant CPD opportunities.	F	F	F	F	F	F	F	F
1.5.2.	There are networking opportunities to share learning and experiences with other MDTs in the same Trust and potentially in other Trusts in the Network or beyond.	Not in place Suggestion: Set up a bi-annual meeting of MDT leads to share learning and experiences	P Need to provide opportunity for MDT Leads to sit-in on other MDT meetings to review practice / share learning and support opportunity for developing	NIP Set up a bi-annual meeting of MDT leads to share learning and experiences	F	F	F	F	F
1.5.3.	There is access to training opportunities as required to support an individual's role in	F	P Suggestion: Bespoke course for	F	P Consideration of MDT training for	P More access to Advanced Communication	F	P Appraisal process & Revalidation	F

	<p>the MDT in areas such as:</p> <ul style="list-style-type: none"> • leadership skills; • chairing skills; • advanced communication skills including listening, presenting and, where relevant, writing; • time management; • confidence & assertiveness; • use of IT equipment e.g. video-conferencing; • knowledge of anatomy, oncology, radiology & pathology (for members not expert in these areas). 		MDT's – mandatory training for new appointees for MDT core members, including CNS's and other specialities		new consultants / nurses / other specialties through their training route / professional bodies e.g. NIMDTA	Skills courses required.		<p>details training/courses completed by members</p> <p>ACST register of core members who have completed the training</p>	
1.5.4.	There is a teaching & training role for MDTs both within the team itself (eg. bringing patient cases back) and beyond (eg. for clinicians in training).	F	F	P Due to COVID there have been less medical students / clinicians-in-training at the MDT	F	F	F	F	F

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2. Infrastructure for Meetings

Physical environment of meeting venue

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
2.1.1.	There is a dedicated MDT room in a suitable (quiet) location with sound proofing if necessary to ensure confidential discussions.	F	F	P Internet connection is intermittent and can be poor at times. Impacts on communication and information-sharing	F	F	P The room size is small and there may be issues at times in relation to the sound quality	P There is a room identified in Ramone for the MDT, IT set-up is not ideal. There may be issues at times in relation to the sound quality	F
2.1.2.	The room is environmentally appropriate in size and layout ie. All team	F	P The venue space is too small for full	P As above	P The venue space is too small for full	NIP Room is too small to accommodate	P The venue space is too small	F	F

	members have a seat and are able to see and hear each other and view all presented data (eg. diagnostics) within and across hospital trusts.		attendance in the room		attendance in the room	all MDT members in person. Have moved to hybrid F2F (socially distanced) /videolink meeting. Acoustics not great in host room and those dialling in can have difficulty capturing all discussion, particularly if by members sitting in the periphery of the room	for full attendance in the room Due to COVID restrictions there is a max. number of 6 people allowed in the room		
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Technology & equipment (availability & use)

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
2.2.1.	Rooms where MDT meetings take place have: <ul style="list-style-type: none"> access to equipment for projecting and viewing radiology 	F	√	F	P Outcomes are recorded live during the MDT discussion,	F	F	P AS PER 2.1.1	F

	<p>images including retrospective images;</p> <ul style="list-style-type: none"> • facilities for projecting and viewing specimen biopsies/resections and accessing retrospective pathology reports; • connection to relevant IT systems; • access to a database or proforma to enable documentation of recommendations in real-time; • projection facilities so members can view and validate the recommendations being recorded; • facilities (when needed) to see and speak to members who are off site (eg. video-conferencing) and share all information that will be viewed (eg. images and reports) with them. 		<p>X</p> <p>√</p> <p>√</p> <p>√</p> <p>√</p>		<p>validated by the independent consultant post MDT</p> <p>Consideration of recap training on CAPPs database to support data interpretation for audits</p>				
2.2.2.	There is commitment/buy-in from all sites to provide technology and	F	P There was a	F	F	P Not sure	F	P As per	F

	<p>equipment (including video-conferencing) that is good quality and reliable, up to at least a minimum network wide specification, which takes into account issues such as:</p> <ul style="list-style-type: none"> standards of data transfer; image quality; bandwidth - speed for loading images, time delay for discussions; inter-hospital compatibility / cross-site co-ordination etc. <p>This specification is kept under review and updated in light of technological advances.</p>		change of video-conferencing provider by the trust which was not communicated to MDTs			who has responsibility for keeping IT /Equipment spec under review and updated		2.1.1	
2.2.3	There is technical support for MDT meetings so that assistance can be provided in a timely fashion (ie. during the meetings) if there are problems with any IT systems or video-conferencing links during the meeting – the quality of MDT decision making can be seriously affected when equipment fails.	F	F	F	F	P No person available for IT / computer issues during MDM	F	P No video-conferencing facility available, though IT support is available when required	F



3. Meeting Organisation & Logistics

Scheduling of MDT meetings

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
3.1.1.	MDT meetings take place regularly (as set out in Manual of Cancer Services).	F	F	F	F	F	F	F	F
3.1.2.	MDT meetings are held during core hours where possible - ('core hours' are defined locally and included in staff job plans) and are set up so as not to clash with related clinics that core members need to attend – such clinics follow MDT meetings where feasible.	F	F	F	F	F	F	F	F

Preparation prior to MDT meetings



No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
3.2.1.	Processes are in place to ensure that all patients diagnosed with a primary cancer have their case considered by the relevant MDT and it is clear when patient cases can be taken back to MDTs including when discussion of patients with metastatic disease/recurrence should take place.	F	F	F	F	F	F	F	F
3.2.2.	There is a locally agreed cut-off time for inclusion of a case on the MDT list/agenda and team members abide by these deadlines – there is flexibility for cases that may need to be added at the last minute due to clinical urgency..	F	F	P Better adherence to cut-off time required	F	F	F	NIP There is no cut-off time for cases to be brought back	F
3.2.3.	Cases are organised on the agenda in a way that is logical for the tumour area being considered and sufficient time is given to more complex Fcases – the structure of	P This could be improved by implementing protocolised pathways for more straight forward cases	F	P Cases are alphabetical for main body of the meeting A small	F	F	F	F	F



	the agenda allows, for example, the pathologist to leave if all cases requiring their input have been discussed.	which just need to be registered and signed off by the MDT Chair. The other more complex cases would be listed for discussion.		number of cases are set aside for regional meeting					
3.2.4.	The structured agenda/patient list is circulated prior to the meeting if members agree this would be useful.	F	F	F	F	F	F	F	F
3.2.5.	A locally agreed minimum dataset of information about patients to be discussed should be collated and summarised prior to MDT meetings wherever possible – this should include diagnostic information (pathology and radiology), clinical information (including co-morbidities, psychosocial and	P Use of a MDT proforma would help to ensure a minimum dataset is completed for each patient being presented – reviewed by chair re. which goes to protocol and	F	P There is no local proforma. The Belfast Trust are introducing an MDT proforma for initial referral to the regional gynae MDT to ensure a	F	F	F	P The MDT follows NICAN guidance in relation to this If all data is not available for discussion it is pulled off the pathology	F



	specialist palliative care needs) and patient history, views and preferences where known. It is important that any data items collected locally that are in existing national datasets or are within the NHS Data Dictionary are in line with these data definitions and codes when collected.	what requires discussion		minimum dataset is completed for each patient being presented				report	
3.2.6.	Members know what information from the locally agreed minimum dataset of information they will be expected to present on each patient so that they can prepare and be ready to share this information (or have delegated this to another member if they cannot attend) prior to and/or at the meeting.	Not in place Use of a MDT proforma would help to ensure a minimum dataset is completed for each patient being presented	F	NIP Use of a MDT proforma would help to ensure a minimum dataset is completed for each patient being presented	F	F	F	P This needs to be looked at further	F



Organisation/administration during MDT meetings

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
3.3.1.	It is clear who wants to discuss a particular patient and why they are being discussed.	P Use of MDT proforma would help to improve this	P Sometimes patients are listed and it is not clear why they are being discussed Use of MDT proforma would help to improve this	P Use of MDT proforma would help to improve this	F	F	P MDT list and referring consultant	F	F
3.3.2.	A locally agreed minimum dataset of information is presented on each patient including diagnostic information (pathology and radiology), clinical information (including co-morbidities, psychosocial and specialist palliative care needs) and patient history, views and preferences – the focus is on what the team need to hear to make appropriate recommendations on the	P Improve listing of patients by indicating which aspects need to be reviewed e.g. pathology, radiology	F	P No formal proforma	F	P Referring clinician presents relevant data to enable discussion of patient and identifies what required discussion e.g. imaging, pathology	F	F	F



	patient in question. It may not, for example, be necessary to show/discuss the pathological or radiological findings in all cases.					There is no agreed minimum dataset			
3.3.3.	There is access to all relevant information at the meeting including patient notes, test results/images/samples (past and present) and appointment dates (or a proforma /summary record with the necessary information) along with access to PAS, radiology & pathology systems etc – relevant past material should be reviewed prior to the meeting if it is not accessible during the meeting.	F	F	F	F	F	F	P Access to patient notes & test results are available through NIECR during the MDM if required	F
3.3.4.	Electronic databases are used to capture recommendations during the meeting (including the rationale for the decision and any uncertainties or disagreements about the recommendations) – a	P CAPPs system is an electronic database which is used to collect data on patients and document MDT decisions.	F	F	F	F	F	F	F



	standard pro-forma is used where such a database is not available.	Investigation plans and treatment recommendations are formulated during the meeting and recorded in narrative format by the MDT Co-ordinator.							
3.3.5.	Core data items are collected during the meeting and cancer datasets completed in real time (where feasible) – training may be required to ensure accurate recording of real-time information to minimise the impact on (i.e. slowing down) the MDT discussion. Some MDTs will wish to collect as much of the core data items before the meeting to save time – the function of the MDT is then to check these are correct. It is important that any data items collected locally that are in existing	Not in place Further discussion/work required to explore how to streamline process.	F	F	F	F	F	F	F



	national datasets or are within the NHS Data Dictionary are in line with these data definitions and codes when collected.								
3.3.6.	Mobile phones are off or on silent during the meeting and if phone calls have to be taken during the meeting the person taking the call leaves the room.	F	P Mobile phones are not turned off	F	F	F	F	P Mobile phones are not turned off	P Mobile phones are not turned off
3.3.7.	There is effective chairing and co-ordination throughout the meeting.	F	F	F	F	F	F	F	F

Post MDT meeting/co-ordination of services

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
3.4.1.	Processes are in place: <ul style="list-style-type: none"> for communicating MDT recommendations to patients, GPs and clinical teams within locally agreed timeframes e.g. patient clinics on the same or next day as MDT meetings where feasible; for ensuring that patients' information 	P Some of the consultant clinics take place the week after the MDT	P F F	P F F NIP - May require Trust	F	F	P F F	P	P



	<p>needs are assessed and met;</p> <ul style="list-style-type: none"> to ensure actions agreed at the meeting are implemented; to ensure the MDT is notified of significant changes made to their recommended treatment/care plan; to manage referral of patient cases between MDTs (including to MDTs in a different Provider); to track patients through the system to ensure that any tests, appointments, treatments are carried out in a timely manner e.g. Within cancer waits standards where applicable. 	NIP	NIP	to support enhanced tracking resource NIP			NIP	Changes are documented in clinician's notes but not brought back to the MDT	
		NIP	F Re-discussed if there is a change				F		
		F	F	F			F		
		F	F	P Patients are tracked from diagnosis up until the 1 st definitive treatment (31 day & 62 day pathways).			F		
		Patients are tracked from diagnosis up until the 1 st definitive treatment (31 day & 62 day pathways).	F					NIP	
3.4.2.	Relevant items from cancer datasets are	F	F	F	F	F	F	F	F



	completed (if this has not been done in real time at the meeting).								
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4. Patient Centered Clinical Decision-Making

Who to discuss?

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
4.1.1.	There are local mechanisms in place to identify all patients where discussion at MDT is needed.	Not sure? Red flag referrals from GPs and other consultants are triaged and depending on outcome are put on 31 day and 62 day pathways which are tracked.	F	F	NIP RF referrals are triaged by consultant of the week and it is assumed that pts are triaged appropriately – there is no check / safeguard in relation to this	F	F	F	F
4.1.2	There are referral criteria in place so it is clear when to send a case to the MDT for consideration i.e. clarity	F	P Some patients are added and at times it is not clear what	F	F	F	F	F	F

	<p>on:</p> <ul style="list-style-type: none"> • which patients should be discussed by the MDT; • the clinical questions that need to be addressed by the MDT; • what information has to be available for the MDT discussion to be productive; • when to refer a patient on to another MDT (e.g. from a local to a specialist MDT). 		the question is – a MDT proforma would help to standardize this						
4.1.3	There is local agreement about if/when patients with advanced/recurrent disease should be discussed at MDT meetings.	P	P Metastatic patients are not always brought back to the MDT and is based on the consultant's decision	F	F	F	F	F	F
4.1.4	A clinician can bring the case of a private patient to the MDT for discussion provided there is time on the agenda - any	NIP	F	F	N/A	F	F	F	F



	reimbursement arrangements are for local determination.								
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Patient-centered care

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
4.2.1.	Patients are aware of the MDT, its purpose, membership, when it meets and that their case is being/has been discussed and are given the outcome within a locally agreed timeframe.	F	F	F	F	F	F	F	F
4.2.2	A patient's views/preferences/holistic needs are presented by someone who has met the patient whenever possible.	F	F	F	F	F	F	P Patient's holistic needs are considered as part of the MDT discussion.	F
4.2.3	A named individual at the MDT has responsibility for identifying a key worker for the patient.	NIP Key worker not identified at the MDT meeting – this may happen afterwards	F	NIP Key worker not identified at the MDT meeting – this may happen afterwards	F	F	F	NIP The key worker is usually the CNS and is identified after the MDT meeting	P There is no dedicated Thyroid CNS – some support is available by the



									Head & Neck CNS's
4.2.4	A named individual at the MDT has responsibility for ensuring that the patient's information needs have been (or will be) assessed and addressed.	F	F	F	F	F	F	NIP The key worker will assess the patient's information needs but this happens after the MDT meeting	F
4.2.5	Patients are given information consistent with their wishes, on their cancer, their diagnosis and treatment options including therapies which may be available by referral to other MDTs, sufficient to make a well informed choice/decision on their treatment and care.	F	F	F	F	F	F	F	F

Clinical Decision-Making Process

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
4.3.1	A locally agreed minimum dataset of information is provided at the meeting i.e. the	NIP An MDT Proforma would help	P Not all of the information is provided	NIP	F	P There is no proforma detailing	F	F	P A regional proforma is



	information the MDT needs to make informed recommendations including diagnostic information (pathology and radiology), clinical information (including co-morbidities, psychosocial and specialist palliative care needs) and patient history, views and preferences. It is important that any data items collected locally that are in existing national datasets or are within the NHS Data Dictionary are in line with these data definitions and codes when collected.	with this	(e.g. co-morbidities)-an MDT Proforma would help with this			minimum dataset			completed to enable discussion at the regional thyroid MDT; there is no local proforma
4.3.2	MDTs consider all clinically appropriate treatment options for a patient even those they cannot offer/provide locally.	F	F	F	F	F	F	F	F
4.3.3.	MDTs have access to a list of all current and relevant clinical trials	P Patients who are referred to	P The MDT does have	P Patients who are referred	P The MDT does have access to	NIP There is no trial co-	P Most of the	P There are only x2 part-time	P There are only x2



	(including eligibility criteria) particularly those in the NCRN portfolio and consider patients' suitability for appropriate clinical trials as part of the decision-making process - the relevant trial coordinator/ research nurse attends MDT meetings where feasible.	the Specialist MDT will have access to clinical trials as they are usually regional trials	access to relevant trials though the Clinical Trial nurse does not attend MDT meeting	to the Specialist MDT will have access to clinical trials as they are usually regional trials	relevant clinical trials though the Clinical Trial nurse does not attend MDT meeting	ordinator and the research nurse does not attend the MDT Most of the open trials are oncology based. Suitable patients are identified through the regional MDT	clinical trial activity is through the regional UGI MDT the Clinical Trial nurse does not attend MDT meeting	cancer clinical trial nurses for the trust, there is no representation at the MDM	part-time cancer clinical trial nurses for the trust and they don't attend the MDT
4.3.4.	Standard treatment protocols are in place and used whenever appropriate	F	Nip There is individual case discussion. The MDT does not use treatment protocols.	F	F	F	F	F	F
4.3.5	A patient's demographic profile and co-morbidities are	F	F	F	F	F	F	F	F



	always considered - age does not in itself act as a barrier to active treatment.								
4.3.6	A patient's psychosocial and supportive & palliative care issues are always considered (e.g. via holistic needs assessment).	F	F	F	F	F	F	F	F
4.3.7	A patient's views, preferences and needs inform the decision-making process when relevant/possible	F	F	F	F	F	F	F	F
4.3.8	The clinical-decision making process results in clear recommendations on the treatment/care plan resulting from the meeting. These recommendations are: <ul style="list-style-type: none"> evidence-based (eg. in line with NICE and/or cancer network guidelines); patient-centered (in line with patient views & preferences when known and taking into account co-morbidities); 	F	F	F	F	F	F	F	F



	<ul style="list-style-type: none"> in line with standard treatment protocols unless there is a good reason against this, which should then be documented. 								
4.3.9	MDT recommendations are only as good as the information they are based on – if there are concerns that key data is missing this should be documented.	F	F	F	F	F	F	F	F
4.3.10	Where a recommendation cannot be made because of incomplete data or where new data becomes available at a later stage it should be possible to bring the patient case back to the MDT for further discussion.	F	F	F	F	F	F	F	F
4.3.11	It is clear who will communicate the MDT recommendation(s) to the patient, GP and clinical team, how and by when and this is minuted.	F	P This is not minuted but each consultant is responsible for review/sign off on	F	P This is not minuted but each consultant is responsible for communicating with other clinical teams,	F	F	F	F



			CAPPS for their own patients		the patient and their GP.				
4.3.12	MDTs collect social demographic data (on age, ethnicity and gender as a minimum) and consider that data periodically to reflect on equality of access to active treatments and to other aspects of treatment, care and experience – Information relating to these issues will/should be on PAS / NIECR / CAPPS (based on NHS Data Dictionary definitions) and MDTs should link up to the source of these data rather than create separate data capture processes.	P Not sure if ethnicity is collected?	P ethnicity is not collected – this would be important particularly in relation to impact on appointment time if interpreters are required	P MDT collects some demographic data but this does not include ethnicity The data is not reviewed periodically to consider equality of access	P ethnicity is not collected – this would be important particularly in relation to impact on appointment time if interpreters are required	P Some demographic data is collected. Ethnicity is not collected unless it is already embedded in CAPPS or NIECR. The data is not considered periodically in relation to equality of treatment – this would require huge numbers to be meaningful	P ethnicity is not collected	P ethnicity is not collected in relation to skin cancers this potentially could have a negative impact on which patients are discussed as some people from EU countries have a higher sunbed usage	P ethnicity is not collected



5. Team Governance

Organisational support

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
5.1.1.	<p>There is Organisational (employer) support for MDT meetings and MDT membership demonstrated via:</p> <ul style="list-style-type: none"> recognition that MDTs are the accepted model by which to deliver safe and high quality cancer care; adequate funding/resources in terms of people, time, equipment and facilities for MDT meetings to operate effectively (as set out in this document). 	<p>F</p> <p>P Issues with cover for Radiology and Oncology</p> <p>Need more resource for audit and tracking</p>	<p>F</p> <p>P Room space does not accommodate all members present in room</p> <p>-Issues with V/C and sound at times</p> <p>-Need more resource for</p>	<p>F</p> <p>P Need more resource for audit and tracking</p>	<p>F</p> <p>P Room space does not accommodate all members present in room</p> <p>-Issues with V/C and sound at times</p> <p>-Need more resource for audit</p> <p>- Additional tracking resource</p>	<p>F</p> <p>P Room space does not accommodate all members</p> <p>More funding required for stoma nurses</p>	<p>F</p> <p>P Room space does not accommodate all members present in room</p> <p>-Issues with V/C and sound at times</p> <p>-Need more resource for audit</p> <p>- Additional tracking resource</p>	<p>F</p> <p>P Room space does not accommodate all members present in room</p> <p>-No V/C facility</p> <p>-Need more resource for audit</p>	<p>F</p> <p>P Room space does not accommodate all members present in room</p> <p>-Issues with V/C and sound at times</p> <p>-Need more resource for audit</p>



			audit		required		required		
5.1.2.	Trusts consider their MDTs' annual assessments and act on issues of concern (see 5.3.10).	NIP	P The screening part of the Breast service is reviewed annually by the Trust SMT but not the full service	F	P Trusts consider and act on concerns highlighted from the peer review process	F	F	NIP This was done through the external peer review visit but not on a regular basis	F

Data collection, analysis and audit of outcomes

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
5.2.1.	Data collection resource (i.e. the ability to capture relevant information in a timely manner etc) is available to the MDT.	P Histology, stage and grade are captured Radiological info All treatment options captured – free text is used to generate an outcome	P Data collection resource is limited and would require further resourcing in terms of staff and setting up an independent database for research / audit purposes	F	P Data collection resource is limited and would require further resourcing in terms of staff and setting up an independent database for research / audit purposes	F	F	F	F
5.2.2.	Key information that directly affects treatment decisions (e.g. staging,	P Performance & co-	P Staging is recorded,	P Performance & co-	F	P Performance status is not	F	P Staging is recorded,	P Staging is recorded,



	performance status and co-morbidity) is collected by the MDT.	morbidity is recorded in the free text box, there is no structured data fields to capture this	co-morbidities may be recorded if it is something significant, performance status is not recorded	morbidity is recorded in the free text box, there is no structured data fields to capture this		recorded in a systematic way		co-morbidities may be recorded if it is something significant, performance status is not recorded locally though it is recorded regionally	co-morbidities may be recorded if it is something significant, performance status is not recorded
5.2.3.	Mandated national datasets are populated prior to or during MDT meetings where possible and appropriate – if this is not possible this takes place shortly after the meetings.	P CAPPs datasets are populated after MDT Under current legislation regarding the use of secondary data, the MDT is not able to provide data for national datasets	F	P CAPPs data fields have been regionally agreed and most are populated during the meeting	F	F	P CAPPs data fields have been regionally agreed and most are populated during the meeting Some of the patients are referred to other teams as required e.g. regional OG and HPB teams	P Under current legislation regarding the use of secondary data, the MDT is not able to provide data for national datasets	F
5.2.4.	Data collected during MDT meetings (including social demographic data)	NIP This is not currently happening and would require further resource to support this. It would support the MDT with forward			P Activity data is collected and	P Social demographic data is not	NIP Activity data is collected and	NIP This is not currently happening	P Some data is fed back to the MDT

	extracted from PAS) is analyzed and fed back to MDTs to support learning.	planning, and provide assurance in relation to meeting standards / guidelines by providing a systematic review of MDT activity			considered by the MDT, social demographic data is not collected.	presented / included	considered by the MDT, social demographic data is not collected.	and would require further resource to support this. It would also require extensive data in terms of numbers of patients to make the data meaningful.	though does not include social demographic data
5.2.5.	The MDT takes part in internal and external audits of processes and outcomes and reviews audit data (eg. to confirm that treatment recommendations match current best practice and to consider trial recruitment) taking action to change practice etc where necessary.	P Limited audits due to lack of resource available to support	P Limited audits due to lack of resource available to support	P Limited audits due to lack of resource available to support	P Limited audits due to lack of resource available to support	P Trials are usually oncology based and therefore recruitment to trials is through the regional MDT	F	F	F
5.2.6.	MDTs consider and act on clinical outcomes data as they become available eg. through peer review, NCIN	NIP Clinical outcomes data not available through peer	F	P Clinical outcomes data not available through peer	F	F	F	F	F



	clinical reference groups etc.	review		review					
5.2.7.	Patient experience surveys include questions relevant to MDT working and action is taken by MDTs to implement improvements needed in response to patient feedback.	P CPES & local surveys don't ask specific questions on MDT working	P As per urology	NIP As per urology response	P Surveys don't ask specific questions on MDT working	F	F	P NI Cancer Patient Experience Survey & Local patient surveys – these are considered at the AGM	F

Clinical governance

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
5.3.1	Data collection resource (i.e. the ability to capture relevant information in a timely manner etc) is available to the MDT.	P Very limited due to lack of support available	NIP As per urology	P As per urology	P Limited due to lack of support available for audits	F	F	F	F
5.3.2	There are agreed policies, guidelines or protocols for: <ul style="list-style-type: none"> how the MDT operates; who the core and extended members are; the roles of 	F	P ? not sure	F	F	F	F	F	F



	members; • how members should work together; • how changes in clinical practice are to be managed; • communications post meetings eg. To patients, GPs and other clinical colleagues.		Perhaps needs to be a policy for this – usually agreed & disseminated through CRG for surgery but unsure of process for other modalities						
5.3.3	User Partnership Groups are given the opportunity to advise on the development of MDT policy and practice – they are given feedback in response to their advice including actions taken in response to their recommendations.	NIP There is a Trust Cancer Service User Group who have acted as a readers panel in relation to new MDT patient information developed. This group is currently being re-established and the terms of reference reviewed. There is scope to explore how the group can support the development of the MDT.							
5.3.4	MDT policies, guidelines and protocols are reviewed at least annually	F	F	F	F	F	F	P	P MDT operational policy is usually reviewed annually. An annual report and work plan is produced in relation to previous year



									MDT activity. This has fallen behind over past couple of years.
5.3.5	<p>There are mechanisms in place to:</p> <ul style="list-style-type: none">record the MDT recommendation(s) versus the actual treatment given and to alert the MDT if their treatment recommendation(s) are not adopted and the reason for this – the MDT has regular opportunities to review and act on learning from such cases;ensure that the MDT is alerted to serious treatment complications and adverse or unexpected events/death in treatment - the MDT has regular opportunities to	<p>NIP will required dedicated support in relation to ongoing audit of MDT outcomes.</p> <p>Reinforces importance of role of CNS at clinics.</p> <p>Department of Health Patient Safety regulations does not overlap with cancer services</p>	<p>NIP Needs to be considered but will required dedicated support in relation to ongoing audit of MDT outcomes</p>	<p>P Needs to be considered but will required dedicated support in relation to ongoing audit of MDT outcomes</p> <p>Reinforces importance of role of CNS at clinics</p> <p>Additional Tracker resource required</p> <p>F</p>	<p>P Changes in treatment plan are fed back to the MDT Further support is required to capture learning and support ongoing audits of MDT outcomes</p> <p>F</p>	<p>P If treatment recommendation is not adopted this is not routinely fed back to the MDT. The clinician will document in their notes.</p> <p>P Serious complications / adverse incidents are fed back to the responsible clinician but may not be communicated to the wider MDT. Surgical</p>	<p>F</p>	<p>NIP Needs to be considered but will be difficult to do, unless it is an snapshot audit for a specific time period</p> <p>Would require additional audit support</p>	<p>F</p>



	review and act on learning from such cases.					morbidity is presented at AGM		F	
5.3.6	<p>There are strategies in place to monitor:</p> <ul style="list-style-type: none"> the proportion of patients discussed without sufficient information to make recommendations/ take action at that meeting; the proportion of patients offered and/or receiving information recommended by the MDT. 	NIP Needs to be considered but will required dedicated support to ensure regular auditing	NIP Needs to be considered but will required dedicated support in relation to ongoing audit of MDT outcomes	NIP As per urology & breast	P If there is not enough information for discussion of the patient, it is sent back to the clinician NIP	NIP Needs to be considered but will required dedicated support to ensure regular auditing	NIP Needs to be considered but will required dedicated support to ensure regular auditing	NIP Needs to be considered but will required dedicated support to ensure regular auditing	NIP Needs to be considered but will required dedicated support to ensure regular auditing
5.3.7	The MDT shares good practice and discusses local problem areas with MDTs within its own trust/Network.	P There is no formal mechanism locally for MDTs to do this but should be considered.	P At network level, there is an opportunity through the regional Clinical Reference Group to share good practice and highlight	P There is an opportunity through the regional Clinical Reference Group to share good practice and highlight areas of	P There is no formal mechanism locally for MDTs to do this but should be considered.	F	F	F	F



			areas of concern	concern					
				No formal mechanism locally					
5.3.8	The MDT has representation on the Clinical Reference Group (CRG) for its cancer site and that representative attends the meetings or sends a deputy.	F	F	F	F	F	F	F	F
5.3.9	Significant discrepancies in pathology, radiology or clinical findings between local and specialist MDTs should be recorded and be subject to audit.	NIP Discrepancies may be recorded but are not audited	NIP There is no specialist Breast MDT unlike some of the other tumour sites e.g. Gynae	P Ad hoc process & no comparator	P No audit or oversight in relation to discrepancies	P It would be uncommon for there to be discrepancies but if there were these would be highlighted – may not be formally recorded or audited	F	F	P Discrepancies may be recorded but are not audited
5.3.10	MDTs reflect, at least annually, on equality issues, for example, that there is equality of access to active treatments and other aspects of treatment, care and experience for	NIP Needs to be considered but will require dedicated support	P MDT has completed an audit to review the age stratified management of women	NIP Needs to be considered but will require dedicated support	NIP Needs further consideration but will require dedicated support to the MDT to	NIP This would require additional audit support to ensure proper consideration of equality issues	p Needs to be considered but will require dedicated support	F	F



	all patients.		with breast cancer in the trust compared to the National audit		enable this				
5.3.11	The MDT assesses (at least annually) its own effectiveness/performance and where possible benchmarks itself against similar MDTs making use of cancer peer review processes and other national tools as they become available – results of the assessment are acted	P The MDT was peer reviewed in September 2015 and submitted self-assessments in 2016 and 2017	F	P The MDT was peer reviewed in September 2014 and submitted a self-assessment in 2015.	F	F	F	F	P The MDT was peer reviewed in September 2016 and submitted a self-assessment the following year



	on by the MDT or employing organisation.								
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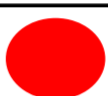

Title	
	Cancer MDT Improvement Plan
Version control date	1st November 2021
Executive Leads	Barry Conway, Assistant Director Cancer & Clinical Services; Dr Shahid Tariq, AMD Cancer; David McCaul Clinical Lead for Cancer Services
Report Author	Mary Haughey; Macmillan Cancer Service Improvement Lead
Timeframe	1st November 2021 - 31st March 2022




Introduction

The Southern Trust is undertaking work to strengthen approaches to cancer multidisciplinary team (MDT) processes. This improvement work will include a review of how MDTs currently function and consider any potential additional assurance measures that may be required. The NCAT tool - Characteristics of an Effective Multidisciplinary Team (MDT), self-assessment and feedback questionnaire (Feb 2010) was adapted by the Trust and amended into a fillable audit proforma to assist with obtaining a baseline of the holistic MDT attributes and help form the basis for quality improvement. The MDT audit is designed to target and drive patient safety and quality improvement by identifying areas for strengthening systems and processes. Between June-August 2021, the x8 local MDTs completed the NCAT self-assessment tool to reflect the views of their own MDT, these were then circulated to the wider MDTs for review and comment. During September-October 2021, the Cancer Services Management Team met with all of the MDT Leads to review the baselines, identify common areas/themes, identify tumour-site specific areas and prioritise areas for improvement. This action plan is a product from those meetings to capture all of the issues identified and agree actions to address. The action plan has been cross-referenced against the Urology SAI recommendations. The initial time frame for this action plan is from 1st November 2021 - 31st March 2022.

NCAT Section / Characteristic	Generic issue	Action/s to address	Action Product	Action owner	Action End date	Status update	RAG rating	Evidence when completed	Cross-reference to Urology SAI recommendation/s
Section 1: The Multidisciplinary Team									
1.1.1 / 1.1.3	All relevant specialities are represented in the team, cross cover for some specialities	Audits of attendance at MDM should be more regular (?quarterly) rather than review at annual business meeting - this will also assure on quoracy and allow for issues to be addressed earlier	Audit of MDT Attendance on regular basis	MDT Administrator / Projects Officer & MDT Leads	Will be on-going quarterly	Dr Tariq has written to all MDT Leads to ensure that attendance is being accurately recorded at MDT meetings. Audits of attendance to take place on a monthly basis starting from Feb 2022. Quorarcy to be shared with MDT Leads and Cancer Management Team	<div></div>	Monthly report of all MDT attendances available from Feb 2022 and circulated to the MDT Leads and Cancer Management Team for review and further escalation as required	Recommendation 1
1.2.1	Dedicated time in job plans for preparation & attendance at MDT	Ensure job plans of all MDT members has dedicated time included to prepare and attend the MDT meeting	Review of MDT Job plans	Dr Tariq / C.Quin	Dec-21	Dr Tariq has written to the surgical & medical directors to clarify that MDT time is included in the job plans of all MDT members. Attendance at the MDT meeting has been confirmed for all tumour sites. Preparation time is not included and falls under the time allocated for general patient admin time. C.Quin has checked with all CNS's - they all attend MDTs as required though not all have formal job plans. C.Quin to link with J.Davenport to confirm oncology input to the local MDTs.	<div></div>	Confirmation received per speciality that all core MDT members have dedicated time to prepare and attend MDT. Awaiting confirmation by BT in relation to oncology input to local MDTs.	Recommendation 1; Recommendation 4
1.2.6	Extended members / non-members attend for cases relevant to them	To be agreed by the MDT and detailed in the MDT operational policy	MDT Operational Policy	MDT Leads / SIL / MDT Administrator	30th Jan 2022	Discuss with MDT Leads and include agreed process in each MDT operational policy. MDT Administrator / SIL to ensure this is documented in the Operational policies.	<div></div>	Detailed in MDT Operational Policies. Reference 1.6 Principle Doc re. quality indicator required to audit/monitor.	Recommendation 1
1.3.5	MDT Leader has a broader remit not confined to MDT meetings	Develop role description of the MDT Lead and ensure adequate time is allocated in their job plan	Job description for MDT Lead role	Dr Tariq; Stephen Wallace	Jan-22	Dr Tariq has liaised with Stephen Wallace in relation to MDT Lead role description. A draft has been circulated to all MDT Leads for review / comment.	<div></div>	MDT Lead role description agreed and signed off	Recommendation 7
1.4.1	Each member has clearly defined roles / responsibilities in the team which they have signed up and included in their job plans	Define and detail the roles and responsibilities of all members involved in the MDM meetings	Review of MDT operational policies to ensure all MDT members roles are clearly defined; Review of MDT job plans	MDT Leads; MDT Administrator & Projects Officer; Medical & Surgical Speciality;AMD	Mar-22	MDT Administrator & SIL to review all MDT Operational policies with MDT Lead to ensure roles and responsibilities are included. To date LGI, UGI policies have been reviewed / updated.	<div></div>	Clearly detailed in each MDT Operational policy.	Recommendation 1
1.5.2	Networking opportunities to share learning & experiences with other MDTs locally	Provide opportunity for MDTs to meet locally, at least once per year, to share learning and experiences	Set up an Annual networking meeting for all MDTs	Dr Tariq; CD for Cancer; AD for Cancer services	Mar-22	Dr Tariq to contact MDTs Leads for feedback on the format and content of an annual networking event and to seek a date early 2022	<div></div>	An annual networking event is arranged if agreed by MDT Leads	Recommendation 6
Section 2: Infrastructure for meetings	0								
3.2.5	Locally agreed minimum dataset of information about patients for discussion collated and summarised prior to meeting (pathology, radiology, clinical, co-morbidities, psychosocial & spec palliative care needs	To develop MDT Proforma per tumour site with locally agreed minimum dataset	MDT Proforma	MDT Administrator / Projects Officer & MDT Leads	Mar-22	MDT proforma for Urology MDT agreed and will be rolled out from 4 Jan 22. Proformas for Lung, UGI and LGI to be considered next.	<div></div>	Each MDT has a proforma implemented for referrals to the MDM	Recommendation 1
3.2.6	Members know what info from locally agreed minimum dataset of info they will be expected to present	To be detailed in the MDT Proforma	MDT Proforma	MDT Administrator / Projects Officer & MDT Leads	Mar-22	To be developed in a phased approach for all MDTs, beginning with Urology MDT (Jan 22)	<div></div>	Each MDT has a proforma implemented for referrals to the MDM	Recommendation 1
3.3.1/3.3.2	It is clear who wants to discuss a patient & why being discussed / a locally agreed dataset of information is presented on each patient including diagnostic information	To develop MDT Proforma per tumour site with locally agreed minimum dataset, clear reason for discussion and sign off from the presenting clinician	MDT Proforma	MDT Administrator / Projects Officer & MDT Leads	Mar-22	To be developed in a phased approach for all MDTs, beginning with Urology MDT	<div></div>	Each MDT has a proforma implemented for referrals to the MDM	Recommendation 5
3.3.5	Core data items are collected during meetings and datasets completed in real time	Review and agreement of which data fields should be completed during MDT discussion and by whom, this should be detailed in MDT Principles/Protocol	Audit process agreed to review and monitor	MDT Leads; MDT Administrator / Projects Officer & MDT Co-ordinators; OSL	Mar-22	To start review with Breast & Gynae MDTs as they have more experienced trackers	<div></div>	Completion of core data fields during MDT meeting & process implemented to check compliance (ref 2.1 Principle doc)	Recommendation 5
3.4.1	Processes in place to ensure patients info needs are assessed and met; to ensure actions agreed are implemented;	CNS to use the Cancer Information Recording form to record the information provided by the clinical team to the patient and file in the patient notes. Holistic needs assessment offered to all newly diagnosed patients and a care plan developed to address concerns raised. All patients offered a written record of their management plan with diagnosis and contact details before they leave clinic.	Audits to check completion of Cancer information recording form & permanent record of consultation. Roll out of electronic health needs assessment by CNS's across all tumour sites.	HOS Cancer, Lead Nurse for Cancer and MDT Administrator / Projects Officer	Feb-22	Audits to take place when MDT Administrator is in post	<div></div>	Roll out of audits to check compliance	Recommendation 2
3.4.2	ensure MDT is notified of significant changes made to recommended treatment/care-plan	Any variation from recommended treatment/careplan should be documented at a MDT meeting. Develop an SOP with a clear pathway on whose role it is to capture , record and document and how this will be done per MDT for any patients that have declined further treatment.	Develop SOP; Include in MDT Principle's document (ref 2.6); agree audit process to check compliance	MDT Leads; MDT Administrator & Project Officer	Mar-22	Principles document developed and agreed. SOP to be developed and audit process to be agreed (ref 2.6 Principles Doc)	<div></div>	Roll out of audits to check compliance	Recommendation 5
Section 4: Patient Centred Clinical Decision-making									

4.1.1	Local mechanisms to identify all patients where discussion at MDT is needed	Define and detail what failsafe mechanisms are in place to ensure that there is a safety net to identify all patients who require MDT discussion	Failsafe mechanism agreed with Pathology	Pathology Clinical Lead; MDT Administrator & Project Officer	Mar-22	A report has been developed by Cellular Pathology & Lab service in Belfast and is currently being reviewed and tested.		Process in place to run a report to enable a cross-check across all the MDTs	Recommendation 5
4.1.3	Local agreement about if/when patients with advanced/recurrent disease should be discussed	MDT site specific agreement if/when patients with advanced or recurrent disease are listed for discussion and this is detailed in operational policy. Audit process to monitor this to be detailed in MDT Principles doc and rolled out.	To be guided by what is agreed and funded regionally. MDT Principles details audit process to be carried out.	MDT Leads; OSL; HOS Cancer; MDT Administrator & Projects Officer	Mar-22	Regional discussion required to agree enhanced tracking definitions and funding secured to implement . Reference 2.6 MDT Principles Doc in relation to audit mechanism		To be guided by what is agreed and funded regionally. Audit process agreed and rolled out.	Recommendation 4
4.2.3	Named individual at MDT has responsibility for identifying a key worker for the patient	To be detailed in MDT Principles doc and audit process required; additional field to be added to CAPPs to identify key worker	MDT Principles document; CAPPs	MDT Leads; HOS Cancer; SIL; MDT Administrator & Project Officer	Feb-22	Principles doc agreed, audit process to be set up once the additional field is added to CAPPs		Audit process agreed and implemented across all MDTs	Recommendation 5 & Recommendation 2
4.2.4	Named individual at MDT ensures patients information needs are assessed and addressed	To be detailed in MDT Principles doc and key worker identified on CAPPs	MDT Principles document - audit of compliance to be agreed	MDT Leads; HOS Cancer; SIL; MDT Administrator & Project Officer	Feb-22	Principles document agreed. Meetings ongoing with CNS's to ensure that patient info needs are assessed and documented appropriately.		Audit proces in place to monitor compliance (ref. 2.8 Principles Doc)	Recommendation 2
4.3.1	A locally agreed minimum dataset of info is provided at the MDT meeting	To develop MDT Proforma per tumour site with locally agreed minimum dataset	MDT Proforma	MDT Leads; MDT Administrator & Project Officer	Mar-22	Proforma for Urology MDT developed and agreed, this will be used from 4 Jan 2022. Next tumour sites for consideration are Lung, LGI and UGI.		Audit process agreed and implemented across all MDTs	Recommendation 1; Recommendation 5; Recommendation 8
4.3.3	MDTs have access to all current clinical trials, consider patients suitability, relevant research nurses attends MDT where feasible	Ensure that all MDTs have access to clinical trials and recruitment is considered as appropriate	MDT Principles document (ref 2.11)	MDT Leads,Clinical research nurses; Peter Sharpe; Irene Knox;	Ongoing	When Principles doc is agreed by MDT Leads, process will be agreed to ensure that MDTs are aware of clinical trials and consider patients suitability		Audit process agreed and implemented across all MDTs	Recommendation 1;
4.3.12	MDTs collect social demographic data (age, ethnicity & gender) & consider data periodically to reflect on equality of access to active treatments	To review systems to identify how this information can be collected and agree a clear process on how this info is captured, whose role it is to do this and when this will be considered by the MDTs	Data collection	OSL/ MDT Administrator & Project Officer / SIL	Feb-22	MDT Administrator to raise at next regional CAPPs meeting. Meeting held with NICR and info request to be submitted in Spring 2022.		Data is collected and reviewed by MDT Leads	Recommendation 6
Section 5: Team Governance									
5.1.1	Organisational support demonstrated via adequate funding/resources in terms of people, time, equipment for MDT meetings to operate effectively	Review of MDT Leads job plans, clear process in place to escalate any issues that may impact negatively on the effectiveness of the MDT meeting, new MDT room suitable equipped for meetings	MDT job plans; MDT room for meetings; process in place to escalate issues of concern, monthly Cancer checkpoint meetings, attendance at MDT AGMs	Cancer Services Management Team	Jan-22	MDT Leads job plans all reviewed; room allocated for MDT meetings; MDT Administrator post; regular meetings set up to escalate issues / concerns		MDT job plans reviewed and adequate time allocated; new MDT room operational for MDMs; clear process in place to escalate concerns; monthly checkpoint meetings; Cancer management attendance at MDT AGMs	Recommendation 9
5.1.2	Trusts consider their MDTs annual assessments and act on issues of concern	Cancer Services team attend MDT annual meetings and process in place to enable escalation of MDT areas of concern	Clear process in place and communicated to all MDT Leads to escalate issues of concern; Representation from Cancer Management Team at MDT annual business meetings	Cancer Services Management Team	Feb-22	Escalation Process agreed and circulated to all MDT Leads; Schedule of MDT business meetings to be agreed at start of each year and communicated to management team to ensure		MDT annual meetings to be agreed for 2022 and Cancer services management representation agreed for all meetings; escalation of other issues of concern as per agreed	Recommendation 3
5.2.1	Data collection resource is available to the MDT	Identify what data support is required by MDTs and explore funding sources with Trust SMT and commisioners	Data resource allocated	AD / HOS Cancer / OSL /	Feb-21	The MDT Administrator took up post on 04/01 and additional data support will be considered		Adequate data support is available to all the MDTs	Recommendation 6
5.2.2	Key info that directly affects treatment decisions is collected by MDT (staging, performance status, co-morbidity)	To ensure this info is captured in the MDT Proforma	Sytems review / MDT Proforma	MDT Administrator / Projects Officer; OSL; MDT Leads	Feb-22	This has started with the Urology MDT and will be rolled out across all of the MDTs in a phased approach		Key info is collected and considered by the MDT in relation to treatment options	Recommendation 5
5.2.3	Mandated national datasets are populated prior to or during MDT meetings or shortly afterwards	Detailed in MDT Principles doc and clear process detailed on what info is collected and by whom	MDT Principles document	MDT Co-ordinator / OSL / MDT Administrator	30th Nov	Draft presented to MDT Leads at Cancer checkpoint meeting and to the Urology Task & Finish Group meeting. Document is now finalised. Audit process to be implemented.	 	Monitoring process is undertaken as defined in the MDT Principles Doc (ref 2.1) and results shared with MDTs	Recommendation 6
5.2.4	Data collected during MDT meetings (including social demographic data) is analysed and fed back to MDT to support learning	Agree what data is collected, who will collect & analyse it and when this will be shared with the MDTs for consideration	Data collection process agreed per MDT	MDT Leads; MDT Co-ordinator; OSL; SIL	Mar-22	Liaise with HSCB to get a regional steer on social demographic collected. Meeting held with NICR and info request to be submitted in Spring 2022.		Data collected is analysed and fed back to the MDT for review and learning	Recommendation 6
5.2.5	MDT takes part in internal and external audits of processes & outcomes, reviews audit data and takes action to change practice where necessary	MDTs to identify and agree their audits at the annual business meeting including whi will lead and what support is required	Completion and and log of audits per MDT	MDT Leads / Dr Tariq / AD / Clinical audit team	Mar-22	Dr Tariq to write to MDT Leads to seek input on completion and review of future audits and the process for this to be discussed and agreed. Additional audit resource to be secured from the Clinical Audit Team		MDTs to take part in audits, both internal and external, and takes action as appropriate. All audits are logged.	Recommendation 6
5.2.7	Patient experience surveys include questions relevant to MDT working and action is taken to implement improvements in response to pt feedback	Local patient experience surveys per MDT should be rolled out at least once every two years.	Patient experience surveys	CNS's / SIL / MDT Leads	Mar-22	Scope what patient experience surveys have been undertaken and identify any gaps across MDT teams		All MDTs undertake patient experience surveys and action plans developed in response to findings	Recommendation 6
5.3.1	Data collection resource is available to the MDT	Identify what data is required for the MDTs and by whom and how often	Data resource calculated	OSL / MDT Administrator / HOS Cancer / MDT Leads	Feb-21	This will be considered further once the MDT Administrator has had to time to settle into the post		Data support is available to all MDTs	Recommendation 6

5.3.3	User Partnership Groups are given the opportunity to advise on the development of MDT policy and practice	Re-establish the Cancer Service User Group and agree the process for involvement in MDT policy and practice	Establishment of Cancer Service User Group	HOS Cancer; SIL ; Macmillan HWB Manager	Feb-22	Terms of reference developed; recruitment process underway; Group is re-established. Further discussion required to agree process for MDT involvement.		Trust cancer service user group is involved in the development of MDT policy and practice	Recommendation 6
5.3.5	Mechanisms in place to record MDT recommendation v actual treatment given and alert MDT if these are not adopted and reason for this; ensure MDT is alerted to serious treatment complications and adverse/unexpected events/death in treatment	To be detailed in MDT Principles document including quality indicator to audit; additional resource to support this needs to be identified and secured.	MDT Principles Document; Additional resource secured	AD; DMD; OSL; MDT Administrator & Projects Officer	Mar-22	Principles document is agreed. BT audit process to be reviewed and implemented intially for the Urology MDT to test and ascertain resource required.		Mechanisms and audit process are in place	Recommendation 8
5.3.6	Strategies in place to monitor: proportion of pts discussed without sufficient information to make recommendations & proportion of patients offered and/or receiving information recommended by MDT	Agree how this data is collected & analysed for MDTs, by whom and when this will be shared with the MDTs for consideration	Data collection & analysis - AUDITS	MDT Leads; MDT Administrator & Project Officer;	Jan-22	To be agreed with MDT Leads once MDT Administrator & Projects Officer is settled into post		Agreed mechanism and audit process in place	Recommendation 1; Recommendation 2
5.3.7	MDT shares good practice & discusses local problem areas with MDTs in own trust/network	Provide opportunity for MDTs to meet locally to share learning and experiences (see 1.5.2)	MDT networking event	Cancer Services Management Team	Feb-22	Dr Tariq has contacted MDT Leads to seek feedback on whether an event is required or to agree other mechanisms to share learning		Agreed mechanism in place between MDTs to share learning	Recommendation 3
5.3.9	Significant discrepancies in pathology, radiology or clinical findings between local and specialist MDTs should be recorded and subject to audit	This is currently done on a one-to-one basis, a process needs to be developed and implemented	To develop an MDT Communications Protocol	MDT Administrator / MDT Leads /	Mar-22	Dr Tariq to liaise with MDT Leads to discuss process. M.Haughey and A.Muldreu to review BT communications protocol in relation to communication back to local MDTs and advise accordingly.		Agreed process and audit in place	Recommendation 6
5.3.10	MDTs reflect annually on equality issues	Data to be agreed and collected for MDT annual reports for review & reflection by the MDT members	Data collection	MDT Leads / MDT Administrator & Projects Officer	Mar-22	Data and process for collection to be agreed when MDT Administrator & Projects Officer is settled into post. M.Haughey to check with NICR.		Process agreed to collect data which are reviewed by MDTs	Recommendation 1; Recommendation 6
Additional areas	Overall governance of MDT and decisions arising from MDTs	Review of JDs for ADs, CDs and AMDs – both for cancer and specialties.	Process set up to review JDs	AMD / Medical Directorate / Specialities	Mar-22	This is ongoing via the Medical Directorate		Clear governance structure and process in place	Recommendation 6; Recommendation 7

RAG Rated Scale for Actions	
	Action not progressed
	Process in progress
	Process complete and action implemented

MDT	NCAT Characteristic	Issue/s	Action/s to address	Action Product	Action owner	Action Start Date	Action End Date	Status update	Sign Off
GYNAE	1.2.2 Core members are present for the discussion of all cases where their input is needed	Pathology input at times	Review MDT attendance on quarterly basis	MDT attendance audit	MDT Administrator	1st Nov-21	Mar-22	Regular reports to be run when MDT Administrator is in post	Y
	1.2.3 Clinician who has met the patient whose case is being discussed is present at the meeting	Patient may be seen by different HCP until confirmation of cancer & management plan agreed	Following confirmation of diagnosis, it will be the same clinician who sees the patient	MDT Principles Document	SIL / MDT Leads	1st Nov-21	30th nov	This is detailed in the Principles document which has now been agreed	Y
	1.5.4 MDTs have a teaching & training role within team and beyond	Due to COVID, there have been less medical students / clinicians-in-training at the MDT	Include in MDT Principles document	MDT Principles dcoument	SIL / MDT Leads	1st Nov-21	30th Nov	This is detailed in the Principles document	Y
	3.2.3 Cases are organised in a way that is logical for tumour area being considered and sufficient time given to more complex cases	Cases are alphabetical for main part of meeting. Small number are set aside for regional meeting	Review of case listing	MDT List	MDT Lead / MDT Tracker / MDT Administrator	1st Nov-21	Mar-22	To be reviewed when MDT Administrator is in post	N
LUNG	1.2.7 Anyone observing should be introduced to team members and their details included on the attendance list	Medical student/registrars are not always recorded. SAS Drs would like their attendance recorded	To consider this going forward	MDT attendance list	MDT Tracker / MDT Lead	1st Nov-21	Dec-21	To be agreed with MDT Leads / MDT Co-ordinator	N
	1.5.3 Access to training opportunities as required to support an individuals role in the MDT	Consideration of MDT training for new consultants/nurses/other specialities through their training route/professional bodies	MDT Principles document shared with all new members	MDT Principles document	SIL / MDT Lead	1st Nov-21	30th Nov	Document is agreed	Y
	4.3.11 It is clear who will communicate the MDT recommendations to the patient, GP and clinical team, how and by when and this is minuted	This is not minuted but each consultant is responsible for communicating with other clinical teams, the patient and their GP	To develop MDT Communication doc	MDT Communication doc	OSL / MDT Co-ordinator	1st Nov-21	Dec-21	Review / amend BT Communication protocol	Ongoing
BREAST	1.4.2 Team has agreed what is acceptable team behaviour/etiquette	Not in place	Include in MDT Principles document; consider 360 questionnaire to audit / measure	MDT Principles document	SIL /MDT Leads	1st Nov-21	30th Nov	Detailed in MDT Principles document	Y
	1.5.3 Access to training opportunities as required to support an individuals role in the MDT	Consideration of MDT training for new consultants/nurses/other specialities through their training route/professional bodies	Consider bespoke course for MDTs - mandatory training for new appointees to MDT	MDT Principles Document	Dr Tariq / SIL / MDT Leads	1st Nov-21	30th Dec	Dr Tariq has written to colleagues in Liverpool and they will share their training course with us for consideration	Ongoing
	4.1.2 There are referral criteria in place so it is clear when to send a case to MDT for consideration	Some patients are added and at times it is not clear what the question is for the MDT	MDT Proforma would help to standardise this	MDT Proforma	Cancer Services Co-ordinator / OSL / mdt Administrator	1st Nov-21	Dec-21	MDT Proforma developed for Urology and this will be rolled out in a phased approach	Ongoing
	4.3.11 It is clear who will communicate the MDT recommendations to the patient, GP and clinical team, how and by when and this is minuted	This is not minuted but each consultant is responsible for communicating with other clinical teams, the patient and their GP	Develop a MDT communications doc	MDT Communication document	OSL /MDT Administrator / MDT Leads	1st Nov-21	30th Jan 22	BT Communications document to be reviewed and adopted	Ongoing
	5.3.2 There are agreed policies, guidelines or protocols how changes in clinical practice are to be managed; communications post meetings	Not sure of process for other modalities / specialities. For Surgery, this is agreed and disseminated through the Breast CRG	To be clearly documented for all specialities	MDT Communications Document	OSL / MDT ADMINISTRATOR/MDT Leads	1st Nov-21	30th Jan-22	BT Communications document to be reviewed and adopted	Ongoing
SKIN	1.4.2 Team has agreed what is acceptable team behaviour/etiquette	Not in place	Include in MDT Principles document	MDT Principles document	SIL /MDT Leads	1ST Nov	30th Nov	Document is now agreed	Y
	1.5.3 Access to training opportunities as required to support an individuals role in the MDT	Through different routes: appraisals, revalidation, training courses completed by members	No specifc training course in relation to the MDT	Explore what training is available	Dr Tariq / MDT Leads	1st Dec	Jan-22	Dr Tariq has written to colleagues in Liverpool and they will share their training course with us for consideration	Ongoing
	3.2.2 Locally agreed cut-off time for inclusion of a case on the MDT list	Not in place - there is no cut-off time for cases to be brought back	Potential to filter out cases that are not suitable and to ensure availability of MDT list earlier in week.	Agree cut-off time for cases	MDT / MDT Co-ordinator	1st Nov-21	Dec-21	MDT Lead to take forward with Pathology	Y
UROLOGY	1.2.7 Anyone observing should be introduced to team members and their details included on the attendance list	Medical student attendees are not recorded	Consider recording all attendees for future MDT meetings	MDT attendance list	MDT Tracker / MDT Lead	1st Nov-21	Dec-21	Ensure all attendees are recorded - this will be picked up through the quarterly attendance audits	

	3.2.3 Cases are organised in a way that is logical for tumour area being considered and sufficient time given to more complex cases		This could be improved by implementing protocolised pathways for more straight forward cases which are registered and signed off by the MDT Chair. The more complex cases would be listed for discussion.	MDT Proforma	Cancer Services Co-ordinator / MDT Lead	1st Nov-21	Dec-21	MDT Proforma developed for Urology and this will be rolled out in a phased approach	Y
	4.1.4 A clinician can bring the case of a private patient to the MDT for discussion provided there is time on the agenda	Not in place	Process to be detailed in MDT Principles document	MDT Principles document	SIL / MDT Leads / Cancer Management team	1st-Nov	Dec-21	MDT Principles document developed and shared with MDT Lead for sign off	Y
	5.2.6 MDTs consider and act on clinical outcomes data as they become available e.g. through peer review	Clinical outcomes not available through peer review	Agree what clinical data will be collected, by whom, & when this will be reviewed by the MDT	Data collection	MDT Administrator / MDT Lead	1st Nov	Mar-22	To be considered with MDT Leads when MDT Administrator is in post	Y
	5.3.11 The MDT assesses at least annually its own effectiveness/performance & benchmarks against similar MDTs	The MDT was peer reviewed in 2015, and submitted self-assessments in 2016 and 2017	Set up a process / ensure mechanism is in place for this to happen outside of peer review programme	Annual business meeting	MDT Administrator / MDT Lead	1st Nov	Mar-22	To be part of all future business meetings	N
LGI	1.2.2 Core members are present for discussion of all cases where their input is needed	Issue with pathology input at times	Review MDT attendance on quarterly basis	MDT Attendance list	MDT Co-ordinator	1st Nov	Mar-22	Attendance audit to be conducted on a quarterly basis when MDT Administrator is in post	Y
	1.2.5 A register of attendance is maintained, members sign in and out with times	Untimed weekly register is maintained by MDT Co-ordinator	To be documented in MDT Principles document	MDT Principles document	SIL / MDT Leads	1st Nov	Dec-21	MDT Principles document developed and shared with MDT Lead for sign off	Y
	1.2.7 Anyone observing should be introduced to team members and their details included on the attendance list	Medical students are introduced but not listed on the attendance sheet	MDT Attendance sheet	MDT Attendance sheet	MDT Tracker / MDT Lead	1st Nov	Mar-22	Attendance audit to be conducted on a quarterly basis when MDT Administrator is in post	Y
	1.5.3 Access to training opportunities as required to support an individual's role in the MDT	More access to ACST is required	Need an update in relation to future ACST courses	ACST Courses provided	HOS Cancer / SIL	1st Nov	Dec-21	Regional meeting convened Dec 21 to discuss a virtual course	Ongoing
UGI	5.3.4 MDT policies, guidelines and protocols are reviewed at least annually	MDT operational policy reviewed, and annual report and workplan updated. This has fallen behind over past couple of years.	To review all MDT docs and arrange a MDT meeting to sign off	MDT Docs updated for 2019	SIL /MDT Lead/ MDT Co-ordinator	1st Nov	Mar-22	All MDT documents to be updated on an annual basis	y
THYROID	5.3.4 MDT policies, guidelines and protocols are reviewed at least annually	MDT operational policy reviewed, and annual report and workplan updated. This has fallen behind over past couple of years.	To review all MDT docs and arrange a MDT meeting to sign off	MDT Docs updated for 2019	SIL / MDT Lead /MDT Co-ordinator	1st Nov	Mar-22	All MDT documents to be updated on an annual basis	Y
	5.3.11 the MDT assesses at least annually its own effectiveness/performance & benchmarks against similar MDTs	The MDT was peer reviewed in 2016, and submitted a self-assessment in 2017	Set up a process / ensure a mechanism is in place for this to happen outside of peer review	Annual business meeting	MDT Lead / MDT Co-ordinator	1st Nov	Mar-22	All MDT documents to be updated on an annual basis and presented for review at an annual MDT meeting	Y

UPDATE

MDT BASELINE ASSESSMENT AND ACTION PLAN
MARCH 2022

OBJECTIVES

- To strengthen approaches to Cancer Multi-disciplinary working
- To drive patient safety and quality improvement
- To identify areas to improve MDT systems and processes

TIMELINE OF PROCESS TO DATE

JUNE-AUGUST 2021: local MDTs completed the NCAT tool – characteristics of an effective multidisciplinary team, self-assessment and feedback questionnaire

SEPT-OCTOBER 2021: Meetings held with MDT Leads to review baselines, identify common areas/themes and agree priorities for improvement

NOVEMBER 2021: MDT Action plan developed for first 6 months to address areas highlighted

DECEMBER 2021: MDT Principles document developed which details key areas for monitoring and audit

JANUARY 2022: MDT Administrator and Projects Officer took up post and will have a key role in providing administration management support to all the MDTs

ACTION PLAN UPDATE

i) Multi-disciplinary Teams (MDTs)

Assurance of dedicated time in MDT core members job plans ✓

Develop a role description for MDT Leads & Clinical Director for Cancer (*ongoing*)

Develop an MDT Proforma per tumour site with locally agreed minimum dataset: Urology proforma agreed and implemented; Lung proforma for extended members/non-members being developed (*ongoing*)

New MDT room with appropriate facilities established ✓

Roll out of monthly audit of MDT attendance to ensure all relevant specialties are represented and to assure quoracy ✓

Two additional trackers appointed to the Cancer Tracking team ✓

Report developed by Cellular Pathology & Lab Service in Belfast currently being tested locally to support a process to cross-check patients being discussed at MDTs ✓

Additional field to be added to CAPPs to identify key worker at MDT meeting (*ongoing*)

Work ongoing locally to re-establish Advanced Communications skills training courses for core members of the MDTs (*ongoing*)

ii) Patient experience, support & Information

Cancer Service User Group re-established, new members recruited and terms of reference developed ✓

Roll out of Care Opinion staff training to capture live patient experience feedback (*ongoing*)

Roll out of electronic health needs assessment training for Cancer Nurse Specialists and Support Workers across all tumour sites ✓

Local standardized process developed to implement eHNA clinics and roll out of a phased implementation across tumour sites (*ongoing*)

A CNS personalised care workshop planned for March 2022 ✓

Meetings held with all CNS's to review the MDT Action plan particularly in relation to reinforcing recording process for patient information, key worker role and holistic needs assessment ✓

iii) Regional work

Data manager funding support identified in Cancer Recovery Plan

Participation in CNS workforce census work and to prepare for the next CNS workforce expansion plan

Participation in relation to enhanced tracking, initially for sequential treatments

Number	Responsible	Recommendation	Date for Completion	Revised Date for Completion	Update 01.03.2022
Recommendation 1.1	Medical Director and Director of Acute Services	The Trust should review Mr As job plan and actual APAs worked in order to ascertain if overpayments have occurred, and seek recompense if required.	Oct-21	Complete	Surgical Division undertook a review of Mr As job plan and did not find any overpayment
Recommendation 1.2	Medical Director/Deputy Medical Director and all Divisional Medical Directors	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report and as per the 'Code of Conduct for Private Practice - recommended standards of practice for HPSS consultants (November 2003)', the Trust must ensure that: <ul style="list-style-type: none"> • All consultants have an annual job planning review. • All consultants completing private practice declare any private practice and as part of the annual job planning process, consultants should disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of HPSS work and out of hours cover. • As part of the job planning process, the Trust should consider total working hours across HSC and private practice. <p>Job plans should be signed and dated by the consultant and their Clinical Director.</p>	Feb-22	Jul-22	As part of ongoing medical leadership review and strengthening exercises the following has been actioned: <ul style="list-style-type: none"> • Clinical directors will have an increased focus on ensuring compliance with job planning processes including ensuring that job planning considers the whole of a clinicians practice and any potential impact of private work activities on their Trust commitments. • A memo has been issued by the Medical Director regarding the Trust 'Declaration of Private Practice' which is to be completed by all substantively employed medical staff for return to the Medical Revalidation team stating if private practice is undertaken in addition to HSC employment. • The declaration requires confirmation that any private patient work must be included within their job plan and declared as soon as possible. • This memo also reminded all staff of the importance of completion of an Annual Declaration on Private Practice (including those doctors who do not undertake private practice) and all clinicians undertaking private practice must have read and are familiar with Regional Guidance and the Trust Private Patient Guidance as per private practice declaration requirements. • In support of our work to strengthen governance arrangements around private practice, the Trust Appraisal round for 2021 incorporates a structured reflective template for those doctors who undertake private practice. A pilot of a structured reflective template for this purpose has been developed and issued to staff for consideration. • As part of the Trust's commitment to strengthen and improve professional governance processes, from 2022 onwards regular routine audits will be completed. • Job planning for 2020/21 is currently 89%: The Revalidation Team are actively pursuing follow up to achieve the expected 100% compliance.
Recommendation 1.3	Medical Director/Deputy Medical Director and all Divisional Medical Directors	The Trust should strengthen their management arrangements in scenarios where a Consultant declares that they conduct private outpatient work only, specifically where the work is carried out outside the NHS including premises not regulated by RQIA. The following specific measures are suggested: <ul style="list-style-type: none"> • Assurances should be sought as to how associated diagnostics/subsequent required treatment are managed. • Medical Director approval should be introduced in the event that Consultants conduct outpatient work privately. • Trust monitoring processes should be alert to ensuring Change of Status patients are placed on the waiting list based on clinical priority. • The Trust "Declaration of Private Practice" form should be amended to clearly identify the type of private practice undertaken (ie outpatient/daycases/inpatients). Trust management should review these declaration as and triangulate the information with appraisals and job plans. 	Feb-22	Jul-22	As part of our work to strengthen governance arrangements in relation to the Trust Appraisal and Revalidation process will for Appraisal round 2021 incorporate a structured reflective template for those doctors who undertake private practice. This template requires the clinician to detail volume and type of private practice completed over previous 12 month period including private practice location, inclusion in job plan, governance arrangements and scope. <p>A pilot of the proposed structured reflective template for this purpose has been completed: Feedback from this pilot has been taken and implemented. Alongside side the structured reflective template, a reflective practice guidance sheet has been developed to assist in the completion of whole practice reflection for Appraisal.</p> <p>In addition, all staff have been reminded of the importance of:</p> <ul style="list-style-type: none"> • The completion of Structured reflective template incorporating private practice as per guidance sheet • The completion of the Annual Declaration on Private Practice (including those doctors who do not undertake private practice) • Clinician's undertaking private practice have read and are familiar with Regional Guidance, Trust Private Patient Guidance and other associated documentation as per private practice declaration requirements. <p>The declaration of private practice has been amended to ask clinician to confirm the following:</p> <ul style="list-style-type: none"> • Where private practice is undertaken and type of private practice • Laboratory tests are not forwards to the Trust laboratory • Have read and understood Trust guidance on paying and private patients • Have read and understood regional guidance • Use of medical sectaries in private/ paying patient work is completed outside of NHS working time and prior approval is required • Any private patient work must be declared and included in job plan <p>Work is in progress in to ensure mechanism are robust in relation to change of status patients to ensure equitable provision of NHS services. This has included the creation on an electronic change of status form that should be completed in respect of all private patient transfers including priority rating. It is proposed once this has been submitted the clinical director, who will have speciality oversight in relation to waiting list priority, can raise issue where required in relation to appropriateness of change of status and clinical priorities.</p> <p>An audit proposal has been created to provide assurance around these processes. This is pending agreement with Finance and Support Services to commence.</p>
Recommendation 1.4	Assistant Director Systems Assurance	The findings in this report indicate issues around patients being able to pay to see a Consultant privately and then receiving preferential treatment in the NHS. The Trust should consider whether these issues are isolated to this one Consultant or indicative of a wider cultural issue. <p>The Trust should review and strengthen management of private patient procedures. As part of this process the new procedures should be shared with all relevant trust staff and roles and responsibilities should be reiterated where required. Specifically consultants must be reminded of their responsibility to ensure that all private work and change of status patients are declared. Consideration should be given as to how Radiology, Laboratories and Pharmacy can strengthen their processes, scrutiny and challenge of service requests that could potentially originate from the private sector.</p>	Feb-22	Jul-22	The Trust is in the process of reviewing its private practice guidance and reporting processes to identify any non-compliance. The proposed electronic change of status form will be reviewed by the relevant Head of Service and Clinical Director. As part of the revised medical declaration process consultants are required to assure they are aware of the parameters of which their private practice should be conducted within. The importance of clinicians ensuring each private patient referred to an elective service has an appropriate formal referral letter submitted via the Trust Referral and Booking Centre using the same process as all NHS referrals. Each referral must be clearly marked 'PRIVATE TO NHS TRANSFER'. Private patients should not join a waiting list via any other entry point including being directly booked by secretarial staff. An audit proposal has been created to provide assurance around these processes. This is pending agreement with Finance and Support Services to commence. <p>Once processes have been finalised a series of information roadshows will be offered to inform consultants of changes and to remind all of their responsibility pertaining to private patients.</p> <p>Pharmacy have a good process for charging identified private patients working in conjunction with the private patient officers and the cashiers. This relies on others to identify that the patient is private and inform Pharmacists. If there was no 'history' on patient centre when a specialist script has been submitted, this would be raised with the consultant's secretary to check if it could be a private case. It is not feasible to check if each discharge or outpatient script received is private or NHS, so can result in supplying to a private patient. To scope if ECM/electronic discharges and paper scripts could have a tick box for the prescriber to confirm that the patient is eligible - HSCB require prescribers to confirm that on their IFR drug applications. Radiology and Laboratories - current considering how to strengthen their process as per 3.3</p>

Number	Responsible	Recommendation	Date for Completion	Revised Date for Completion	Update 01.03.2022
Recommendation 1.5	Medical Director/Deputy Medical Director and all Divisional Medical Directors	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report, Consultants should be instructed to complete the required declaration in relation to Private practice for the current year.	Oct-21	Jul-22	The Declaration of Private Practice has been circulated to all clinicians: The Medical Director issued a memo to remind to all of the importance of completing the 'Declaration'. The Revalidation Team are continting to proactively engage with who have not responded in order to achieve 100% completion rate.
Recommendation 1.6	Assistant Director Systems Assurance	The Change of Status process should be strengthened. Specifically: <ul style="list-style-type: none"> • The Change of Status form currently in use within the Trust for patients transferring from Private Practice to NHS must be reviewed and updated to include all relevant information including clear documentation of the reason for change. The effective date of change of status should be amended to the approved date for change of status and it should be clear on the form that the effective date of change will be the date that the form is approved by the agreed appropriate senior clinical and operational leads. The agreed appropriate senior clinical and operational leads should sign and date all change of status forms. Patients should only be added to the HSC waiting list when the change of status form has actually been signed and dated by the by the agreed appropriate senior clinical and operational leads. Previously reported in 2019/20 <ul style="list-style-type: none"> • The Trust should increase scrutiny and challenge over Change of Status forms that have been completed and sent to the Private Patient Office. The Trust should appropriately enforce the stated condition on the Change of Status form, namely until the form is approved, the patient will remain private and may be liable for charges. Previously reported in 2019/20 	Feb-22	Sep-22	A revised Change of Status form has been developed for pilot. The Trust is considering the development of an electronic form to assist with the recording and reporting of processes. The form requires substantial more detail than previous version including 'Reason for Transfer' which is a mandatory completed field. The form explicitly informs the author the form is subject to review by Clinical Director/ Head of Service and confirmation of effective date of transfer by paying patients office following 5 day review period. The governing processes are under review with plans to have localised medical management sign off for approval of change of status
Recommendation 1.7	Assistant Director Systems Assurance, Assistant Director Functional Support Services	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report, the Trust should develop a process to monitor change of status patients and to ensure that the process for changing status is effectively controlled and documented as an assurance that the delivery of service is equitable. <p>The Trust should implement the regional PAS code for patients transferring from private to NHS and develop a mandatory requirement to indicate changes of status on PAS. A printout from PAS should then be regularly reviewed and reconciled to Change of Status forms received.</p>	Feb-22	Sep-22	The Trust has created a report in Business Objects and shared with Private Patient Officer to cross check. All secretaries reminded of codes and when to use. The reports are set up and PP officer runs them. Training re all the codes complete and all secretaries met with. <p>An audit proposal has been created to provide assurance around these processes. This is pending agreement with Finance and Support Services to commence.</p>
Recommendation 1.8	Assistant Director ATICS	The Trust should increase controls over prescription pads held in consulting rooms. These should be maintained as controlled stationery.	Feb-22	Complete	New Process <ul style="list-style-type: none"> • Prescription pads are ordered via BSO e-procurement by Nursing staff • Now on receipt these are stored in locked cupboards • Cupboards located in each consultant rooms in outpatients • Only Nursing staff hold the keys for these cupboards and they take the prescription pads out at the start of clinic and return to the locked cupboard at the end. • Still to implemented will be that the Pads will be numbered and signed in and out of each of the cupboards to ensure control.
Recommendation 2.1	Medical Director	The Trust should consider charging for the identified private activity. Internal Audit appreciate that this needs to be considered, and may not be feasible, in the wider context of a patient recall.	Jul-21	Complete	This has been considered by the Trust and it was felt it would not be appropriate to charge these patients.
Recommendation 2.2	Assistant Director Functional Support Services and Operational ADs	The Trust should develop a written procedure around the use of protected review clinic appointments. The Trust should also introduce monitoring of compliance with the procedure.	Feb-22	Sep-22	The Trust has commenced discussions within the divisions to agree and implement a written procedure for the use of protected review clinics appointment. Once agreed this will be shared and implemented with agreed timescales for monitoring compliance.
Recommendation 2.3	Assistant Director Systems Assurance	Trust Guidance and Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007) should be re-issued and sign-off by doctors engaging in private practice. Where concerns are raised about a consultants' compliance, the Department of Health's framework Maintaining High Professional Standards in the Modern HPSS should be followed.	Feb-22	Complete	As part of the revised process to govern the 'Declaration of Private Practice' all medical staff engaging in private practice will be required to provide signed cofirmation that they are aware and will abide by the Trust Guidance on Private Practice and the regional Management of Private Practice in Health Service Hospitals in Northern Ireland (2007).
Recommendation 3.1	Assistant Director of ATICS	As previously recommended in the 2019/20 Management of Pre-Op Assessments audit report, Management should ensure all patients due for elective surgery have an up to date pre-operative assessment completed no more than 13 weeks ahead of planned admission date for surgery. Management should focus on improving processes in those specialties with higher volumes of exceptions including Urology.	Sep-21	Complete	Due to covid 19 pressures there is limited theatre capacity. Currently only priority 2 patients according to the Federation of surgical speciality association (FSSA) guidelines are scheduled and these lists are all shared with Pre-OP as soon as they are identified by the consultant and added to the priority 2 spreadsheets.
Recommendation 3.2	Assistant Director of ATICS	As previously recommended in the 2019/20 Management of Pre-Op Assessments audit report, Management should review processes to ensure all private outpatients transferring to NHS inpatient waiting lists are promptly notified to the Pre-operative Assessment team.	Sep-21	Complete	All private patients (PP) are listed onto the Patient Administrative System (PAS) by the secretarial admin staff and if they are priority 2 and added to the spreadsheet (3.1) then they are sent to Pre-Op and identified as previous PP. The report advised can be run via Business objects by Pre Op team
Recommendation 3.3	Director Performance & Reform/ AD Cancer & clinical Services	The Trust should liaise with BSO in order to resolve this referring Consultant recording error in the NIPACS system.	Feb-22	Sep-22	There is a flag on NIPACS for private patient but previously, we would be have depended on the referrer to note this as 'free text' in the referral. We can ID a referral as private by the referral source which can hep indicate that likely to be private. Contact was made with BSO but their view is that this is for each Trust to establish their own process. Trust linking with colleagues in other Trusts to confirm their process for dealing with imaging referrals for private patients to influence our approach as there is currently no straightforward way to capture this.
Recommendation 3.4	Assistant Director Functional Support Services	The processes for registration should be reviewed and training given to all appropriate staff on the correct use of PAS, including consultant secretaries.	Feb-22	Complete	PAS identifies "open registered patients". These are reviewed and reported on and followed up/ escalated for timely closure.

Number	Responsible	Recommendation	Date for Completion	Revised Date for Completion	Update 01.03.2022
Recommendation 3.5	Assistant Medical Director Clinical Directors and Assistant Operational Directors	The processes surrounding electronic and manual sign off and review of the "DISCHARGE AWAITING RESULT" should be strengthened and monitored.	Feb-22	Complete	This is a PAS function to prompt re "Discharge awaiting results" – DARO is used only for patients awaiting results and is reflected in monthly Service Administrators reports. Process for escalation currently to HOS and AD.
Recommendation 5.1	Director of Finance	The Trust should remind staff that all donations received from the public in respect of their care should be lodged to the Trust's Charitable Trust Funds only and that staff are not permitted to use their position of employment within the Trust to advance personal interests, causes or charities as it could give rise to reputational damage to the Trust.	Dec-21	Dec-22	To be completed by December 2022



Southern Health & Social Care Trust

Review of Mr A's Compliance with Relevant Authorities/Guidance in terms of his Private Work 2020/21



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Acknowledgement

Internal Audit wishes to thank management and staff at the Southern Health and Social Care Trust for their assistance and co-operation during the course of the assignment.

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Introduction

In November 2020, at the request of the Urology Assurance Group, the SHSCT Chief Executive requested a review of Mr A's patients transferring into SHSCT as HSC patients. In addition, the review will consider any Trust involvement with the Craigavon Urological Research & Education organisation.

Terms of Reference

The audit focused primarily on Mr A's change of status private patient's work during the period 1 January 2019 to 30 June 2020 in order to:

1. Establish the extent of SHSCT awareness of Mr A's private work, through the job plan process and their private patient identification and management processes.
2. Establish the extent to which Mr A's private work interacted with HSC services and facilities.
3. To identify all of Mr A's patients that changed status (private/NHS) and check that there is evidence that relevant guidance/authorities have been adhered to. This will include providing assurance that:
 - The appropriate Change of Status paperwork has been completed and authorised and that this is supported by an assessment, by the consultant, of the patient's clinical priority for treatment as a Health Service patient.
 - For all private work identified above, the patient joined the HSC waiting list at the same point as if their consultation had taken place as an NHS patient.
 - The Consultant fulfilled all obligations with regard to recording and identifying private activity.
 - Where private work was conducted on HSC premises, ensure the patient has been invoiced for relevant costs.

Internal Audit also considered whether the Trust has any involvement with CURE - Craigavon Urological Research & Education, to understand if there was a flow of money into the Trust and to check, as much as is possible from review of Trust records and engagement with Trust staff, whether any Directors/staff benefited from the operation of the company.

Limitation of Scope: Internal Audit would caution that the analysis conducted is largely based on the data provided by the Trust. Internal Audit did not walk through each individual patient's journey on their patient file and therefore the analysis may not be fully complete.

Executive Summary

Internal Audit has identified issues with Mr A's compliance with relevant guidance around private practice. Significant issues with the timing, completion and approval of change of status paperwork were identified when patients transferred from private to NHS care. Occasions were also found when patients that had been seen privately, were treated more quickly than the Trust standard waiting times.

Significant issues were also found around the Trust's management and monitoring of compliance with private patient guidance in particular the change of status process and their ability to monitor that patients transferring from private to NHS care, are treated in an equitable manner. The findings in this report indicate issues around patients being able to pay to see a Consultant privately and then receiving preferential treatment in the NHS. The Trust should consider whether these issues are isolated to this one Consultant or indicative of a wider cultural issue.

In total in the review period, 5 of Mr A's private patients were identified as having been treated at the Trust without/prior to receipt of a change of status form. A further 8 patients were potentially private when they were seen in the Trust (excluding those cases that the Trust believe are poor administration rather than private work). 5 patients switched status more than once (from NHS-private-NHS). 6 change of status patients were seen ahead of Trust waiting times. A further 2 patients were added to PAS retrospectively effectively being placed on the waiting list ahead of where they should have been placed.

In addition to private practice issues, there are also patient safety matters identified in the report primarily around performance of Pre Operative Assessments.

The findings of the review are summarised as:

Trust Processes and Awareness of Mr A's Private Work

Trust Knowledge of Mr A's Private Work

1. The Trust were aware that Mr A holds a private outpatient clinic at his home. It is unclear what happened these private outpatients if they required diagnostics and/or inpatient/daycase procedures. The Trust does not appear to have explored or challenged the potential interaction with the Trust in the scenario where private outpatients may require diagnostics/procedures etc. There is learning for the Trust in this matter in terms of considering circumstances when a Consultant conducts private outpatients work only.

Job Planning & Payment

2. In line with job planning guidance and Consultant terms and conditions, a job plan review should take place annually. The most recent job plan available for Mr A is an unsigned job plan, dated 1 April 2018.

3. Personal Information redacted by USI

The Trust's Change of Status Process

4. The Trust's Change of Status form for when a private patient transfers to NHS treatment, has limited monitoring or control value. The Change of Status activity is not effectively approved by the Medical Director or reviewed by the Trust Clinical/Directorate Management. The Change of Status form itself and the Change of Status process require strengthening.
5. The Trust is not compliant with the regional guidance issued in 2018 which requires all Change of Status patients to be identified with a 'PTN' code on PAS.
6. The Trust does not have a process in place to ensure all change of status patients have been identified for monitoring purposes and to ensure that the process for changing status is effectively controlled and documented, as an assurance that the delivery of service is equitable.

Identification of Private Work

7. Laboratories, Radiology and Pharmacy are reliant on Consultants highlighting any private activity. There is a risk therefore that private activity in these departments may not be identified.
8. There is insufficient control over prescriptions pads to prevent the use of Trust prescription pads for private work.

Mr A's Change of Status Patient Activity

Approved Effective Change of Status Date

9. Contrary to Trust written procedure, the date the patient is added to PAS as an NHS patient is the effective date as per the Change of Status form, not the date the Change of Status form was approved by Medical Director.

Change of Status Patients who had Diagnostic (Radiology) Tests

10. In 10 out of the 21 Change of Status cases during the period from January 2019 to June 2020, the patient was referred for 1 or more imaging tests. In 3 of these 10 cases, the patient had the imaging tests in the Trust prior to changing status to NHS ie whilst still private patients. A further 5 out of the 10 patients had diagnostic requests made on the same date as the effective change of status date and the same date the patient was last seen privately. Given that these 5 Change of Status forms are unlikely to have been submitted and approved by the Medical Director on the same day as the patients' private appointments, these patients should potentially have been treated by the Trust as private patients.
11. 3 (including 1 of the 3 patients found to be private) out of the 10 patients were seen sooner than the Trust waiting time for the diagnostic/imaging test.

Patients who changed Status and had Inpatient/Daycase Procedure

12. Out of the 13 Change of Status cases transferred into the NHS for an inpatient/day procedure, 5 had their procedure during the review period (ie up to June 2020). The Trust Consultant Urologist assisting Internal Audit in this review considered that 2 of the 5 patients were not seen in line with the Trust waiting list time. These cases were not Urgent/red flag procedures (as categorised on PAS) and were seen significantly sooner than other patients on the waiting lists.

Retrospective Entry to PAS

13. Two change of status forms had been added retrospectively to PAS. Most significantly, one of these patients was added to the waiting list from September 2018 but this was not actually added to PAS in May 2020. At December 2020 this Change of Status had not been approved by Medical Director.

Protected Reviews

14. The Trust does not monitor the use of protected review appointments and there is a risk that private patients or Change of Status patients could potentially be seen quicker in a protected review appointment slot.
15. Internal Audit identified 1 case where a routine outpatient was seen in a protected review slot, 15 days after being added to the waiting list and therefore seen ahead of NHS patients with the same clinical priority.

Multiple Switches in Status

16. Contrary to guidance, in 5 of the 21 cases where a change of status form had been completed, the patient moved between NHS to Private to NHS for the same referral.

Analysis of Mr A Activity Data*Pre-Operative Assessments (POAs)*

17. In 86 (25%) of the 351 procedures conducted by Mr A during the period January 2019 to June 2020 which required a Pre-Operative Assessment, a POA was not completed.
18. Upon further analysis, 1 of these 86 cases related to a private patient who was subsequently treated in the NHS. No Change of Status form had been completed.
19. 95% of the POAs completed on Mr A patients during the review period were completed less than 3 weeks before admission for surgery. The Trust requires POAs to be completed at least 3 weeks before (and up to 13 weeks before) admission for surgery,
20. The lack of POA or the short time scales between the completion of a POA and the date of admission for surgery is a potential indicator that a patient may have been seen privately and then had their procedure in the NHS.

Elective Surgery With No Outpatient Appointment

21. Out of a sample of records where a patient had surgery but there was no evidence on PAS of an outpatient appointment, we found:
- 1 patient changed from NHS to private and back to NHS status in one day, with no Change of Status forms. This is a blatant breach of proper process and is an example whereby a significant advantage has been gained in terms of speed of treatment, by paying privately for an outpatient appointment. In the absence of an approved Change of Status form, this is arguably a private patient having a procedure using trust facilities and staffing.
 - In 2 cases, there was no outcome letter completed for the procedure potentially indicating that the patient may have transferred back to the private sector for review. *It should be noted that the Trust believe that these are poor administration issues rather than private patients.*

Elective Surgery with an Outpatient Appointment

22. Out of a sample of 29 patients who had an elective procedure and an outpatient appointment in the period under review, 4 occasions were found where the patient may potentially have been a private patient. In one case the patient was a Personal Information redacted by the USI and in another case the patient was a Personal Information redacted by the USI. *It should be noted that the Trust believe that one of these cases associated with non completion of an outcome letter is poor administration rather than a private patient.*

Other Observations

23. Other issues have been noted by Internal Audit around the audit trail when ordering scans on NIPACS (Sectra); changes being made to the referral date on PAS (which should not be changed); registrations for episodes of care on PAS that remain open rather than being closed; and use and monitoring of electronic sign off on NIECR.

Extent of Trust Involvement with CURE

24. CURE - Craigavon Urological Research & Education – is an independent entity, separate from the Trust. Whilst a number of Trust staff sit on the CURE Committee, these roles are independent from their role in the Trust. From discussion with Trust Management and Trust staff involved with CURE, there is no indication of any flow of money into the Trust or Trust involvement in fund raising in recent years. Internal Audit understands from the Committee members that Trust staff may apply to CURE for funding and if granted, a cheque will be written from CURE to the applicant. Trust procedures do not provide guidance in respect of staff involvement in independent organisations with a potentially perceived affiliation to the Trust by their nature.
- Internal Audit did not have access to CURE financial records as part of this review and therefore do not have visibility over any payments made by CURE to Trust staff.

Detailed Findings Of The Review

1. TRUST'S AWARENESS OF MR A'S PRIVATE WORK AND MANAGEMENT OF COMPLIANCE WITH PRIVATE PATIENT GUIDANCE

1.1 Job Plan Document

The Consultant Job Planning - Standards of Best Practice (November 2003) and Consultant Terms and Conditions of Service (Northern Ireland) 2004 states that a job plan review should take place annually. A similar requirement is contained in the Medical and Dental terms and conditions 2008.

Internal Audit requested a copy of Mr A's job plan for the period 1 January 2019 to 30 June 2020. In line with the annual job plan review schedule, there should be 2 job plans to cover this period. There is no signed off job plan held by the Trust for the period 1 April 2011 to 30 June 2020. The most recent job plan available for Mr A is an unsigned job plan, dated 1 April 2018 and there is no end date recorded. This document is not signed by Mr A or his Clinical Director.

The most recent job planning meeting appears to have been held in November 2018. Regular, annual job plan meetings have not been held.

1.2 Trust Knowledge of Mr A's Private Practice

"A Code Of Conduct For Private Practice - Recommended Standards Of Practice For HPSS Consultants (An Agreement between the BMA(NI) Northern Ireland Consultants and Specialists Committee and the Department of Health, Social Services and Public Safety for consultants in Northern Ireland) (November 2003)" requires that Consultants declare any private practice and as part of the annual job planning process, consultants should disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of NHS work.

Trust procedures "Trust Guidance on Paying/Private Patients – 2018 states: In section 2.2 "Under the appraisal guidelines agreed in 2001, NHS consultants should be appraised on all aspects of their medical practice, including private practice. In line with the requirements of revalidation, consultants should submit evidence of private practice to their appraiser" In Section 5.1 "While Medical Consultant staff have the right to undertake Private Practice within the Terms and Conditions of the Consultant Contract (2004) as agreed within their annual job plan review, it is the responsibility of Consultants, prior to the provision of any diagnostic tests or treatment to:

- ensure that their private patients are identified and notified to the Paying Patients Officer.*
- ensure full compliance with the Code of Conduct for Private Practice (see Appendix 2) in relation to referral to NHS Waiting Lists.*
- ensure that patients are aware of and understand the range of costs associated with private treatment including hospital costs and the range of professional fees which the patient is likely to incur, to include Surgeon/Physician, Anaesthetist, Radiologist, hospital charges.*
- Ensure that information pertaining to their private patient work is included in their annual whole practice appraisal.*

Although there is no private work identified in Mr A's most recent job plan, the Trust were aware that Mr A conducted private work outside the Trust:

- Mr A submitted a Trust "Declaration of Private Practice" in February 2018. In this declaration form, Mr A advised that he did not complete private practice within the Trust, however he did

treat private patients outside of the Trust. The declaration form is not sufficiently clear to clarify the type of private practice undertaken (ie outpatient/daycases/inpatients). On the Declaration Mr A did not confirm that he had read and understood the Trusts Guidance on Paying/Private patients. He did declare that he understood that any private patient work whether undertaken inside or outside of the Trust must be included in his job plan. *The Trust Declaration of Private Practice process should be conducted every year. A declaration therefore should have been made by Mr A in 2019 however this was not submitted to the Trust and the annual declaration process was not conducted in 2020 due to COVID-19.*

- The most recent appraisal completed for Mr A was in 2018. Internal Audit do not require access to this appraisal document, however the Trust have confirmed that Mr A declared that he conducted a private outpatient clinic at his home.

In the event that a private outpatient seen at Mr A's home clinic required diagnostics including blood tests or a daycase/inpatient procedure, it is unclear how this private activity was administered and whether or not such work entered the Trust either as private or NHS work. This issue is considered further in sections 2 and 3 of this report.

The Trust does not appear to have explored or challenged the potential interaction with the Trust in the scenario where private outpatients may require diagnostics/procedures etc. There is learning for the Trust in this matter in terms of considering circumstances when a Consultant conducts private outpatient work only.

1.3 Reconciliation of Job Plan to Payroll

Personal Information redacted by the USI

1.4 Change of Status Process

The "Management of Private Practice in Health Service Hospitals in Northern Ireland: A Handbook – November 2007" requires that patients changing status from Private to NHS must have a Change of Status form completed by the consultant. The form must also detail the clinical priority for treatment as a health service patient. The Trust should be able to clearly identify these patients for monitoring purposes. It is important that the process of changing patient status is effectively controlled and documented as an assurance that the delivery of service is equitable.

The Trust Guidance on Paying/Private Patients procedures require Consultants to complete a Change of Status form when a private patient transfers to NHS treatment. However, effectively this form has limited monitoring or control value because:

1. The form is signed by the Consultant and stamped as approved by the Medical Directors office. It is not possible to establish who applied this stamp or the date it was applied. The change of status forms are filed in the cash offices at Craigavon Area Hospital/Daisy Hill Hospital and no

- action or reporting takes place within the Trust. The Change of Status activity is not effectively approved by the Medical Director or reviewed by the Trust Clinical/Directorate Management.
2. The form contains no detail of the reason for the change of status.
 3. The date the patient changes status to NHS is recorded on PAS as the effective date as per the Change of Status form, not the date the Change of Status form was approved by the Medical Director. This appears contrary to Trust Guidance on Paying/Private Patients procedures which state *"It is important to note that until the change of status form has been approved by the Medical Director, the patient's status will remain private and they may well be liable for charges."* The Change of Status form is confusing this matter, by including an effective date of change of status rather than, an approved date. The form does not clearly state that the approval date will be the date of transfer to NHS from private status.
 4. There are no dates applied to the change of status form by either the Paying Patient Officer on receipt of the form or by the Medical Director's Office on approval of the form. Therefore Internal Audit were unable to establish whether the Change of Status forms were approved prior to the patient receiving an appointment/treatment, potentially impacting on income that may have been due to the Trust.

Prior to 11 September 2018 when the regional PAS Technical Guidance approved a code (PTN) to identify private patients transferring to NHS status, the Patient Administration System (PAS) did not require a change of status to be recorded on the system. The change of status may have been entered in a free text field which is not a mandatory field. The Southern HSC Trust has not yet implemented the regional code 'PTN' for patients transferring from private practice to NHS. A PAS report cannot therefore be run showing all change of status patients.

The Trust does not have a process in place to ensure all change of status patients have been identified for monitoring purposes and to ensure that the process for changing status is effectively controlled and documented, as an assurance that the delivery of service is equitable.

1.5 Private Patient Identification Processes

In line with the "Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007)" Consultants have a contractual obligation to cooperate in recording all private outpatient and day patient attendances, treatments and procedures. The patient's records and referral forms etc should always be suitably marked. Records kept in departments away from the main outpatient area (e.g. x-ray, pathology and physiotherapy) should identify private patients.

Internal Audit met with senior staff in Laboratories, Radiology and Pharmacy to discuss the processes in these departments for the identification and management of private patients. All three departments are reliant on Consultants highlighting any private activity. There is a risk therefore that private activity in these departments may not be identified.

Pharmacy:

When a consultant prescribes medication to a private/NHS patient at an outpatient clinic, there are 2 different prescription pads used:-

- Prescription which can be written and given to the patient to take to the hospital pharmacy for dispensing. These are numbered but there is no control over the issue of the prescription pads. These are in quadruplicate – White copy –to GP, yellow copy to Pharmacy, Blue copy community nursing and pink copy patient notes.
- Prescription letter which the patient must take to their GP and the GP writes a prescription for dispensing at the community pharmacist.

There are inadequate controls surrounding the issue and use of prescription pads. Pads are held in consulting rooms and may be used by multiple consultants who apply their own name labels to the scripts.

If a patient takes the script to the Trust pharmacy for dispensing, the pharmacy have no mechanism to identify whether the patient is private or has come from a NHS outpatient appointment. Similar to the rest of private practice, the Trust are reliant on the Consultant declaring activity as private and in this case, writing the prescription advising that the patient is private so that pharmacy can ensure that the cost of the medications are invoiced.

Internal Audit discussed 6 sampled cases with Pharmacy to identify if any of these patients had received medication while still private patients. No issues were identified.

Laboratory Services:

The Head of Laboratory Services advised that within the Trust they are reliant on the Consultant/doctor who completes the laboratory request ticking a box to identify a private patient. There is no other mechanism to identify private patients.

Laboratory results are put on NIECR and there is nothing to identify private tests unless the consultant has declared this on the lab request.

Diagnostic Services:

The Head of Acute Information in conjunction with the NIPACS Manager confirmed referrals received for scans etc are all completed on the same referral form and there is no mechanism to identify private or change of status patients on the system. Consultants order scans etc directly themselves on the NIPACS (Sectra) system.

As per Section 2 of this report, radiology activity was identified that should potentially have been declared and treated as private.

Recommendations Specific to Review of Mr A's Practice:

Recommendation 1.1	The Trust should review Mr As job plan and actual APAs worked in order to ascertain if overpayments have occurred, and seek recompense if required.
Management Action	ACCEPTED
Responsible Manager	Medical Director and Director of Acute Services
Implementation Date	October 2021

General Recommendations Regarding Trust Process:

Internal Audit completed an audit in 2019/20 (finalised in October 2020 following delay in obtaining Management Response to the report due to COVID-19) and provided limited assurance in relation to Management of Private Medical Practice (including patient change of status processes). A number of the recommendations included in the 2019/20 report have been restated throughout this report.

Recommendation 1.2	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report and as per the 'Code of Conduct for Private Practice - recommended standards of practice for HPSS consultants (November 2003)', the Trust must ensure that: <ul style="list-style-type: none"> • All consultants have an annual job planning review. • All consultants completing private practice declare any private practice and as part of the annual job planning process, consultants should
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	<p>disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of HPSS work and out of hours cover.</p> <ul style="list-style-type: none"> As part of the job planning process, the Trust should consider total working hours across HSC and private practice. <p>Job plans should be signed and dated by the consultant and their Clinical Director.</p>
Management Action	ACCEPTED
Responsible Manager	Medical Director/Deputy Medical Director and all Divisional Medical Directors
Implementation Date	February 2022

Recommendation 1.3	<p>The Trust should strengthen their management arrangements in scenarios where a Consultant declares that they conduct private outpatient work only, specifically where the work is carried out outside the NHS including premises not regulated by RQIA. The following specific measures are suggested:</p> <ul style="list-style-type: none"> Assurances should be sought as to how associated diagnostics/subsequent required treatment are managed. Medical Director approval should be introduced in the event that Consultants conduct outpatient work privately. Trust monitoring processes should be alert to ensuring Change of Status patients are placed on the waiting list based on clinical priority. The Trust "Declaration of Private Practice" form should be amended to clearly identify the type of private practice undertaken (ie outpatient/daycases/inpatients). Trust management should review these declaration as and triangulate the information with appraisals and job plans.
Management Action	ACCEPTED
Responsible Manager	Medical Director/Deputy Medical Director and all Divisional Medical Directors
Implementation Date	February 2022

Recommendation 1.4	<p>The findings in this report indicate issues around patients being able to pay to see a Consultant privately and then receiving preferential treatment in the NHS. The Trust should consider whether these issues are isolated to this one Consultant or indicative of a wider cultural issue.</p> <p>The Trust should review and strengthen management of private patient procedures. As part of this process the new procedures should be shared with all relevant trust staff and roles and responsibilities should be reiterated where required. Specifically consultants must be reminded of their responsibility to ensure that all private work and change of status patients are declared.</p> <p>Consideration should be given as to how Radiology, Laboratories and Pharmacy can strengthen their processes, scrutiny and challenge of service requests that could potentially originate from the private sector.</p>
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Management Action	ACCEPTED
Responsible Manager	Assistant Director Systems Assurance,
Implementation Date	February 2022

Recommendation 1.5	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report, Consultants should be instructed to complete the required declaration in relation to Private practice for the current year.
Management Action	ACCEPTED
Responsible Manager	Medical Director/Deputy Medical Director and all Divisional Medical Directors
Implementation Date	October 2021

Recommendation 1.6	<p>The Change of Status process should be strengthened. Specifically:</p> <ul style="list-style-type: none"> The Change of Status form currently in use within the Trust for patients transferring from Private Practice to NHS must be reviewed and updated to include all relevant information including clear documentation of the reason for change. <p>The effective date of change of status should be amended to the approved date for change of status and it should be clear on the form that the effective date of change will be the date that the form is approved by the agreed appropriate senior clinical and operational leads.</p> <p>The agreed appropriate senior clinical and operational leads should sign and date all change of status forms. Patients should only be added to the HSC waiting list when the change of status form has actually been signed and dated by the by the agreed appropriate senior clinical and operational leads. <i>Previously reported in 2019/20</i></p> <ul style="list-style-type: none"> The Trust should increase scrutiny and challenge over Change of Status forms that have been completed and sent to the Private Patient Office. The Trust should appropriately enforce the stated condition on the Change of Status form, namely until the form is approved, the patient will remain private and may be liable for charges. <i>Previously reported in 2019/20</i>
Management Action	ACCEPTED
Responsible Manager	Assistant Director Systems Assurance
Implementation Date	February 2022

Recommendation 1.7	As previously recommended in the 2019/20 Management of Private and Paying Patients audit report, the Trust should develop a process to monitor change of status patients and to ensure that the process for changing status is effectively controlled and documented as an assurance that the delivery of service is equitable.
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	The Trust should implement the regional PAS code for patients transferring from private to NHS and develop a mandatory requirement to indicate changes of status on PAS. A printout from PAS should then be regularly reviewed and reconciled to Change of Status forms received.
Management Action	ACCEPTED The Trust have now set up two codes PHS & PTN, 1 for Inpatients and 1 for Outpatients. A report has been set up in Business Objects and shared with the Private Patient Officer to cross check. All secretaries have reminded of codes and when to use them.
Responsible Manager	Assistant Director Systems Assurance, Assistant Director Functional Support Services
Implementation Date	February 2022

Recommendation 1.8	The Trust should increase controls over prescription pads held in consulting rooms. These should be maintained as controlled stationery.
Management Action	ACCEPTED
Responsible Manager	Assistant Director ATICS
Implementation Date	February 2022

2 REVIEW OF MR A's COMPLIANCE WITH RELEVANT PRIVATE PRACTICE GUIDANCE/AUTHORITIES – CHANGE OF STATUS PATIENTS

2.1 Change of Status Activity During the Period January 2019 to June 2020

The "Management of Private Practice in Health Service Hospitals in Northern Ireland: A Handbook – November 2007" requires that patients changing status from Private to NHS must have a Change of Status form completed by the consultant. The form must also detail the clinical priority for treatment as a health service patient. The Trust should be able to clearly identify these patients for monitoring purposes. It is important that the process of changing patient status is effectively controlled and documented as an assurance that the delivery of service is equitable.

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

Internal Audit requested all of Mr A's patient Change of Status forms for the period January 2019 to June 2020, from the cash office at Daisy Hill Hospital. Internal Audit were provided with the database which recorded 21 Change of Status Patients.

Internal Audit requested and reviewed the 21 Change of Status forms completed by Mr A from January 2019 to June 2020 and noted the following issues:

- 16 Change of Status forms had the Medical Director stamp on them as evidence of approval but it is not possible to establish who applied this stamp or the date it was applied.
- 4 Change of Status forms were still with the Medical Director at the 7 December 2020 awaiting approval. The dates that these patients transferred to NHS as per the change of status forms ranged from 2 - 14 months earlier than December 2020. Internal Audit were unable to establish when the forms were received in the Medical Directors Office.
- 1 Change of status form had been physically signed by the Medical Director, approximately 10 weeks after the effective Change of Status date.

2.2 Management of Patients Transferring from Private to NHS, Joining the HSC waiting list

Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007) states:

"A change of status from private to Health Service must be accompanied by an assessment, by the appropriate consultant, of the patient's clinical priority for treatment as a Health Service patient. It is important that any private patient who wishes to become a Health Service patient should gain no advantage over other Health Service patients by so doing."

"No patient should proceed –except in emergencies – to an investigation or treatment in a Health Service hospital until some mechanism has been applied which makes their status clear. Whichever system is introduced it must be capable of identifying the patient's status at every stage."

Internal Audit reviewed PAS data (provided by the Trust) for the 21 patients who changed status from private practice to NHS during the audit period January 2019 to June 2020. 13 of the 21 Change of Status forms related to day case or inpatient referrals and the remaining 8 forms were for outpatient appointments.

A range of issues were found in respect of Mr A's practice and administration of these 21 Change of Status cases (as outline below). However the issues also demonstrate the inadequacies in Trust monitoring processes around Change of Status patients and the limited control in the current process. The following issues were identified on review of the Change of Status forms:

Approved Effective Change of Status Date

The date the patient is added to PAS as an NHS patient is the effective date as per the Change of Status form, not the date the Change of Status form was approved by Medical Director. *This is contrary to Trust's procedures and Change of Status form which state "It is important to note that until the change of status form has been approved by the Medical Director, the patient's status will remain private and they may well be liable for charges."*

On all 21 Change of Status forms, the effective date of transfer to NHS was the same as the date the patient was last seen privately.

Change of Status Patients who had Diagnostic (Radiology) Tests

In 10 of the 21 change of status cases, the patient had been referred for a diagnostic test (radiology) in the period 1 January 2019 to 30 June 2020:

- In 3 of the 10 cases, the diagnostic work was performed prior to the date of change of status. This diagnostic work was performed at a time when there was no referral on PAS for the patient ie whilst they were still a private patient.
 - One patient had a change of status date of 31/08/2019 – this patient had 2 imaging tests requested and performed in June 2019 whilst still private.
 - One patient had a Change of Status date of 09/11/2019 - this patient had 3 imaging tests requested and performed in June 2019 whilst still private.
 - One patient had a change of status date 09/11/2019 and had 1 imaging test requested in June 2019 with the test performed in July 2019 whilst still private.
- 5 of the 10 diagnostic tests were requested on the same date as the effective change of status date and the same date the patient was last seen privately (according to the Change of Status Form). Given that these Change of Status forms are unlikely to have been submitted and approved by the Medical Director on the same day as the patients' private appointments, these patients should potentially have been treated by the Trust as private patients.
- 2 of the 10 Change of Status patients had an exam/diagnostic test requested after the effective date on the Change of Status form (1 was 3 weeks, 1 was 4 months). However given the weaknesses in the Change of Status process, it is unclear if this NHS test was performed after the change of status was approved.

3 (including 1 of the 3 patients found to be private) out of the 10 patients were seen sooner than the Trust waiting time for the diagnostic/imaging test:-

- 1 of the 3 patients identified as private (above) was seen within 6 weeks against a waiting list of 21-32 weeks (at least 15 weeks earlier than Trust waiting time). This patient was seen in South Tyrone Hospital.
- For 1 patient the Trust waiting time for the imaging was 16-20 weeks and the patient had their imaging test within 5 weeks of request (at least 11 weeks earlier than Trust waiting time).
- For 1 patient the Trust waiting time was 5-10 weeks and the patient had their imaging test within 3 weeks of request (at least 2 weeks earlier than Trust waiting time).

Patients who changed Status and had Inpatient/Daycase Procedure

Out of the 13 Change of Status cases transferred into the NHS for an inpatient/day procedure, 5 had subsequently had their procedure. The other 8 patients, whilst added to waiting list, had not had their procedure as at June 2020.

Internal Audit in conjunction with Senior Trust staff reviewed the patient journeys of the 5 cases who have had their inpatient/daycase procedures. All 5 cases were classed as URGENT on PAS per the report received by Internal Audit.

As part of this audit review, a Trust Urology Consultant considered the waiting times for treatment in the context of the clinical priority and Trust standard waiting times. The Consultant advised that:

- 3 cases were in line with Patient Target List (PTL) waiting times/ for the procedure for the relevant clinical priority.
- 2 of the 5 patients were not seen in line with the Trust waiting list time. The Trust Consultant Urologist assisting Internal Audit in this review considered that these cases were not Urgent/red flag procedures and were seen significantly sooner than other patients on the waiting lists:
 - Patient 1 - the time between being added to waiting list and the procedure taking place was 23 days (approx. 3 weeks). The PTL waiting times for the same procedure for Mr A patients at this time were between 15 weeks and 217 weeks so we can conclude this Change of Status patient was seen much quicker than other patients waiting on the same procedure.
 - Patient 2 - the time between being added to the waiting list and the procedure taking place was 12 days. The Consultant Urologist advised that given the symptoms, this patient was seen much quicker than other patients requiring the same procedure at that time.

Retrospective Entry to PAS

Through review of change of status patients on PAS, it was noted that two change of status forms had been added retrospectively to PAS:

- One patient was added to the waiting list from 09/09/2018 but this was not actually added to PAS until 12/05/2020. At December 2020 this Change of Status had not been approved by Medical Director.
- One patient had a Change of Status on 11/10/2019 however the patient was not added to PAS by the consultant secretary until 01/02/2020, 4 months after the Change of Status.

See section 6 for related registration issue.

2.3 Protected Reviews

Internal Audit understand from the Trust that most Consultants retain a number of protected review appointments at each of their outpatient clinics. These slots should be for patients that the Consultant needs to see urgently (for example cancer patients) however there is no documented Trust procedure around the use of protected review clinic slots. The Trust does not monitor the use of protected review appointments and there is a risk that private patients or Change of Status patients could potentially be seen quicker in a protected review appointment slot.

Internal Audit were advised that the central booking team at the Trust are responsible for booking new and review outpatient appointments. However Mr A's secretary was responsible for booking Mr A's Protected Review appointments.

Internal Audit have not specifically tested Protected Review bookings however we identified 1 case where a routine outpatient was seen in a protected review slot, 15 days after being added to the waiting list. Internal Audit queried this case with the Trust and the Consultant Urologist agreed that the protected review appointment had not been used for the correct purpose and therefore the patient would have been seen ahead of NHS patients with the same clinical priority.

2.4 Capturing and Invoicing of Private work Conducted on HSC Premises

In line with the "Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007)" Consultants have a contractual obligation to cooperate in recording all private outpatient and day patient attendances, treatments and procedures. The patient's records and referral forms etc should always be suitably marked. Records kept in departments away from the main outpatient area (e.g. x-ray, pathology and physiotherapy) should identify private patients.

As per Trust procedures no private activity was declared to the Cash Office in Daisy Hill Hospital during the audit period by Mr A and no invoices have been raised for private treatment – both indicating that Mr A did not perform private work on HSC premises.

However, as outlined above, upon review of the 21 Change of Status Forms, Internal Audit noted cases whereby Mr A's Private Patients had received treatment in the NHS while still being a private patient.

Furthermore as described below, there are examples of patients seemingly switching several times between private and NHS and potentially receiving private treatment on the NHS, without declaration or charging. As per the *NHS A Code of Conduct for Private practice* and The Trust Change of Status Form – “Consultants are reminded that in good practice a patient who changes from private to NHS status should receive all subsequent treatment during that episode of care under the NHS as outlined in *A Code of Conduct for Private practice*”

In 5 of the 21 cases where a change of status form had been completed, the patient moved between NHS to Private to NHS for the same referral.

- In one case the patient had been under the care of another urology consultant within the Trust around the time of seeing Mr A privately.
- In one case from the review of PAS it was determined that the patient has seen a number of urology consultants and had been NHS and moved to Private and then subsequently transferred back to NHS.
- One patient had been seeing another Urology Consultant in 2018 and was called for a follow up outpatient appointment in July 2018 but didn't attend. It would appear that this patient then attended Mr A privately who completed a Change of Status form with an effective date of 17/08/2019.
- One patient had been under the care of the Trust at 31/01/2019 and was due for review at the end of 2019. This appointment was delayed and it would appear that this patient then attended Mr A privately who completed a Change of Status form with an effective date of 15/02/2020 and added the patient to the waiting list.
- One patient who had been added to the Elective waiting list for a procedure on 09/11/2019 (effective date of Change of Status) but had a consultation with Mr A in early March 2020 which is not on PAS. This patient would have had a procedure done in late March 2020 except for COVID-19 resulting in all elective procedures being cancelled from approximately w/c 16 March 2020.

Recommendations Specific to Review of Mr A's Practice:

Recommendation 2.1	The Trust should consider charging for the identified private activity. Internal Audit appreciate that this needs to be considered, and may not be feasible, in the wider context of a patient recall.
Management Action	ACCEPTED This has been considered by the Trust and it was felt it would not be appropriate to charge these patients.
Responsible Manager	Medical Director
Implementation Date	July 2021

General Recommendations Regarding Trust Process:

Recommendation 2.2	The Trust should develop a written procedure around the use of protected review clinic appointments. The Trust should also introduce monitoring of compliance with the procedure.
Management Action	ACCEPTED
Responsible Manager	Assistant Director Functional Support Services and Operational ADs
Implementation Date	February 2022

Recommendation 2.3	Trust Guidance and Management of Private Practice in Health Service Hospitals In Northern Ireland: A Handbook (November 2007) should be re-issued and sign-off by doctors engaging in private practice. Where concerns are raised about a consultants' compliance, the Department of Health's framework <i>Maintaining High Professional Standards in the Modern HPSS</i> should be followed.
Management Action	ACCEPTED
Responsible Manager	Assistant Director Systems Assurance
Implementation Date	February 2022

Also see recommendations in section 1

3 REVIEW OF MR A's COMPLIANCE WITH RELEVANT PRIVATE PRACTICE GUIDANCE/AUTHORITIES – DATA ANALYSIS

Internal Audit completed data analysis using information provided by the Trusts Acute Informatics department. Internal Audit were provided with the following reports from PAS, TMS, Pre Operative Assessment Unit:

- Patient Level List of Elective Inpatient Admissions, Daycases and Regular Attenders for Mr A Date of Admission only between 01/01/2019 and 30/06/2020 from PAS
- Patient Level List of Outpatient Attendances (Including Outpatient Urodynamic Attendances) for Mr A Appointment Date only between 01/01/2017 and 30/06/2020 from PAS
- Patient Level List of Outpatient Urodynamic Attendances for Mr A Appointment Date Only between 01/01/2019 and 30/06/2020 from PAS
- Patient Level List of Imaging Exams Performed which were Requested by Referring Clinician Mr A Exams Performed between 01/01/2019 and 30/06/2020 from NIPACS
- Patient Level Report of Theatre Cases Carried out by Mr A – By hospital, theatre and operation date based on operation date between 01/01/2019 and 30/06/2020 from TMS.
- Pre-operative Assessment Database for Urology with the Trust Identifying Mr A's patient's for pre-op assessments performed between 01/01/2019 and 30/06/2020

3.1 Pre-Operative Assessments

All elective patients who require a General Anaesthetic whilst undergoing a procedure are required to have a Pre-Operative Assessment (POAs) to assess their fitness for surgery. The Trust deem the optimum time to complete a patients' POAs is between 13 weeks and approximately 3 weeks ahead of planned admission date for surgery. Consequently to ensure this happens in a timely manner and no patients scheduled for theatre are overlooked, it is essential that all elective theatre lists are prepared and notified to the POA team 6 weeks in advance of the theatre date.

Theatre rotas are compiled by the Head of Service for Theatres, detailing which surgeons have access to the theatres at each session. When Consultants become aware of the theatre rota they then select the patients for each list, any who require pre op should be sent to the pre op assessment unit. Mr A selected his own patients and arranged his own theatre lists. It is understood that Mr A would have provided his secretary with a list of patients to be booked into his theatre lists and she would have completed an "Arrange Admission List".

Completion of POA

According to Trust PAS report provided, during the period January 2019 to June 2020, there were a total of 1,096 elective procedures performed on 576 of Mr A's patients. In consultation with the Head of Urology and Pre-operative Assessment Manager, Internal Audit analysed a PAS report of all elective procedures performed on Mr A's patients during January 2019 to June 2020. With the Trust's expert input, we were able to eliminate procedures where a pre op assessment was not required from our analysis. These cases related to procedures done under a local anaesthetic; or where the patient had previous surgery and the previous POA was still valid.

For 351 of the 1,096 procedures performed by Mr A, a POA was required. In 86 (25%) of these 351 cases, a POA was not completed. Internal Audit reviewed these 86 cases with the Pre-Operative Assessment Manager and found:

- In 24 procedures, the patient was assessed upon admission rather than having a scheduled POA ahead of time. An appropriate POA in line with Trust requirements was not therefore conducted.
- 62 procedures required a POA for the procedure but this was not completed. In 2 of these procedures, the patient did not attend/complete their POA but a POA had been requested in both cases. Both patients underwent surgery nonetheless.

Lack of POA as Potential Indicator that Patient was Seen Privately and then Treated in NHS

Internal Audit reviewed these 86 cases further from information on PAS and NIECR to establish if there was any information that pointed to these 86 cases being private patients. This work identified:

- In 49 procedures, the patient had an appropriate footprint on PAS.
- For the remaining 37 procedures, the patient had either no outpatient appointment (according to the PAS data provided by the Trust) or there was a short timeframe between being seen at an outpatient appointment and the date of surgery. Internal Audit selected a sample of 23 of these procedures for further analysis on PAS and NIECR in conjunction with the Head of Urology. In 22 of the 23 procedures whilst a pre-op assessment was required, the patient was not deemed to be private as they had come in initially through ED and been given date for surgery on discharge, another Speciality or another Consultant was involved in their care. 1 of the 23 procedures related to a private patient who was subsequently treated in the NHS. No Change of Status form had been completed.

Timeliness of POA

As outlined above, the optimum time for a patients' POAs to take place is between 13 weeks and approximately 3 weeks ahead of planned admission date for surgery. In effect, PoAs are valid for a period of 13 weeks pre-admission for surgery.

On review of 265 procedures where a POA was undertaken for Mr A's patients, Internal Audit noted:-

- There were only 8 procedures (3%) where the POA was conducted within the timescale required by the Trust, in advance of surgery.
- 252 procedures (95%) were added to the POA list less than 21 days before their admission:
 - 105 procedures (40%) were added to POA list 5 days or less before admission
 - 131 procedures (49%) were added to POA list 10 days before admission
 - 16 procedures (6%) were added to POA list between 11 and 20 days before admission
- In 5 (2%) cases, there was insufficient information to confirm the timeliness of the POA.

3.2 Elective Surgery With No Outpatient Appointment

From the PAS data received from the Trust Acute Information Department, Internal Audit joined elective surgery data in the period 01/01/2019 to 30/06/2020 to outpatient appointments in the period 01/01/2017 to 30/06/2020. The purpose of this analysis was to establish patients who had surgery but did not have an outpatient appointment potentially indicating that they may have been seen privately for an outpatient appointment by Mr A prior to surgery.

Note: We considered outpatient information for a longer period than the audit period to factor in the waiting list times.

We found that there is no record of a Trust outpatient appointment (either pre or post surgery) for 220 patients who had at least one elective procedure (total 284 procedures) between 1 January 2019 and 30 June 2020.

Where a patient had surgery and no outpatient appointment, the patient could potentially have been a private patient as the normal patient route for elective surgery is to be seen at an outpatient appointment and then if required, listed for elective surgery.

Internal Audit reviewed the 284 procedures where there was no recorded Trust outpatient appointment on PAS. With the expert input of Head of Service for Urology, 138 records were excluded from further analysis because the nature of the procedure did not involve the need for an outpatient appointment (for example stent replacement/removal); or the waiting time for the procedure appeared in line with Trust waiting list; or the patient (5 cases) was declared as a Change of Status patient.

Out of the remaining 146 records, Internal Audit selected a sample of 54 records (relating to 50 patients) which the Head of Service for Urology then reviewed on PAS and NIECR, particularly considering whether referrals had been received for these cases and where patients had been seen in relatively short-timeframe that there were valid clinical reasons for this. Internal Audit then walked through 21 of these 50 patients with the Head of Urology to validate the data. This work identified:

- 1 patient who was initially referred by a GP in January 2018 but was then discharged from this referral on PAS in July 2019 to attend Mr A privately. This patient was added to Mr A's Day Surgery waiting list from the same date in July 2019 as an Urgent case. This was done retrospectively on PAS on 20 August 2019, approximately a week before the patient had their Pre-Op Assessment in late August 2019. The patient had their procedure in early September at CAH Day Surgery Unit, 2 weeks after being entered onto the waiting list on PAS (albeit the entry was made retrospectively to an earlier time in July). The Trust has advised that the normal waiting time for this procedure is 91 weeks.
In effect, this patient changed from NHS to private and back to NHS in one day, with no Change of Status forms. This is a blatant breach of proper process and is an example whereby a significant advantage has been gained in terms of speed of treatment, by paying privately for an outpatient appointment.
In the absence of an approved Change of Status form, this is arguably a private patient having a procedure using trust facilities and staffing.
- In 2 cases, there was no outcome letter completed for the procedure potentially indicating that the patient may have transferred back to the private sector for review. It should be noted that the Trust believe that these are poor administration issues rather than private patients.

3.3 Elective Surgery with an Outpatient Appointment

There were 812 records (356 patients) out of the 1,096 (576 patients) that had elective procedures who also had an outpatient appointment in the period under review.

From review of a sample of 29 of these patients, Internal Audit noted 4 occasions where the patient may have potentially been a private patient:

- 1 patient (Personal Information redacted by the USI) who had been seen privately by Mr A in 2017 was then seen in 2020 in the Trust as an NHS patient. A change of status form had not been completed.
- 1 patient was under the care of another urology consultant on PAS but the patient was seen by Mr A. There was no rationale as to why Mr A became involved in the patient's care.
- 1 patient was seen within 2 days of a red flag referral. Internal Audit observed that as per a letter on NIECR, this patient was a (Personal Information redacted by the USI).
- In 1 case, there was no outcome letter completed following the procedure, which potentially could be an indicator that the patient may have been reviewed privately following the procedure. It should be noted that the Trust believe that these are poor administration issues rather than private patients.

3.4 Other Observations

During the course of the audit, Internal Audit identified a number of other issues:

- There were 371 radiology diagnostic tests requested by Mr A from Urology Outpatients in the period 1 January 2019 to 30 June 2020 where the patient had no outpatient/surgical procedure, as per the PAS reports provided by the Trust. Upon further investigation and sample checking by Internal Audit in conjunction with the Head of Service for Urology, Head of Diagnostics and a Urology Consultant, it was identified that these cases were not all Mr A patients. When a junior doctors signs in with their own log-in into NIPACS (Sectra), their request will default to the last Consultant they ordered a scan on behalf of. The junior doctor should amend this to the name of the consultant they are actually making the request on behalf of, however Internal Audit was advised that this is not routine practice. Therefore scan requests are being attributed to

consultants when the patient wasn't actually under their care. If a consultant makes the request themselves, this is not an issue as system maps directly to them it doesn't default to the last user. This means the audit trail on the system in terms of the requesting Consultant is incorrect in some cases and could mean that the test results go to the wrong Consultant, potentially creating a patient safety issue.

- The referral date on PAS, which is the date the referral of the patient is received by the hospital and will be the date the patient enters any relevant waiting lists, should not be changed however the date can be changed on the system. Internal Audit noted instances where the date had been changed, affecting the patient's position on the waiting lists. In the context of this audit, Internal Audit observed referral dates being changed to later dates rather than earlier dates.
- When a patient is entered onto PAS, a registration will be opened for the episode of care, this registration should be closed when a patient is discharged with their treatment complete. Open registrations on PAS should be reviewed on an ongoing basis. Instances were observed where the patient had been discharged but the registration had not been closed.
- Up to 2020 there was no mechanism for electronic signoff on NIECR. From 2020 this became available and is reportedly monitored however it is not routinely used across the Trust. Internal Audit queried how the Trust ensures that consultants are getting their own patient results – and where advised that there is a monthly check completed of all patients who are recorded as "DISCHARGE AWAITING RESULT" by Consultant secretaries. Internal Audit were advised that this is not conducted routinely. Internal Audit were advised that there 1,000 records on NIECR not signed off by Mr A.

General Recommendations Regarding Trust Process:

Recommendation 3.1	As previously recommended in the 2019/20 Management of Pre-Op Assessments audit report, Management should ensure all patients due for elective surgery have an up to date pre-operative assessment completed no more than 13 weeks ahead of planned admission date for surgery. Management should focus on improving processes in those specialties with higher volumes of exceptions including Urology.
Management Action	ACCEPTED
Responsible Manager	Assistant Director of ATICS
Implementation Date	September 2021

Recommendation 3.2	As previously recommended in the 2019/20 Management of Pre-Op Assessments audit report, Management should review processes to ensure all private outpatients transferring to NHS inpatient waiting lists are promptly notified to the Pre-operative Assessment team.
Management Action	ACCEPTED
Responsible Manager	Assistant Director of ATICS
Implementation Date	September 2021

Recommendation 3.3	The Trust should liaise with BSO in order to resolve this referring Consultant recording error in the NIPACS system.
Management Action	ACCEPTED

Responsible Manager	Director Performance & Reform
Implementation Date	February 2022
Recommendation 3.4	The processes for registration should be reviewed and training given to all appropriate staff on the correct use of PAS, including consultant secretaries.
Management Action	ACCEPTED
Responsible Manager	Assistant Director Systems Assurance
Implementation Date	February 2022
Recommendation 3.5	The processes surrounding electronic and manual sign off and review of the "DISCHARGE AWAITING RESULT" should be strengthened and monitored.
Management Action	ACCEPTED
Responsible Manager	Assistant Medical Director Clinical Directors and Assistant Operational Directors
Implementation Date	February 2022

See also recommendation 1.4

4 INTERACTION OF MR A's PRIVATE WORK WITH HSC SERVICES AND FACILITIES

A Code Of Conduct For Private Practice - Recommended Standards Of Practice For HPSS Consultants (November 2003) states that HSC facilities, staff and services may only be used for private practice with the prior agreement of the HSC employer.

Internal Audit were advised by the Trust that Mr A's private practice did not interact with HSC services and facilities. However as per the findings in this report, there are a number of issues and exceptions that would indicate a degree of interaction – particularly for services that could not be performed or delivered from Mr A's home practice.

The queries around the timing of changes of status outlined in this report, mean there is a risk that Trust staff have been involved in the administration or treatment of patients that should have been categorised as private.

General Recommendations Regarding Trust Process:

See recommendations in section 1-3

5 CRAIGAVON UROLOGICAL RESEARCH EDUCATION (CURE)

In line with the Terms of reference of this review, Internal Audit also considered whether the Trust has any involvement with CURE - Craigavon Urological Research & Education, to understand if there was a flow of money into the Trust and to check, as much as is possible from review of Trust records and engagement with Trust staff, whether any Directors/staff benefited from the operation of the company.

According to the Companies House website/Articles of Association, a previous Trust Chairperson and Mr A set up CURE in 1996 as a 'Charitable Company Limited by Guarantee and not having Share Capital'.

The objectives of CURE are:

- To advance education for the public benefit in Urological disorders.
- Conducting and commissioning research into Urological disorders and the effective treatment of persons suffering from Urological disorders and to disseminate the useful results of such research.
- Raising public awareness and understanding of Urological disorders and their treatment and promoting training in the treatment of Urological disorders.

The CURE committee is currently made up of Mr A and three other people - 2 of whom are current Trust employees (1 Consultant Urologist and 1 Specialist Nurse in Health Promotion). The CURE committee secretary is a previous Trust employee.

Whilst these Trust staff are members of the CURE Committee, Internal Audit were advised by Senior Trust staff that their role should be separate and independent from their roles in the Trust. Internal Audit met with the two Trust staff who are currently on the Committee of CURE who both confirmed that their role within CURE is entirely independent of their job with the Trust. The Trust advised of some historical Trust involvement with CURE (pre-creation of SHSCT) including preparation of CURE accounts. Internal Audit also note that the registered office of CURE (until July 2012) was on the Craigavon Area Hospital site.

From discussion with Trust Management and Trust staff involved with CURE, there is no indication of any flow of money into the Trust or Trust involvement in fund raising in recent years.

Internal Audit understands from the Committee members that Trust staff may apply to CURE for funding. A written request is completed and will be reviewed/approved by the CURE committee. If approval is granted by the Committee, the staff member will pay for the course and on submission of relevant paperwork invoices, a cheque from the CURE bank account is made payable to the applicant.

It should be noted that Internal Audit did not have access to CURE financial records as part of this review and therefore do not have visibility over payments made by CURE to Trust staff.

Trust procedures do not provide guidance in respect of staff involvement in independent organisations with a potentially perceived affiliation to the Trust by their nature.

General Recommendations Regarding Trust Process:

Recommendation 5.1	The Trust should remind staff that all donations received from the public in respect of their care should be lodged to the Trust's Charitable Trust Funds only and that staff are not permitted to use their position of employment within the Trust to advance personal interests, causes or charities as it could give rise to
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	reputational damage to the Trust.
Management Action	ACCEPTED
Responsible Manager	Director of Finance
Implementation Date	December 2021

Note to Report

This audit report should not be regarded as a comprehensive statement of all weaknesses that exist. The weaknesses and findings set out are only those which came to the attention of Internal Audit staff during the normal course of their work. The identification of these weaknesses and findings by Internal Audit does not absolve Management from its responsibility for the maintenance of adequate systems and related controls. It is hoped that the audit findings and recommendations set out in the report will provide Management with the necessary information to assist them in fulfilling their responsibilities.

Internal Audit Service – Ballymena Office
Greenmount House
Woodside Road Industrial Estate
BALLYMENA
BT42 4TP
TEL Irrelevant information
redacted by the USI

Internal Audit Service – Londonderry Office
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Gransha Park
Clooney Road
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BT47 6WJ
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Internal Audit Service – Belfast Office
2 Franklin Street
BELFAST
BT2 8DQ
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Internal Audit Service – Armagh Office
Pinewood Villa
73 Loughgall Road
ARMAGH
BT61 7PR
TEL Irrelevant information
redacted by the USI

Private Practice / Medico-Legal Declaration

TO BE COMPLETED ANNUALLY

Any professional service that a doctor carries out for a third party and which are not part of their contractual services must be declared to the Trust. Therefore, in order to comply with financial governance controls, all doctors as part of their contractual obligations must inform the Trust of any paying / private patient work they are undertaking.

PLEASE RESPOND TO ALL THAT APPLY

Name of doctor:	GMC No:
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Question	Question	Yes	No
1.	Do you treat /intend to treat private outpatients/ medico-legal patients (inpatient/ day patient/ outpatients) in addition to your contracted work within the Trust?		
2.	Please confirm you have appropriate medical protection / indemnity arrangements in place to conduct your private practice <i>(GMC requires private practitioners to arrange adequate and appropriate insurance or indemnity - even if this work takes place on NHS or HSC body premises. This applies even if the work is in addition to work you do for an NHS or HSC body)</i>		
3.	Where do you undertake your private practice (Tick all that apply)		
	NHS Hospitals <input type="checkbox"/> Outpatients <input type="checkbox"/> Inpatients <input type="checkbox"/> Daycases <input type="checkbox"/>		
	Independent Clinics <input type="checkbox"/> Outpatients <input type="checkbox"/> Inpatients <input type="checkbox"/> Daycases <input type="checkbox"/>		
	Home / Domestic Premises <input type="checkbox"/>		
	Virtual Clinics <input type="checkbox"/>		
	Medico-Legal Work <input type="checkbox"/>		
	Event Support (Sporting etc) <input type="checkbox"/>		

Question	Question	Yes	No
4.	Do you treat/intend to treat private outpatients/ medico-legal patients <u>inside</u> the Trust (i.e. on Trust premises)?		



5.	<p>If you treat / are intending to treat private outpatients / medico-legal patients inside the Trust, you agree to submit a quarterly return to the Paying Patients Team for the use of Trust facilities.</p> <p><i>This return must include the names of the patients seen together with details of any treatment or tests undertaken relating to outpatient / medico-legal work – click here for forms.</i></p> <p>By ticking this box I confirm I will comply with the requirements set out above</p>	<input type="checkbox"/>
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Confirmation of Requirements for Medical Staff Undertaking Private Practice in Any Setting

	Question	Tick to Confirm
6.	I understand that any laboratory tests taken either on or off Trust premises <u>must not</u> be forwarded to the Southern H&SC Trust Laboratory for reporting and I have made alternative arrangements for these to be reported on via another private facility.	
7.	I confirm that I have read and understood the Trust's Guidance on Paying / Private Patients and accept the responsibilities outlined therein – click here	
8.	I confirm that I have read and understood the Trust's Code of Conduct relating to on Paying / Private Patients and accept the responsibilities outlined therein – click here	
9.	I confirm that I have read and understood the regional guidance titled Management of Private Practice in the Health Service – November 2007 and accept the responsibilities outlined therein Click here	
10.	I understand that any work carried out by medical secretaries to assist my paying / private patient work must be completed <u>outside</u> NHS working time and prior approval to retain the services of any member of staff should be agreed in advance with the Trust.	
11.	I understand that any private patient work whether undertaken inside or outside the Trust must be included in my job plan and declared as soon as possible.	

Signed:	
Date:	

If undertaking Private Practice in any form as defined above Clinical Director awareness is required

Clinical Director Name	
Clinical Director Signature	
Date:	

Please return this declaration via email to [Redacted] or via internal mail to the Revalidation Team, Beechfield House, Craigavon Area Hospital.

Version 1 29th October 2021



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Private Practice / Medico-Legal Structured Reflective Template

Principles agreed by the Academy of Medical Royal Colleges April 2020

Name of doctor:		GMC No:
Date reflective template completed:		Appraisal Year:
Where have you undertaken your private practice / medico-legal over the last twelve months? (Tick all that are appropriate)		
	Y/N	Estimated % of Private Practice
NHS Hospitals	<input type="checkbox"/>	<input type="text"/>
Independent Clinics	<input type="checkbox"/>	<input type="text"/>
Home / Domestic Premises	<input type="checkbox"/>	<input type="text"/>
Virtual Clinics	<input type="checkbox"/>	<input type="text"/>
Medico-Legal Work	<input type="checkbox"/>	<input type="text"/>
Event Support (Sporting etc)	<input type="checkbox"/>	<input type="text"/>
Job Planning – Is your private practice / medico-legal activity fully declared in your Trust job plan?		
Medical Protection / Indemnity Arrangements Describe your arrangements for medical protection / indemnity regarding your medico-legal / private or independent practice? GMC requires private practitioners to arrange adequate and appropriate insurance or indemnity (even if this work takes place on NHS or HSC body premises). This applies even if the work is in addition to work you do for an NHS or HSC body.		
Scope of Practice – Describe the nature of your private practice / medico-legal work (Consider factors including; are you doing a low volume of work of this type? Are you deliberately limiting your scope of practice? Are you returning to this type of work after a prolonged break for some reason?):		
Volume worked in the last twelve months – How much private practice / medico-legal work have you undertaken over the last twelve months of practice? (Is your work evenly spread throughout the year or do you regularly have significant breaks e.g. > 6 weeks? Please describe your annual arrangements. When was the last time you did any work of this type?):		



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Experience

What prior experience do you bring to this role? How long have you worked as a qualified doctor in this type of work?

And/or If appropriate, explain how many skills based clinical procedures of this type you have done in the past and how you have kept your skills up to date.

Duration of working in this way and future plans

How long have you been working in your current way, and what are your plans?

- If you do a low volume of work in this role, will you increase, maintain or decrease the volume of your work over the coming year?

And/or

- If you have a limited scope of practice, will you be changing this over the coming year?

And/or

- If you are coming back to work after a prolonged absence, what induction and support will you have / have you already had?

Record Keeping

Please describe how you manage and process private practice / medico-legal records

- As a private practitioner who collects and holds information about patients have you registered as a data controller with the Information Commissioner's Office?

- What processes do you have for responding to a Subject Access Requests? - that is, a request for access to the notes you hold about a patient. The request could be made for a number of different reasons, including clinical negligence claims.

- What processes do you have to meet requirements of General Data Protection Regulation 2018 (GDPR) and Department of Health Code of Practice for Records Management. Although, as a private practitioner, you are working outside the HSC / NHS, and are therefore technically exempt from the Public Records Acts, the GMC guidance in 'Confidentiality' (2009) makes clear that everyone should use the retention schedule and does not distinguish between private and HSC / NHS records.

- If you are planning to end your private practice, as long as you hold information, you will need to be able to fulfil your duties as a data controller under GDPR. Please give details of your arrangements to meet this requirement



Overlap with other roles

Please describe the overlap between this part of your scope of practice and other roles you may currently have / have recently had. How well does the experience from your other roles help you to maintain your knowledge and skills for this one?

Benchmarking, integration and support

Are you able to compare your scope of practice in this role with that of your peers? For example:

Do you receive organisationally generated data on your activity which compares you to your peers? Do you meet regularly with your peers to discuss your work, e.g. multidisciplinary team meetings? Do you have easy access to support and advice from your peers (either through work or externally)?

Personal approach to risk and governance around your private practice

How do you limit the impact of your private practice / medico-legal on any risk to your patients (e.g. How do ensure that continuity of care is provided if you have an unforeseen absence?, how you access diagnostic testing?)

Do you regularly ask for patient feedback that is undertaken by an independent body and can you provide examples/statistics?

What arrangements do you have in place to stay within the boundaries of your competence? (e.g. when a patient presents with a condition that is beyond the scope of your private practice services what processes do you follow, onward referrals etc?)

If you move around, what actions do you take to ensure you have access to adequate induction and systems information?

How do you ensure you are informed promptly of complaints and any other patient safety incidents? And, how do you report these to the organisations you work in?

Continuous Professional Development (CPD)

Please describe how your approach to CPD helps to ensure you are up to date for your scope of practice.

Does your CPD give you an ongoing exposure to the breadth of your potential workload such as to mitigate any reduction in experience?



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Do you access any other learning through groups or social media discussion forums?
Do you rely predominantly on advice from peers on site?

Are you able to confidently access up to date, authoritative factual information about issues relevant to your scope of practice?

Actions

Going forward are there any further actions you feel may be necessary to ensure you retain your competencies across your scope of practice and support your development?

You may wish to formulate these as ideas for a Personal Development Plan or as actions to take forward with your employers in relation to the governance around your role

Feedback after discussion at appraisal:

(Complete at appraisal considering how your outcome will improve patient care)

Memorandum

To:	All Medical Staff
c.c.	Trust SMT; Medical Revalidation Team; Brigid Quinn, Paying Patients Officer; Anita Carroll, Assistant Director Support Services; Katherine Robinson, Booking Centre Manager; Simon Gibson, Assistant Director, Medical Directors Office
From:	Dr Maria O'Kane, Medical Director; Dr Damian Scullion, Deputy Medical Director Appraisal and Revalidation
Date:	12 th January 2022
Subject:	Medical Private Practice and Paying Patients

Dear Colleagues,

You will now have received a copy of the Trust *Declaration of Private Practice* which is to be completed by **all** substantively employed medical staff for return to the Medical Revalidation team stating if you undertake private practice in addition to your HSC employment.

In addition to this and in support of our work to strengthen governance arrangements around private practice, the Trust Appraisal round for 2021 incorporates a structured reflective template for those doctors who undertake private practice.

A pilot of a structured reflective template for this purpose is drawing to conclusion and a final version will be issued shortly.

In addition to these assurance arrangements and as part of the Trust's commitment to strengthen and improve professional governance processes, from 2022 onwards regular routine audits will be completed in relation to the following:

Audit Type	Purpose
Audit of Completion of Change of Status Forms for Patients who transfer from Private to HSC Care	To ensure that where patients have transferred from Private to HSC care an appropriate change of status form has been completed by

	the referring doctor
Audit of patient record documentation relating to referrals for transfer from Private to HSC care	To ensure that patients who are referred to join a HSC waiting list have an appropriate documented referral
Audit of private patient triage and prioritisation within the Trust	To ensure that private patients who are referred for and join an HSC waiting list are appropriately triaged and prioritised in the same fashion as HSC referrals.

Therefore in preparation for this I would like to remind you of the importance of the following:

1	Completion of an Annual Declaration on Private Practice (including those doctors who do not undertake private practice)
2	Ensure each private patient referred to an elective service has an appropriate formal referral letter submitted via the Trust Referral and Booking Centre using the same process as all NHS referrals. Each referral must be clearly marked 'PRIVATE TO NHS TRANSFER'. Private patients should not join a waiting list via any other entry point including being directly booked by secretarial staff.
3	Ensure change of status forms are completed for all relevant private patient transfers to NHS and returned to the Paying Patients Officer
4	<p>Clinician's undertaking private practice have read and are familiar with Regional Guidance, Trust Private Patient Guidance listed below as per private practice declaration requirements</p> <ul style="list-style-type: none"> - Management of private practice in health service hospitals in Northern Ireland Department of Health (health-ni.gov.uk) - A code of conduct for private practice - Recommended standards of practice for HPSS consultants Department of Health (health-ni.gov.uk) - Trust Guidance on Paying and Patients Private Patients (2018)

If you have any questions regarding this please do not hesitate to contact the Medical Revalidation team

Personal Information redacted by the USI

Yours sincerely

Personal Information redacted by the USI

**DR MARIA O'KANE
MEDICAL DIRECTOR**

Personal Information redacted by the USI

**DEPUTY MEDICAL DIRECTOR
APPRAISAL AND REVALIDATION**

Minutes
Patient Safety Meeting /Urology
Friday 18th February 2022 AM session

1. Welcome , attendance and apologies received by Chair:

Attendance:

John O'Donoghue, Michael Young, Matthew Tyson, Dolores Campbell, Leanne McCourt

Apologies:

Sabahat Hasnain, Mark Haynes, Jenny McMahon, Jason Young

2. Review of Previous Minutes / Verification of last meeting report

a. Matters Arising / outstanding issues

Personal Information redacted
by the USI

HCN

Personal Information redacted
by the USI

**Dr Yusuf will have the delay with regards to the CTkUB investigated by Radiology and Mr
Tyson will submit a DATIX**

3. Deaths within 30 days Discharge



**FOR INFORMATION
DEATHS OUTSIDE H**

4. Mortality Reporting

Personal Information redacted by the USI

HCN

Personal Information redacted by the USI

This patient was discussed and his death had been expected. The other patients will be discussed at the next PSM as the treating consultants could not attend.

5. Morbidity



Personal Information redacted by the USI

HCN

Personal Information redacted by the USI

This patient suffered urethral trauma during insertion of a urethral catheter in the Emergency Department. Mr Tyson will submit a DATIX.

6. Local incident themes : Ward / Unit issues

7. Pharmacy issues, incidents and medicine safety alerts

8. Shared learning from Complaints / SAI/ IR1 forms / Other meetings / Learning Letters

9. Shared learning from Litigation / Coroners cases / PM reports / Ombudsman

10. Safety alerts and Circulars (Safety Quality Reminder) sent to M&M chairs

- a. Safety and Quality Reminders
- b. E-Alerts
- c. PHA Letters

Issued Standards & Guidelines Circulars: for Dissemination, Review & Implementation

Title of Correspondence	Date of Issue from External Agency	Reference	Guidance Type	NICE Assurance 3 month	Full Implementation Date for S&G
PALIVIZUMAB RSV in At Risk Preterm Infants <i>Provision of Palivizumab passive immunisation to the existing and additional cohorts should be stopped at the end of January 2022. Updates and replaces letter issued on 16/07/2022</i>	28/01/2022	HSS MD 03 2022	CMO Correspondence	n/a	31/01/2022
Inducing Labour <i>Updates and replaces CG 70 that was previously issued on 01/07/2009</i>	27/01/2022	NG 207	NICE Clinical Guideline	27/04/2022	27/01/2023
Sodium Zirconium Cyclosilicate Hyperkalaemia	26/01/2022	TA 599	NICE Technology Appraisal Update	n/a	26/04/2022
Glaucoma Diagnosis and Management <i>Clinical Guideline was initially endorsed by DOH on 21/12/2017</i>	26/01/2022	NG 81	NICE Clinical Guideline Update	n/a	26/04/2022

Title of Correspondence	Date of Issue from External Agency	Reference	Guidance Type	Deadline Date for Implementation
Management HSC Staff Confirmed Cases COVID 19 <i>Previous version of this CMO letter was issued on 21/01/2022</i> The Trust's COVID19 Toolkit (Version 4) [click here] has been updated to reflected these recent changes from the Chief Medical Officer. It may now be possible to return to work after 5 days of isolation after testing positive for COVID 19 provided staff adhere to stringent lateral flow testing.	25/01/2022	HSS MD 02-2022 (revised)	CMO Correspondence	With Immediate Effect
Updated guidance Care Homes COVID 19	25/01/2022	n/a	PHA Correspondence	With Immediate Effect
PHA Letter - Testing for HCAI	24/01/2022	n/a	PHA Correspondence	With Immediate Effect

Title of Correspondence	Date of Issue from External Agency	Reference	Guidance Type	Deadline Date for Implementation
Managing COVID	27/01/2022	NG 191	NICE COVID-19 Rapid Guideline Update	n/a

Title of Correspondence	Date of Issue from External Agency	Reference	Guidance Type	NICE Assurance 3 month	Full Implementation Date for S&G
Antenatal care (updates and replaces CG62)	13/01/2022	NG 201	NICE Clinical Guideline	13/04/2022	13/01/2023
Foreign Body Aspiration During Intubation, Advanced Airway Management or Ventilation <i>Regional Circulation – Clear Your Clutter Poster</i>	12/01/2022	HSC (SQSD) 17/20	Patient Safety Alert	n/a	n/a

Title of Correspondence	Date of Issue from External Agency	Reference	Guidance Type	Deadline Date for Implementation
Visiting with Care – A Pathway	14/01/2022	n/a	CNO Correspondence	N/A

Title of Correspondence	Date of Issue from External Agency	Reference	Guidance Type	NICE Assurance 3 month	Full Implementation Date for S&G
Budesonide Eosinophilic Oesphagitis	11/02/2022	TA 708	NICE Technology Appraisal	11/05/2022	11/11/2022
Andexanet alfa Reversing anticoagulation Apixaban Rivaroxaban	11/02/2022	TA 697	NICE Technology Appraisal	11/05/2022	11/11/2022
Bempedoic Acid with Ezetimibe	11/02/2022	TA 694	NICE Technology Appraisal	11/05/2022	11/11/2022
Dapagliflozin Chronic Heart Failure	11/02/2022	TA 679	NICE Technology Appraisal	11/05/2022	11/11/2022
Mepolizumab Severe Eosinophilic Asthma	11/02/2022	TA 671	NICE Technology Appraisal	11/05/2022	11/11/2022
Naldemedine for treating opioid-induced constipation	11/02/2022	TA 651	NICE Technology Appraisal	11/05/2022	11/11/2022
NOT RECOMMENDED Fostamatinib Chronic Immune Thrombocytopenia	10/02/2022	TA 759	NICE Technology Appraisal	n/a	10/03/2022
Updated DoH Guidance Death Certification <u><i>Previous HSS MD 01/2019 has been superceded</i></u> <i>Recipients of this circular must ensure that all Medical Practitioners are informed of this updated guidance which can be found at 'Guidance surrounding Death' under the heading 'Death Certification and Completing a MCCD'. Refer to link below:</i>	09/02/2022	HSS MD 07/2022	CMO Correspondence	n/a	n/a

Guidance surrounding Death Department of Health (health-ni.gov.uk)					
TERMINATED - Pembrolizumab Metastatic Urothelial Cancer	01/02/2022 (SHSCT did not receive this notification hence delay in issue)	TA 674	NICE Technology Appraisal	Not Applicable to SHSCT	

Title of Correspondence	Date of Issue from External Agency	Reference	Guidance Type	Deadline Date for Implementation
<p>Updated HSS MD 06-2022 nMABs non hospitalised patients with COVID</p> <p><i>Please note the published Interim Clinical Commissioning Policy 'Antivirals or neutralising monoclonal antibodies (nMABs) for non-hospitalised patients with COVID-19' and associated clinical guide have been updated since the issue of the above letter on 1 February 2022.</i></p>	11/02/2022	HSS MD 06-2022	CMO Correspondence	n/a
<p>Updated HSS MD 04-2022 COVID 19 Alert antivirals nMABs treatment of COVID patients</p> <p><i>Please note the published Interim Clinical Commissioning Policy 'Antivirals or neutralising monoclonal antibodies (nMABs) in the treatment of COVID-19 in hospitalised patients' and associated clinical guide have been updated since the issue of the above letter on 31 January 2022.</i></p>	11/02/2022	HSS MD 04-2022	CMO Correspondence	n/a
<p>Updated PHA Guidance Testing to reduce HCAI</p> <p><i>Updates guidance issued on 24/01/2022 and 09/02/2022</i></p>	11/02/2022	n/a	PHA Correspondence	With Immediate Effect

Title of Correspondence	Date of Issue from External Agency	Reference	Guidance Type	NICE Assurance 3 month	Full Implementation Date for S&G
Revised HSCB Letter Nivolumab Ipilimumab Chemotherapy untreated metastatic non-small-cell lung cancer - NOT RECOMMENDED <i>There was an error in the previous HSCB letter dated 20/12/2021 (wrong cancer type stated). Assurance has been already provided that the Trust is compliant with the recommendation not to recommend this regime for the treatment of this condition</i>	21/01/2022	NICE TA 724	NICE Technology Appraisal	n/a	n/a
Pentosan Polysulfate Sodium Bladder Pain Syndrome	21/01/2022	NICE TA 610	NICE Technology Appraisal	21/04/2022	21/10/2022
Xeomin Treating chronic sialorrhoea	21/01/2022	NICE TA 605	NICE Technology Appraisal	21/04/2022	21/10/2022
Updated Never Events Guidance - Never Event Number 4	20/01/2022	HSC SQSD 04-22	CMO Correspondence	n/a	n/a
Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management	19/01/2022	NG 206	NICE Clinical Guideline	19/04/2022	19/01/2023

<i><u>(Updates and replaces NICE CG 53 previously endorsed on 31/08/2008)</u></i>					
<u>MBRRACE UP Perinatal Mortality Surveillance Report Jan to Dec 2019</u>	18/01/2022	n/a	MBRRACE	n/a	n/a
<u>MBRRACE UK Learning from Standardised Reviews when Babies Die</u>	18/01/2022	n/a	MBRRACE	n/a	n/a
<u>Rehabilitation after Traumatic Injury</u> Forms part of the regional Equality Screening consultation process (6 weeks)	18/01/2022	NG 211	NICE Equality Screening Questionnaire	n/a	28/02/2022
<u>Children Young Persons experience of Healthcare</u>	17/01/2022	NG 204	NICE Clinical Guideline	18/04/2022	18/01/2023

NICE Technology Appraisals Issued by the HSCB (29th January to 4 February 2022)

Title of Correspondence	Date of Issue from External Agency	Reference	Guidance Type	NICE Assurance 3 month	Full Implementation Date for S&G
Guselkumab Active psoriatic arthritis after inadequate response to DMARDs	31/01/2022	TA 711	NICE Technology Appraisal	30/04/2022	31/10/2022
Ravulizumab Atypical Haemolytic Uraemic Syndrome	31/01/2022	TA 710	NICE Technology Appraisal	30/04/2022	31/10/2022
Pembrolizumab Metastatic Colorectal Cancer with High Microsatellite	31/01/2022	TA 709	NICE Technology Appraisal	30/04/2022	31/10/2022
Ofatumumab Relapsing Multiple Sclerosis	31/01/2022	TA 699	NICE Technology Appraisal	30/04/2022	31/10/2022
Ravulizumab Paroxysmal Nocturnal Haemoglobinuria	31/01/2022	TA 698	NICE Technology Appraisal	30/04/2022	31/10/2022
Carfilzomib with dexamethasone and lenalidomide Multiple Myeloma	31/01/2022	TA 695	NICE Technology Appraisal	30/04/2022	31/10/2022
Ribociclib Advanced Breast Cancer after Endocrine Therapy	31/01/2022	TA 687	NICE Technology Appraisal	30/04/2022	31/10/2022
Pembrolizumab with Pemetrexed and Platinum Chemotherapy NSC Lung Cancer	31/01/2022	TA 683	NICE Technology Appraisal	30/04/2022	31/10/2022
Baricitinib Moderate to severe Atopic Dermatitis	31/01/2022	TA 681	NICE Technology Appraisal	30/04/2022	31/10/2022

11. Local Audit reports/Quality Improvement

- a) All clinical audits to be registered via clinical audit registration form. DAA form to be completed also.



Data Access
Agreement (v4.0)



Clinical And Social
JuCare Audit Registrati

12. Consultant outcome data (NCEPOD / National / Regional / Speciality)

13. Any Other Business

14. Date of Next Meeting - Friday 11th March 2022, PM, Combined

15. Calendar 2022



1.Combined Surgical
Anesthetics MM Rollir

Next meeting Friday 11th March PM
Combined Meeting

From: [Haffey, Raymond](#)
To: [Arava, Shiva](#); [Campbell, John](#); [Charnock, Rob](#); [Korda, Marian](#); [ODonoghue, JohnP](#); [Thompson, Richard](#); [Watson, Bruce](#)
Cc: [Doyle, Caroline](#); [McConville, JoanneE](#); [Harte, Terri](#); [McLoughlin, Sandra E](#); [Markey, Mary](#); [Feely, Roisin](#); [Haffey, Raymond](#)
Subject: FOR INFORMATION: DEATHS OUTSIDE HOSPITAL - DEATHS RECORDED ON PAS AFTER LAST DISCHARGE REPORT:NOVEMBER - DECEMBER 2021
Date: 28 January 2022 11:47:52
Attachments: [Anaesthetics and Surgery mortality post discharge \(December 2021 report\).xlsx](#)
[Anaesthetics and Surgery mortality post discharge \(January 2022 report\).xlsx](#)
[Anaesthetics and Surgery mortality post discharge \(November 2021 report\).xlsx](#)

Dear all

Please find attached report for Deaths Outside a SHSCT Hospital Where the Patient had a Hospital Discharge for periods 01/10/2021 – to 17/11/2021, 01/11/2021 to 15/12/2021 and 01/12/2021 to 12/01/2022. Reports are ran by the Information Team based in Bannvale primarily for the CAH Medical M&M. The CAH medical cases are shared with the Chair for the meeting. I have filtered the Anaesthetics / Surgery cases out of the main report for each time period.

Regards

Raymond Haffey

Senior Audit Facilitator

Southern Health & Social Care Trust

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

e-mail Personal Information redacted by the USI

DEATHS OUTSIDE A SHSCT HOSPITAL SITE WHERE THE PATIENT HAD A HOSPITAL DISCHARGE BETWEEN 01/10/2021 – 17/11/2021 (Run Date 18/11/2021)

Date of Death	HCN	Casenote	Forenames	Surname	Date of Discharge Only	Days post Discharge	Timeband	Hospital on Discharge	Specialty On Discharge Descript (R)	Consultant on Discharge - Name	Ward on Discharge	Method of Discharge	Comment
						37	31 - 60 Days	CRAIGAVON AREA HOSPITAL	GENERAL SURGERY	Epanomeritakis E Mr	Ward 4 Ramone	Normal	
Personal Information redacted by the USI						6	<30 Days	CRAIGAVON AREA HOSPITAL	GENERAL SURGERY	Hewitt G.R. Mr	4n - Emergency Surgical Ward	Normal	On previous list also
						22	<30 Days	CRAIGAVON AREA HOSPITAL	UROLOGY	Khan N Mr	Ward 4 Ramone	Normal	
						12	<30 Days	CRAIGAVON AREA HOSPITAL	GENERAL SURGERY	Neill A K Mr	1 West Admissions Ward	Normal	
						9	<30 Days	CRAIGAVON AREA HOSPITAL	ANAESTHETICS	Shevlin C Dr	Intensive Care Unit	Transfer-Other Hosp	

DEATHS OUTSIDE A SHSCT HOSPITAL SITE WHERE THE PATIENT HAD A HOSPITAL DISCHARGE BETWEEN 01/11/2021 – 15/12/2021 (Run Date 16/12/2021)													
Date of Death	HCN	Casenote	Forenames	Surname	Date of Discharge Only	Days post Discharge	Timeband	Hospital on Discharge	Specialty On Discharge Descript (R)	Consultant on Discharge - Name	Ward on Discharge	Method of Discharge	Comment
Personal Information redacted by the USI						4	<30 Days	CRAIGAVON AREA HOSPITAL	TRAUMA AND ORTHOPAEDICS	Roberts V Miss	Trauma Ward	Normal	
						12	<30 Days	CRAIGAVON AREA HOSPITAL	GENERAL SURGERY	Epanomeritakis E Mr	4n - Emergency Surgical Ward	Normal	
						3	<30 Days	CRAIGAVON AREA HOSPITAL	UROLOGY	Young M Mr	4s - Progressive Care Ward	Nurse Disc - Normal	
						2	<30 Days	CRAIGAVON AREA HOSPITAL	GENERAL SURGERY	Epanomeritakis E Mr	4n - Emergency Surgical Ward	Normal	
						16	<30 Days	DAISY HILL HOSPITAL	GENERAL SURGERY	Malik M Mr	Dhh Elective Admissions Ward	Discharged-Self/Rel	
						12	<30 Days	DAISY HILL HOSPITAL	GENERAL SURGERY	Mahmood M S Mr	Dhh Elective Admissions Ward	Normal	
						26	<30 Days	CRAIGAVON AREA HOSPITAL	GENERAL SURGERY	Neill A K Mr	Ward 4 Ramone	Normal	
						12	<30 Days	DAISY HILL HOSPITAL	GENERAL SURGERY	Mahmood M S Mr	Female Surgical	Normal	
						1	<30 Days	CRAIGAVON AREA HOSPITAL	UROLOGY	Omer S Dr	1 West Admissions Ward	Normal	
						31	31 - 60 Days	CRAIGAVON AREA HOSPITAL	UROLOGY	Young M Mr	4s - Progressive Care Ward	Normal	

DEATHS OUTSIDE A SHSCT HOSPITAL SITE WHERE THE PATIENT HAD A HOSPITAL DISCHARGE BETWEEN 01/12//2021 – 12/01/2022 (Run Date 13/01/2022)

Date of Death	HCN	Casenote	Forenames	Surname	Date of Discharge Only	Days post Discharge	Timeband	Hospital on Discharge	Specialty On Discharge Descript (R)	Consultant on Discharge - Name	Ward on Discharge	Method of Discharge	Comment
Personal Information redacted by the USI						1	<30 Days	CRAIGAVON AREA HOSPITAL	UROLOGY	Omer S Dr	1 West Admissions Ward	Normal	
						10	<30 Days	DAISY HILL HOSPITAL	GENERAL SURGERY	Thompson R Mr	Female Surgical	Normal	
						1	<30 Days	CRAIGAVON AREA HOSPITAL	ANAESTHETICS	Stewart D Dr	Recovery Ward	Transfer-Other Hosp	
						21	<30 Days	CRAIGAVON AREA HOSPITAL	UROLOGY	Young M Mr	Ward 4 Ramone	Normal	
						5	<30 Days	CRAIGAVON AREA HOSPITAL	GENERAL SURGERY	Hewitt G.R. Mr	4s - Progressive Care Ward	Normal	



**UROLOGY DEPARTMENT
THORNDALE UNIT
CRAIGAVON AREA HOSPITAL**

DR E. SMITH
THE SURGERY
BEGNEY HILL ROAD
DROMARA
BT25 2AT

Dear DR SMITH

Re: Name:
D.O.B:
Address:
Hospital No:

Personal Information redacted by the USI

Personal Information redacted by the USI

H&C No:

Personal Information redacted by the USI

Personal Information redacted by the USI

Past medical history:

Personal Information redacted by the USI

Personal Information redacted by the USI

Plan:

Personal Information redacted by the USI

Yours sincerely,

Dictated but not signed by

Mr Matthew Tyson
Consultant Urologist

Date Dictated: 21/01/2022

Date Typed: 25/01/2022-TL

CRAIGAVON AREA HOSPITAL, 68 LURGAN ROAD, PORTADOWN, BT63 5QQ

Secretary: Miss Teresa Loughran

Telephone: Personal Information redacted by the USI

E-mail: teresa.loughran@hsc.uk
Personal Information redacted by the USI

DATA ACCESS AGREEMENT

IT IS IMPORTANT THAT YOU READ THIS SECTION BEFORE COMPLETING THE DATA ACCESS AGREEMENT (DAA) FORM

This Data Access Agreement (DAA) template should be completed **ONLY** where personal identifiable data is to be shared for a secondary purpose.

‘Identifiable’ means data which could lead to any individual being identified and includes pseudonymised data. (See Section A). A secondary purpose is a reason other than the initial purpose for which the data was collected

A DAA is NOT appropriate for the following purposes:

- When only anonymous (non-identifiable) data is to be shared
- Where identifiable data is to be shared for a primary purpose e.g. for a purpose linked to the direct care of the patient or service user; or a purpose linked directly to a staff member’s employment. Contact your IG Department for further advice.
- Research (see below re Research Governance Framework)
- Software maintenance contracts (will be covered by the appropriate contract)
- Internal audits (seek advice from the Audit Department)
- Where a legally binding contract is more appropriate (e.g. with a 3rd party supplier)

When information is required for a secondary purpose other than those included above, it is important that you consider what type of data meets your requirements and that you complete section A before proceeding with this DAA.

Please note that the purpose of a DAA is only to address any data protection issues associated with the sharing of personal data. Any other issues regarding the availability or interpretation of data and arrangements or resources required to comply with the request should be discussed separately with the relevant Service / Information Dept. staff within the Trust(s).

Introduction

All Health and Social Care (HSC) organisations must ensure that when sharing HSC data for non-direct care (secondary purposes), assurances are provided by the requesting organisations that they comply with data protection (DP) legislation and that staff are aware of the relevant DP policies and procedures in place.

Researchers undertaking studies and who require access to patient identifiable information and / or anonymous HSC data should follow the research protocol (Research Governance Framework for Health and Social Care in Northern Ireland). There is no need for an additional DAA to be completed.

Please be aware that it may be more appropriate to make use of the Honest Broker Service (HBS) rather than completing a Data Access Agreement. The HBS will enable the provision of anonymised, aggregated and in some cases pseudonymised health and social care data to the Department of Health (DoH), HSC organisations and in the case of anonymised data for approved Health and Social care related research.

Arrangement for access to personal data for a secondary purpose may already be covered by a contract (e.g. a contract for supplier support on an information system) therefore organisations need to be clear that any proposed data sharing is either covered adequately by that contract or make sure that a Data Access Agreement is completed.

The following Data Access Agreement must be completed and signed by any organisation wishing to access HSC identifiable data for a secondary purpose not already covered by a contract or research application. It must be considered for approval and signed by the owner organisation's Personal Data Guardian or Senior Information Risk Owner (SIRO).

In the event of a breach of this agreement which results in a financial penalty, claim or proceedings, the parties agree to co-operate to identify and apportion responsibility for the breach and the defaulting party will accept responsibility for any such claim.

Please refer to Appendix 2, 'Principles Governing Information Sharing' for guidance.

The form is divided into Sections (A-I) as detailed below:

- Section A:** Classification of data required
- Section B:** Title of Agreement / Details of Organisations to which the data will be shared
- Section C:** Details of Identifiable Data Items required and rationale
- Section D:** Consent or other Lawful Basis for accessing personal data
- Section E:** Data Protection arrangements (of receiving organisation)
- Section F:** Measures / Controls to prevent inappropriate disclosure of information
- Section G:** Data Retention
- Section H:** Declaration: Organisation to which data will be shared
- Section I:** Declaration: Owner Organisation

Appendix 1: Data Destruction Notification

Appendix 2: Principles Governing Information Sharing

Appendix 3: Definitions

Appendix 4: Contact Details

*******IMPORTANT*******PLEASE REVIEW AND COMPLETE SECTION A BEFORE PROCEEDING

(A) Classification of data required (for secondary purpose)		
Identifiable data	The data to be shared with our organisation will contain Client Identifiable Details i.e. any of the following: Name, Address, Full Postcode, Date of Birth, HSC Number; Case-note Number; or other unique identifier that would link the data to identifiable details	Yes <input type="checkbox"/> Please complete ALL sections of this DAA
Pseudonymous data	<p>The data to be shared with our organisation contain no personal identifiers (as described above); however a unique code or key will be included that allows the possibility of linking this in future to a specific data subject.</p> <p>The pseudonymisation process will be completed at source by the HSC organisation who alone will securely retain the key to re-identify the data.</p>	Yes <input type="checkbox"/> Please complete sections B, C, and H of this DAA
Anonymous data	The data to be shared with our organisation will contain NO identifiable data items (as described above). At no stage will any party be able to link the data to an identified or identifiable natural person.	Yes <input type="checkbox"/> A DAA is not required

When a DAA is appropriate, please ensure that the completed / signed form is returned to the relevant contact in each organisation (**see attached Appendix 4 for contact details**)

Please note that the completed Data Access Agreement will be immediately returned unless the receiving organisation has signed section H.

(B) Title of Agreement / Organisations to which the data will be shared

Title of Agreement	
Date of Request	

Please indicate as follows, by ticking the relevant box. This is:-

- a) A New application ☐
- b) Extending an earlier Agreement with no changes to what was previously agreed ☐
- c) An update of an earlier Agreement with changes to what was previously agreed ☐

Please ensure that any changes from a previous agreement are clearly highlighted at Section C.

Date Access to Begin: _____

Date Access Ends: _____

2 yearly review date if on-going agreement: _____

Details of the Organisation the data will be shared with	
Name of Organisation:	
Name of Authorised Officer requesting Access to Trust Data	
Position/Status	
Address	
Postcode	
Telephone Number	
Email Address	
Name and Telephone Number of Organisation's Personal Data Guardian/Caldicott Guardian	

If you require the data to carry out work **on behalf of another organisation**, please complete the additional Table below. If not, please go straight to section (C).

Commissioning Organisation (if relevant)	
Name of Commissioning Organisation	
Contact Name	
Title	
Contact Number	
Email Address	

(C) Details of Identifiable Data Items required and rationale (NB. only minimum identifiable data should be requested for the required purpose)	
Please provide a list of data items that can identify an individual (e.g. Name, Address, Full Postcode, Date of Birth, HSC Number; Case-note Number; or other unique identifier that would link the data to identifiable details).	Please indicate the reasons for requiring each of these data items
1 _____	1 _____
2 _____	2 _____
3 _____	3 _____
4 _____	4 _____
5 _____	5 _____
6 _____	6 _____
7 _____	7 _____
8 _____	8 _____
9 _____	9 _____
10 _____	10 _____
Continue on separate sheet if necessary	Continue on separate sheet if necessary

Processing of information

Please complete all sections below to explain how information will be processed

- *complete all sections using language easily understood by lay reviewers*
- *continue on a separate sheet if necessary or attach any relevant documentation*

A brief description of the data flow(s):

The purpose for which the data is required:

How you propose to process the data once received:

Details of any record linking or matching to other data sources:

Other relevant information:

Please list the System(s) from which data is to be extracted (if known) for Example PAS, SOS CARE, PARIS, NIECR, etc. Please also include sites or geographical locations (if known):

Frequency of transfers (*Please Tick*)

Once ☐

Other ☐
(Please specify)

(D) Consent or other Lawful Basis for accessing personal data

If you are requesting personal identifiable/special category data for a secondary purpose, there is an expectation that you will have explicit written consent from the service user(s) or another lawful basis for accessing their information.

When relying on consent as the lawful basis, this means offering individuals genuine choice and control. This will require a very clear and specific statement of consent, which should be in writing and held on the service user's file. It should be clear to the individual what they are consenting to and who will have access to their information. It should be easy for individuals to withdraw consent and they should be made aware that they can do this at any time.

Do you have the individuals' **informed consent** for their data to be shared for the purpose specified in this DAA?

Yes ☐ No ☐

If yes, please provide a copy of the Consent Form with this application

If you are NOT obtaining informed consent, what other **lawful basis** are you relying on to obtain the data for this purpose?
(please discuss with your Data Protection Officer / IG department regarding relevant legislation and GDPR conditions – see Appendix 3 below re lawful basis under article 6 and article 9)

**In the absence of consent or any other lawful basis, it will only be appropriate to share anonymous data or pseudonymous data (data pseudonymised at source).
Please refer back to Section A.**

(E) Data Protection arrangements of the Organisation receiving the identifiable data – to provide assurance that the data shared is processed and stored securely by you, please answer the following questions:	
You must be registered with the Information Commissioner's Office (ICO) to process personal data. Please provide your ICO registration number	
Do you have a confidentiality / privacy policy which complies with Data Protection legislation?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are confidentiality clauses included within contracts of all staff with access to the person identifiable information?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are all staff trained and aware of their responsibilities under Data Protection legislation and adhere to the Data Protection principles?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have an ICT security policy?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you conducted a Data Protection Privacy Assessment (DPIA)? (please see App. 3 for further details on when a DPIA is necessary)	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes please include a copy with this form.

(F) Measures / Controls in place by the receiving organisation to prevent the inappropriate disclosure of <u>Person Identifiable Information</u>	
How do you require the information to be securely transferred to your organisation?	
Describe the physical security arrangements for the location where person identifiable data is to be: <ul style="list-style-type: none"> - processed; and - stored 	
Provide details of access and/or firewall controls implemented on the system, and measures to encrypt which are in place.	

Will this data be accessed or transferred by you to another organisation; or shared with another organisation?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If applicable, how will you secure information provided being transferred by you to another organisation?	
Is a separate agreement in place to ensure the security of the data held by the 3 rd party?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If the data is to be stored or shared outside the UK please provide details (e.g. country):	

(G) Data Retention –	
Please indicate how long the receiving organisation will retain identifiable data	
<p>Please state the date by which you will be finished using the identifiable data.</p> <p>If this is not applicable you need to explain why?</p>	
<p>If the data retention period for identifiable data is greater than two years, please indicate the reasons for this.</p> <p>(The maximum data retention period is 2 years, after this time a review of this agreement is required)</p>	
Describe the method of data destruction you will employ when you have completed your work using person identifiable data	

When appropriate, please ensure that the Data Destruction Notification (Appendix 1) is completed within the specified retention period and returned to the appropriate contact person (see Appendix 4).

(H) Declaration: Organisation to which data will be shared

Please note that the completed Data Access Agreement will be immediately returned unless the receiving organisation has signed section H.

Data Protection Undertaking on Behalf of the Organisation Wishing to Access the Data

My organisation requires access to the data specified and will conform to Data Protection legislation; the Information Commissioner's Data Sharing Code of Practice; and the guidelines issued by the Department of Health in *"The Code of Practice on Protecting the Confidentiality of Service User Information (updated April 2019)"*.

I confirm that:

- The information requested and any information extracted from it is for a specified, explicit and legitimate purpose
- It is adequate, relevant and limited to the stated purpose
- It will be processed fairly and lawfully and used only for the stated purpose
- It will be processed and stored in a manner that ensures appropriate security
- It will be held no longer than is necessary for the stated purpose
- It will be disposed of fully and in such a way that it is not possible to reconstitute it
- All measures will be taken to ensure identifiable data is not disclosed to third parties
- Where appropriate, the Health and Social Care organisation will be informed of the identifiable data being deleted / destroyed (see Appendix 1)
- In the case of pseudonymised data, the process of de-identifying data will be completed at source. The key to re-identification will be held only by the data controller and at no stage will the data we receive be attributed to an identified or identifiable natural person
- Any loss, theft or corruption of the shared data by my organisation will be immediately reported to the Personal Data Guardian / SIRO of the owning organisation and we will assist fully in any investigation. I understand that any serious breaches, data loss, theft or corruption will be reported to the ICO within 72 hours of the breach first being discovered.

As the Authorised Officer of the organisation to which data will be shared, I declare that I have read and understand my obligations and adhere to the conditions contained in this Data Access Agreement.

Signed: _____
(Personal Data Guardian / Caldicott Guardian / Authorised Officer)

Signed: _____
(IAO/SIRO)

Date: _____

(I) Declaration – HSC Owner Organisation**DATA ACCESS AGREEMENT****I CONFIRM THAT:**

The _____ (HSC owner organisation)
consents to the disclosure of the data specified, to the organisation identified in Section B
of this form. The disclosure of the data conforms to the guidelines issued by the
Department of Health Code of Practice on Protecting Confidentiality of Service User
Information (updated April 2019); and the Information Commissioner's Data Sharing Code
of Practice.

Signed: _____ *(HSC Organisation internal use)*
(Information Governance and / or ICT Security)

Signed: _____
(Personal Data Guardian) OR (Senior Information Risk Owner SIRO)

Date: _____

Please note that this organisation has the right to inspect the premises and processes of the requesting organisation to ensure that they meet the requirements set out in the agreement.

Appendix 1**Data Destruction Notification**

(to be completed on all occasions when data is transferred external to HSC NI)

Authorised users of the person identifiable data have, under the terms and conditions of the Data Access Agreement, a requirement to destroy the data on or before the retention date stated in Section (G).

This form should be completed on destruction of the data, and returned to the relevant Trust contact (see Appendix 4):-

Data Destruction Notification	
Name of Organisation	
Name of Authorised Officer (please print)	
Position/Status	
Address	
Telephone Number	
Mobile Number (Optional)	
Fax Number	
Email Address	
Title of Agreement	
Date Declaration Signed	
Date Data Received	
Date Data Destroyed	

Signature	
Date	

Appendix 2 - Principles Governing Information Sharing¹

Code of Practice Principles	GDPR Principles	Caldicott Principles ²
<p>The Code of Practice is principally concerned with identifiable service user information.</p> <p>The nature of the obligation to protect confidentiality can be expressed in terms of three core principles:</p> <ul style="list-style-type: none"> • individuals have a fundamental right to the confidentiality and privacy of information related to their health and social care; • individuals have a right to control access to and disclosure of their own health and social care information by giving, withholding or withdrawing consent; • when considering whether to disclose confidential information, health and social care staff should have regard to whether the disclosure is necessary, proportionate and accompanied by any undue risks. <p>Particular care is needed on the part of health and social care staff to ensure that the right to privacy of vulnerable people – specifically adults with incapacity and children – is respected and that the duty of confidentiality owed to them is fulfilled.</p> <p>https://www.health-ni.gov.uk/publications/code-practice-protecting-confidentialityservice-user-information</p>	<ol style="list-style-type: none"> 1. processed lawfully, fairly and in a transparent manner 2. Purpose limitation - collected for specified, explicit and legitimate purposes and not further processed in a manner that is incompatible with those purposes 3. Data minimisation - adequate, relevant and limited to what is necessary in relation to the purposes for which they are processed 4. Data Quality - accurate and, where necessary, kept up to date 5. Storage Limitation - kept for no longer than is necessary. 6. Integrity and Confidentiality - processed in a manner that ensures appropriate security of the personal data 7. Overarching Accountability principle –take responsibility for what you do with personal data and how you comply with the other principles, having appropriate measures and records in place to be able to demonstrate your compliance. <p>Principles relating to individuals' rights and overseas transfers of personal data are specifically addressed in separate GDPR articles.</p>	<ol style="list-style-type: none"> 1. Justify the purpose(s) for using confidential information. 2. Only use it when absolutely necessary. 3. Use the minimum that is required. 4. Access should be on a strict need-to-know basis. 5. Everyone must understand his or her responsibilities. 6. Understand and comply with the law. 7. The duty to share information can be as important as the duty to protect patient confidentiality

¹ These principles must be followed by health and social care organisations when considering use and disclosure of service user information.

² PDG Principles are adopted from the Caldicott Principles (revised September 2013) established in England and Wales.

Appendix 3- Definitions

Personal Data

'Personal data' means any information relating to an identified or identifiable natural person ('data subject'); an identifiable natural person is one who can be identified, directly or indirectly, in particular by reference to an identifier such as a name, an identification number, location data, an online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person;

Consent

'Consent' of the data subject means any freely given, specific, informed and unambiguous indication of the data subject's wishes by which he or she, by a statement or by a clear affirmative action, signifies agreement to the processing of personal data relating to him or her;

Processing

'Processing' means any operation or set of operations which is performed on personal data or on sets of personal data, whether or not by automated means, such as collection, recording, organisation, structuring, storage, adaptation or alteration, retrieval, consultation, use, disclosure by transmission, dissemination or otherwise making available, alignment or combination, restriction, erasure or destruction;

Pseudonymisation

'Pseudonymisation' means the processing of personal data in such a manner that the personal data can no longer be attributed to a specific data subject without the use of additional information, provided that such additional information is kept separately and is subject to technical and organisational measures to ensure that the personal data are not attributed to an identified or identifiable natural person;

Data Controller

'Controller' means the natural or legal person, public authority, agency or other body which, alone or jointly with others, determines the purposes and means of the processing of personal data; where the purposes and means of such processing are determined by Union or Member State law, the controller or the specific criteria for its nomination may be provided for by Union or Member State law;

Data Processor

'Processor' means a natural or legal person, public authority, agency or other body which processes personal data on behalf of the controller;

Third party

'Third party' means a natural or legal person, public authority, agency or body other than the data subject, controller, processor and persons who, under the direct authority of the controller or processor, are authorised to process personal data;

Data Protection Impact Assessment (DPIA)

A Data Protection Impact Assessment (or DPIA) is part of the accountability obligations under the GDPR and is an integral part of the 'data protection by default and by design' approach. It is a process to help you identify and minimise the data protection risks of a project

A DPIA is mandatory when introducing a new system or process that is likely to include a high risk to the privacy of the individuals involved. An effective DPIA will document the data flows and help to identify and fix problems at an early stage, demonstrate compliance with data protection obligations, meet individuals' expectations of privacy and help avoid reputational damage which might otherwise occur. For further information please see:

<https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/accountability-and-governance/data-protection-impact-assessments/>

Lawful Basis

You must have a valid lawful basis in order to process personal data. The conditions for processing personal data are included under article 6 of GDPR and for processing special category personal data under article 9.

There are six available lawful bases under Article 6 for processing personal data. No single basis is 'better' or more important than the others and the most appropriate basis to use will depend on your purpose and relationship with the individual. Most lawful bases require that processing is 'necessary' for a specific purpose. You must determine your lawful basis before you begin processing, and you should document it.

For full details of Article 6 lawful basis for processing personal data please refer to: <https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/>

In order to lawfully process 'special category data'*, you must identify both a lawful basis under Article 6 (in exactly the same way as for any other personal data); however you will also need to satisfy a specific condition under Article 9.

For full details of Article 9 lawful basis for processing personal data please refer to: <https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/lawful-basis-for-processing/special-category-data/>

Special Category Data*

Special category data is personal data which the GDPR says is more sensitive, and so needs more protection. This type of data could create more significant risks to a person's fundamental rights and freedoms. For example, by putting them at risk of unlawful discrimination.

Special category data is information about an individual's:

- race;
- ethnic origin;
- politics;
- religion;
- trade union membership;
- genetics;
- biometrics (where used for ID purposes);
- health;
- sex life; or
- sexual orientation.

Appendix 4 - Contact details

Belfast Health and Social Care Trust

Gillian Acheson - Senior Data Protection Manager

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Southern Health and Social Care Trust

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Western Health and Social Care Trust

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Health and Social Care Board

Ken Moore | Information Governance Manager

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Business Services Organisation

Alan McCracken - Data Protection Officer (DPO)

Business Services Organisation Headquarters | 2 Franklin Street | Belfast | BT2 8DQ

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Audit Title:	
Directorate: Acute Services <input type="checkbox"/> Children & Young People <input type="checkbox"/> Older Persons & Primary Care <input type="checkbox"/> Mental Health & Disability <input type="checkbox"/> Corporate request <input type="checkbox"/>	
Division:	
Auditor's name:	Audit Supervisor's Name :
Contact details: (email)	
Is this a: National audit <input type="checkbox"/> Regional audit <input type="checkbox"/> Trust audit <input type="checkbox"/> International audit <input type="checkbox"/> Proposed audit commencement date .../.../... Proposed audit completion date .../.../...	
Rationale for the audit (please tick all that apply)	
Topic is included in the Directorate's clinical audit work-plan <input type="checkbox"/> Compliance with standards & guidelines <input type="checkbox"/> National Healthcare Quality Improvement Partnership (HQIP) audit <input type="checkbox"/> Regional RQIA/GAIN audit <input type="checkbox"/> Other national / international audit <input type="checkbox"/> Trust based audit topic important to team/division <input type="checkbox"/> Clinical risk <input type="checkbox"/> Recommendation from national / regional report <input type="checkbox"/> Serious Adverse Incident or Adverse Incident review <input type="checkbox"/> Clinician / personal interest <input type="checkbox"/> Incident reporting <input type="checkbox"/> Educational audit <input type="checkbox"/> Other – please specify	
Priority levels for clinical audit (please see criteria overleaf)	
Level 1 <input type="checkbox"/> Level 2 <input type="checkbox"/> Level 3 <input type="checkbox"/> Level 4 <input type="checkbox"/>	
Audit approval process	
Has this audit been approved based on the priority level? Yes <input type="checkbox"/> No <input type="checkbox"/> Level 1 - Approval required by Associate Medical Director or Clinical Director or Directorate Governance Forum Level 2 - Approval required by Associate Medical Director or Clinical Director or Directorate Governance Forum Level 3 – Approval required by Supervising Consultant Level 4 – Approval required by Supervising Consultant Please be advised that the audit cannot proceed without approval as above.	
Information Team Requests	
<u>Please Note:</u> The Information Team have advised they will not release data to the requestor unless the clinical audit has been approved as above. The clinical audit team will also advise contact with Information Governance for any advice required.	
Trust's M&M and Clinical Audit team contacts	
The clinical audit team can be contacted via: Email: [Redacted] Tel: Fiona Davidson [Redacted] Sandra McLoughlin [Redacted] Raymond Haffey [Redacted] Mary Markey [Redacted] Terri Harte [Redacted] Roisin Feely [Redacted] Philip Sullivan [Redacted]	
<i>In submitting this audit registration form, I agree to share the audit findings, recommendations and audit summary template with: the Audit Supervisor, appropriate Divisional/Directorate Committee and the Trust's Clinical audit team</i>	
Please submit your audit registration form to: [Redacted]	

Priority levels for clinical audit

Level	Audit type - projects identified through	
Level 1 audits, "external must dos" (where the service is applicable to SHSCT)	<ul style="list-style-type: none"> • National audits (NHS England Quality Accounts List (HQIP), including the National Confidential Enquiry into Patient Outcomes and Deaths (NCEPOD) / Other Confidential Inquires 	1
Level 2 audits, other national audits and 'internal must dos'	<ul style="list-style-type: none"> • National audits not contained within the HQIP list, or other clinical audits arising from: • Clinical risk • Serious untoward incident / internal reviews • National Institute of Clinical Excellence Standards & Guidelines • Complaints • Re-audit • Regional audits initiated by RQIA / GAIN 	2
Level 3 audits, 'divisional priorities'	<ul style="list-style-type: none"> • Local topics important to the division 	3
Level 4 audits	<ul style="list-style-type: none"> • Clinician / personal interest • Educational audits 	4

Southern Health and Social Care Trust
M&M: Combined Surgery, Anaesthetics
January – December 2022

Day	Date	Month	Time	M&M
Thursday	13th	January	PM	Speciality specific
Friday	18th	February	AM	Speciality specific
Friday	11th	March	PM	Combined
Tuesday	12th	April	AM	Speciality specific
Tuesday	17th	May	PM	Speciality specific
Wednesday	15th	June	AM	Combined
Wednesday	20th	July	PM	Speciality specific
Thursday	18th	August	AM	Speciality specific
Thursday	15th	September	PM	Combined
Friday	14th	October	AM	Speciality specific
Friday	18th	November	PM	Speciality specific
Tuesday	13th	December	AM	Combined

JOB DESCRIPTION

POST: Divisional Medical Director – Urology Improvement
(Temporary post – 2 years initially)

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Care

ACCOUNTABLE TO: Medical Director

COMMITMENT: 3 PAs

LOCATION: Trustwide

Context:

The Divisional Medical Director (DivMD) will be a leader of the Urology Divisional Management Team, member of the Directorate Senior Management Team and Medical Directors divisional representative. The DivMD will have a lead role in ensuring the division maintains high quality, safe and effective services and will also contribute to the division's strategic direction.

The DivMD will embody HSC values of Openness & Honesty, Excellence, Compassion and Working Together. The Trust is firmly committed to embedding the "right culture" where everyone's "internal culture" or values are realized through the provision of caring, compassionate, safe and continuously improving high quality health and social care.

For the Southern Trust, the "right" culture is underpinned by a collective and compassionate leadership approach, model and behaviours. This Collective Leadership approach will be supported with the implementation of a more collective leadership (CLT) model within the Service Directorates.

Job Purpose:

The DivMD has a lead responsibility within the Division for the delivery and assurance surrounding all aspects of Professional and Clinical and Social Care Governance.

In partnership with the Assistant Director and Professional Leads the DivMD will also be responsible for setting divisional direction; service delivery; development; research and innovation; collaborative working; communication; financial and resource management; people management and development; information management and governance and performance management.

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.

- To medically lead on all aspects of patient safety.
- To lead on all aspects of medical professional and clinical and social care governance including:

<ul style="list-style-type: none"> • Professional Medical Governance <ul style="list-style-type: none"> –Staffing and Staff Management –Professional Performance Management –Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Coronial Matters • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control) • Medications management 	<ul style="list-style-type: none"> • Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Medical Education in conjunction with DMD/ Dir Med Ed • Medical Workforce development • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement • Medical leadership in delivery of MCA and Safeguarding
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Specific Divisional Responsibilities

- Provide medical leadership and direction regarding strategic development of Urology Services within the Southern Trust.
- In conjunction with the AD Surgery and Elective Care lead on the Urology review lookback and coordinate clinical resources as appropriate.
- In conjunction with the AD Surgery and Elective Care provide clinical leadership on the development of business cases to involve independent sector support for lookback reviews as required.
- Be the Trust key clinical contact for liaising with external bodies such as the Royal College of Surgeons and BAUS to gain independent expert advice on urology lookback and quality improvement proposals.
- Review and provide input into the modification of the department to improve and expand Urology services and have an active involvement in the implementation of quality improvement initiatives. This includes specifically:
 - Chairing the urology quality improvement group designated with responsibility for ensuring effective, high quality care is provided.
 - Co-Chairing the Urology SAI task and finish group responsible for ensuring compliance with SAI recommendations made in the 2016 and 2021 urology SAI reviews regarding urology and cancer services.
- Ensure all clinical staff are aware of Trust policies and procedures in relation to good medical practice, and compliant with relevant standards and guidelines.

- Ensure Southern Trust policies and procedures in relation to Urology services are reviewed and updated regularly, and develop short term and long range plans for the department to maintain standards, implement improvements, define and measure progress to meet Southern Trust objectives.
- Provide oversight to senior management to ensure compliance with established practices, to implement new policies and to ensure employees are aware of changes and current standards

Leadership Responsibilities

- To provide assurance on the quality of the professional, clinical and patient safety / Multi-Disciplinary Team systems, processes and meetings within the division.
- To promote quality improvement and to grow and embed a culture of Collective Leadership within the Division.
- To manage the clinical quality of care within the Division, promoting a climate of continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.
- To promote and strengthen links with primary care services including communications and development of service pathway improvements.
- To develop and ensure guidelines and clinical pathways are maintained and embedded within clinical and social care governance structures and culture.
- To be a leader in the alignment and commitment of developing a culture that delivers caring, compassionate, safe and continuously improving high quality health and social care.
- To be a leader in developing an inspiring vision that is put into practice at every level within the division, identify clear, aligned objectives for all teams, departments and staff, provide supportive enabling people management, develop high levels of staff engagement, support learning, innovation and quality improvement in the practice of all staff.
- To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full potential.
- To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:
 - (a) delivery of safe, high quality and effective person-centred care
 - (b) secures activity and performance
 - (c) maintains ongoing financial viability
 - (d) is aligned to corporate goals
- The Divisional Medical Director with the Assistant Director and professional leads will work in partnership to achieve the above objectives.
- To be a leader in the development of key performance indicators for the Division and to ensure that effective performance management arrangements are in place.
- To ensure robust financial management of all medical staff across the Division.
- To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
- To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.

- To model the HSC values.
- To act as an advocate for the Division.
- To represent the Division at the relevant senior Trust meetings.
- To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.
- To ensure that systems are in place so that all Health and Safety and other statutory requirements for patients, visitors, employees and contractors and the wider public are met.
- Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
- Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options.
- To provide quarterly updates on the progress of aspects of professional and social care governance.
- Perform any other duties that are consistent with the post.

Appraisal and Revalidation

To work with the Appraisal and Revalidation Team to ensure that all doctors are engaged in Appraisal and Revalidation in a timely fashion.

Through the Collective leadership team and medical management structures to ensure that areas of concern raised within the Appraisal and Revalidation process are addressed.

In conjunction with the Medical Director's Office to be involved in the oversight of Revalidation and Appraisal processes including undertaking at least 8 appraisals annually, equating to 0.25SPA of DivMD allocation.

Job Planning

- Provide leadership and support for Job planning process within the Directorate for Consultants, Associate Specialists and Specialty Doctors.
- Co-ordinate the implementation of Job Planning within Job Planning guidelines.
- Monitor the completion of Job Plans within agreed timescales.
- Undertake Job Planning for Clinical Directors (and Lead Clinicians) and any other relevant medical staff.
- Advise and mediate in cases that cannot be resolved by Clinical Directors within existing job planning guidance.
- Ensure that Job Planning process and outcomes reflects the Directorate's service capacity needs and Service and Budget Agreement with our Commissioner.

Implementation of HR policies for medical staff

- Co-ordinate and monitor implementation of all relevant policies including:
 - Annual Leave
 - Study Leave
 - Performance
 - Sickness absence
 - Locum cover (long and short term)
- Liaise with Human Resources for appropriate advice and support.
- Liaise with the Director of Medical Education and Training and NIMDTA with regard to junior doctors in training for appropriate advice and support.

Budgetary management

- Monitor financial information on medical staffing to ensure staff costs are within budget including the Division's collective training and development budget for non-training medical staff.
- Receive reports from Finance and work with Finance staff support on management of the budget.
- Take account of medical staffing costs within the Job Planning context.

GENERAL REQUIREMENTS:

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.
4. Adhere at all times to all Trust policies including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
5. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
6. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
7. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.
8. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.
9. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

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

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

SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE Divisional Medical Director – Urology Improvement

DIRECTORATE Acute

Notes to applicants:

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

ESSENTIAL CRITERIA – these are criteria all applicants **MUST** be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form

whether or not they meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below;

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

1. Applicants must be a permanent Consultant within the Southern Health and Social Care Trust.
2. Hold a medical qualification, GMC registration with Licence to Practice and specialist accreditation (CCT).
3. Experience of leadership within a team that led to successful service development and/or quality improvement.
4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

The following are essential criteria which will be measured during the interview stage.

5. Excellent communication skills, both orally and in writing.
6. Be prepared to undertake clinical management development.

IMPORTANT NOTES REGARDING SELECTION PROCESS / INTERVIEW PREPARATION:

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

Prior to interview all shortlisted applicants will be offered the opportunity to meet with Dr Maria O'Kane, Medical Director to allow further discussion of the role of Divisional Medical Director in the Trust. You can do this at any time during the application process or immediately following shortlisting. To arrange a suitable appointment please contact Emma Campbell on Personal Information redacted by the ULS.

You should also note that shortlisted applicants will be assessed against the criteria stated in this specification as it links to the NHS Healthcare Leadership Model. Candidates who are shortlisted for interview are therefore advised to familiarise

themselves with this model to ensure that at interview they can adequately demonstrate they have the required skills to be effective in this demanding leadership role. Further information may be obtained from <http://www.leadershipacademy.nhs.uk/healthcare-leadership-model/>

Please note that interviews for this post will be held week commencing 5th July 2021 (subject to change).

The post will be for a period of 3 years and will be offered under a separate contract which will attract additional programmed activities of 3PA's and a fixed management allowance of £14,800 per annum. Successful applicants can opt to have the responsibility allowance superannuable or non-superannuable at the outset of the contract agreement – which will then apply for the duration of the contract.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Understanding of system wide strengths and weaknesses which has been obtained by the Trust on the basis of the findings of the review

Strengths and Weaknesses	Who is responsible for considering strengths and weaknesses	Describe any further actions this may have stimulated	Describe how they are being taken forward	Name who is taking these forward	Detail what stage has been reached
1. Weakness- No cycle of audit to allow assurance that MDT recommendations are implemented within Urology Cancer Service (or any tumour site)	A. Collective. B. Identified by Task & Finish Group initially (comprised of clinicians, Clinical nurse specialists and operational managers)	A. Discussions at Senior Level within the Trust raising the need to build an audit team to support continuous auditing of the MDT's ensuring actions agreed are completed and therefore providing assurance. This resource and function will become part of the Corporate Clinical Audit Team.	A. Job Description has been obtained from Belfast Trust and will be provided to Senior Management team within the Trust for discussion and following this for progress through for Human Resources and onward progression to recruitment through HR and Finance	A. Senior Management Team within the Trust & Human Resources	A. Job Description obtained from Belfast Trust and has been reviewed B. It is our intention to submit for discussion and agreement a briefing paper outlining the role and requirement of this auditing function of the MDT actions and recruitment thereafter.
2. Weakness- Patients & Families knowledge of their diagnosis, prognosis, lifestyle changes required, appropriate & relevant information supplied & timely access to key worker support as required.	A. Collective. B. Task & Finish Group C. Through service user engagement.	A. The feedback from our service users outlined the gaps they had in their journey and how information is or is not communicated. The gap in patient information was also referenced through several of the SAI recommendations and the timely access to a Key worker.	A. Service Users and External PPI Representative developing a targeted patient and relative survey focused on information given to patients/ relatives. Not just focused on the actual information but if it is available in various formats for specific needs/ electronic, timing of information and what signposting is in place for the patient/ relative. This will lead to further areas of development/ review following outcomes of the survey. B. The Trust had developed a Principals Document which has been accepted by the MDT's this document references the role and requirement of keyworker to be aligned to each patient discussed at the MDT.	A. Service Users, QI Team and PPI	A. Final draft of patient and relative survey in progress. (This survey will audit the information provided to patients pre, intra and post diagnosis clinic . B. On completion of A then this will be piloted with patients and assigned CNS. C. To provide assurance and evidence the regional CaPPS system will be used to record the allocated key worker.
3.The Cancer Tracking Team was unable in the past to identify all patients on the Cancer 31 & 62 day pathways in a timely fashion. Recognising this deficit the Trust at financial risk has been able to secure additional staff to work within the Cancer Tracking Team to ensure that these patients are now identified in real time.	A. Cancer Services	A. Currently with this additional resource each patient is tracked along their individual 31 & 62 day pathway. B. This additional resource has also enabled patients to progress along the pathway through the escalation process where previously this would not have happened.	A. Regional performance requirements is to track patients on the 31 & 62 day pathway to their first definitive treatment only. Increasingly there is a recognition that patients should be tracked "whole pathway"- refers to the patients entire treatment including for any reason they require rediscussion at the MDT or review. This will require regional discussion, agreement and funding.	A. Region	A. Trust compliant with current 31 & 62 tracking requirements.

4. Strength- Work being progressed in Trust is now in focus by Region and other Trusts. Despite the originating SAI's being related to Urology the Trust took the direction to review all tumour sites	A. Collective B Task & Finish Group	A. Undertaking a benchmarking exercise to determine the "state of health" of each MDT using the NCAT framework. B. The Trust has appointed an MDT Administrator & Project Coordinator which is the first role of its kind in the region. C. This role is now providing an auditing role to review quoracy at MDT on a monthly basis rather than quarterly as previous. This allows for issues in quoracy to be identified quickly and addressed. D. The development of the Principals Document. E. Recording of Keyworker on CaPPS at MDT.	A. As a result of the benchmarking exercise action plans for each tumour site have been developed and shared with each individual tumour site for progress and action. B. Region is now reviewing the MDT Administrator & Project Coordinator role and other Trusts are seeking the Job Description for this. C. Region also looking to review A & C as described in column C6 .	A. MDT Leads & Cancer Services Region for B & C	A, B & C as described in column C6 are fully implemented.
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Use of the findings of the review which has been used to promote learning

Learning promoted	Who is responsible for promoting this learning	Describe any further actions this may have stimulated	Describe they are being taken forward and by	Name who is taking these forward	Detail what stage has been reached
1. An audit process would provide assurance that the MDT recommendations are fully implemented.	A. Collective. B. Identified by Task & Finish Group initially (comprised of clinicians, Clinical nurse specialists and operational managers)	A. The Principles Document created based on the NCAT Framework to support the function of the MDT details the specific audit processes required to provide assurance that patients receive the recommended care. B. The development of Standard Operating Procedures to support the audit process is our next step to ensure that outcomes from the audits are actioned and the feedback reaches the MDT chair to ensure compliance with the Principals Document.	A. Approval of the role and development of a Job Description/, Roles & Responsibilities by Human Resources. B. Post will be advertised and recruited C. Establishing Audit Proforma to collect data. D. Development of Standard Operating Procedures and ensuring robust system of feedback to MDT Leads	A. Senior Management Team within the Trust & Human Resources	A. Job Description obtained from Belfast Trust and has been reviewed and is being progressed B. It is our intention to submit for discussion and agreement a briefing paper outlining the role and requirement of this auditing function of the MDT actions and recruitment thereafter.

2. Education through information for patients and relatives enables patient to have ownership of their pathway and enable a collaborative approach to care planning with staff. Patients having a named Key worker ensures a consistent point of contact, development of rapport and support throughout their care pathway.	A. Collective. B. Identified by Service User Group C. Clinicians and Nurse Specialists	A. The feedback from our service users outlined the gaps they had in their journey and how information is or is not communicated. The gap in patient information was also referenced through several of the SAI recommendations and the timely access to a Key worker.	A. Service Users and External PPI Representative developing a targeted patient and relative survey focused on information given to patients/ relatives. Not just focused on the actual information but if it is available in various formats for specific needs/ electronic, timing of information and what signposting is in place for the patient/ relative. This will lead to further areas of development/ review following outcomes of the survey. B. The Trust had developed a Principles Document which has been accepted by the MDT's this document references the role and requirement of keyworker to be aligned to each patient discussed at the MDT.	A. Service Users, QI Team and PPI	A. Final draft of patient and relative survey in progress. (This survey will audit the information provided to patients pre, intra and post diagnosis clinic . B. On completion of A then this will be piloted with patients and assigned CNS. C. To provide assurance and evidence the regional CaPPS system will be used to record the allocated key worker
3. Recognised deficit in the Cancer Tracking Team which enables all patients on the Cancer 31 & 62 day pathways to be monitored in almost real time. Recognising this deficit the Trust at financial risk has been able to secure additional staff to work within the Cancer Tracking Team.	A. Cancer Services	A. Currently with this additional resource each patient is tracked along their individual 31 & 62 day pathway. B. This additional resource has also enabled patients to progress along the pathway through the escalation process where previously this would not have happened.	A. Regional performance requirements is to track patients on the 31 & 62 day pathway to their first definitive treatment only. Increasingly there is a recognition that patients should be tracked "whole pathway"- refers to the patients entire treatment including for any reason they require rediscussion at the MDT or review. This will require regional discussion, agreement and funding.	A. Region	A. Trust compliant with current 31 & 62 tracking requirements
4. Work being progressed in Trust is now in focus by Region and other Trusts. Despite the originating SAI's being related to Urology the Trust took the direction to review all tumour sites	A. Collective B Task & Finish Group	A. A. Undertaking a benchmarking exercise to determine the "state of health" of each MDT using the NCAT framework. B. The Trust has appointed an MDT Administrator & Project Coordinator which is the first role of its kind in the region. C. This role is now providing an auditing role to review quoracy at MDT on a monthly basis rather than quarterly as previous. This allows for issues in quoracy to be identified quickly and addressed. D. The development of the Principals Document. E. Recording of Keyworker on CaPPS at MDT.	A. As a result of the benchmarking exercise action plans for each tumour site have been developed and shared with each individual tumour site for progress and action. B. Region is now reviewing the MDT Administrator & Project Coordinator role and other Trusts are seeking the Job Description for this. C. Region also looking to review A & C as described in column C6 .	A. MDT Leads & Cancer Services Region for B & C	A, B & C as described in column C6 are fully implemented.

Use of the report findings to improve the quality and safety of care and treatment provided

Quality and Safety Improved	Who is responsible for this	Describe any further actions this may have stimulated	Describe they are being taken forward and by	Name who is taking these forward	Detail what stage has been reached
1. An audit process would provide assurance that the MDT recommendations are fully implemented.	A. Collective. B. Identified by Task & Finish Group initially (comprised of clinicians, Clinical nurse specialists and operational managers)	A. The Principles Document created based on the NCAT Framework to support the function of the MDT details the specific audit processes required to provide assurance that patients receive the recommended care. B. The development of Standard Operating Procedures to support the audit process is our next step to ensure that outcomes from the audits are actioned and the feedback reaches the MDT chair to ensure compliance with the Principles Document.	A. Approval of the role and development of a Job Description/, Roles & Responsibilities by Human Resources. B. Post will require advertising and recruited to. C. Establishing Audit Proforma to collect data. D. Development of Standard Operating Procedures and ensuring robust system of feedback to MDT Leads	A. Senior Management Team within the Trust & Human Resources	A. Job Description obtained from Belfast Trust and has been reviewed B. It is our intention to submit for discussion and agreement a briefing paper outlining the role and requirement of this auditing function of the MDT actions and recruitment thereafter.
2. Patients & Families knowledge of their diagnosis, prognosis, lifestyle changes required, appropriate & relevant information supplied & timely access to key worker support as required.	A. Collective. B. Task & Finish Group C. Through service user engagement.	A. The feedback from our service users outlined the gaps they had in their journey and how information is or is not communicated. The gap in patient information was also referenced through several of the SAI recommendations and the timely access to a Key worker.	A. Service Users and External PPI (Patient and Public Involvement) Representative developing a targeted patient and relative survey focused on information given to patients/ relatives. Not just focused on the actual information but if it is available in various formats for specific needs/ electronic, timing of information and what signposting is in place for the patient/ relative. This will lead to further areas of development/ review following outcomes of the survey. B. The Trust had developed a Principles Document which has been accepted by the MDT's this document references the role and requirement of keyworker to be aligned to each patient discussed at the MDT.	A. Service Users, QI Team and PPI	A. Final draft of patient and relative survey in progress. (This survey will audit the information provided to patients pre, intra and post diagnosis clinic . B. On completion of A then this will be piloted with patients and assigned CNS. C. To provide assurance and evidence the regional CaPPS (system will be used to record the allocated key worker.
3. Recognised deficit in the Cancer Tracking Team which enables all patients on the Cancer 31 & 62 day pathways to be monitored in almost real time. Recognising this deficit the Trust at financial risk has been able to secure additional staff to work within the Cancer Tracking Team.	A. Cancer Services	A. Currently with this additional resource each patient is tracked along their individual 31 & 62 day pathway. B. This additional resource has also enabled patients to progress along the pathway through the escalation process where previously this would not have happened.	A. Regional performance requirements is to track patients on the 31 & 62 day pathway to their first definitive treatment only. Increasingly there is a recognition that patients should be tracked "whole pathway"- refers to the patients entire treatment including for any reason they require rediscussion at the MDT or review. This will require regional discussion, agreement and funding.	A. Region	A. Trust compliant with current 31 & 62 tracking requirements

4. Work being progressed in Trust is now in focus by Region and other Trusts. Despite the originating SAI's being related to Urology the Trust took the direction to review all tumour sites	A. Collective B Task & Finish Group	A. A. Undertaking a benchmarking exercise to determine the "state of health" of each MDT using the NCAT framework. B. The Trust has appointed an MDT Administrator & Project Coordinator which is the first role of its kind in the region. C. This role is now providing an auditing role to review quoracy at MDT on a monthly basis rather than quarterly as previous. This allows for issues in quoracy to be identified quickly and addressed. D. The development of the Principles Document. E. Recording of Keyworker on CaPPS at MDT.	A. As a result of the benchmarking exercise action plans for each tumour site have been developed and shared with each individaul tumour site for progress and action. B. Region is now reviewing the MDT Administrator & Project Coordinator role and other Trusts are now replicating the Job Description for this. C. Region also reviewing A & C as described in column C6 .	A. MDT Leads & Cancer Services Region for B & C	A, B & C as described in column C6 are fully implemented.
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