Mr. Ronan Carroll
Assistant Director Surgery/Elective Care/Anaesthetics
Southern Health and Social Care Trust
Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

30 March 2022

Dear Sir,

**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 in your roles 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 may be aware the Trust has 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 your 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 an 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


**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 5 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:** **Mr. Ronan Carroll**
**Assistant Director of Surgery/Elective Care/Anaesthetics**
**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 11th May 2022.**

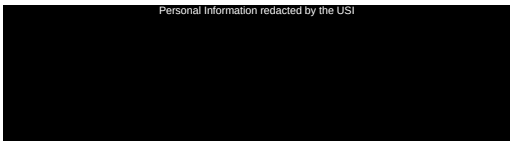
**APPLICATION TO VARY OR REVOKE THE NOTICE**

**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 4th May 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 30th March 2022

Signed: 


**Christine Smith QC**

Chair of Urology Services Inquiry

**SCHEDULE**

**[No 5 of 2022]**

**General**

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

2. Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.

3. Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person.

**Your position(s) within the SHSCT**

4. Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.

5. Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.

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

7. With specific reference to *the operation and governance of urology services*, please set out your roles and responsibility and lines of management.

8. It would be helpful for the Inquiry for you to explain how those aspects of your role and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, the roles of the Medical Director, Clinical Director, Associate Medical Director and Head of Urology Service or with any other role which had governance responsibility.

**Urology services/Urology unit - staffing**

9. The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the urology unit in the Southern Trust area.

10. What, if any, performance indicators were used within the urology unit at its inception?

11. Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, provided to or disseminated in any way by you or anyone else to urology consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?

12. How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits within it) impact on the management, oversight and governance of urology services? How, if at all, were the time limits for urology services monitored as against the requirements of the protocol? What action, if any, was taken (and by whom) if time limits were not met?

13. The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog.

    I. What is your knowledge of and what was your involvement with this plan?
    II. How was it implemented, reviewed and its effectiveness assessed?
    III. What was your role in that process?
    IV. Did the plan achieve its aims in your view? OR Please advise whether or not it is your view that the plan achieved its aims? If so, please expand stating in what way you consider these aims were achieved.

14. Were the issues raised by the *Implementation Plan* reflected in any Trust governance documents or minutes of meetings, and/or the Risk Register? Whose role was to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.

15. To your knowledge, were the issues noted in the *Regional Review of Urology Services, Team South Implementation Plan* resolved satisfactorily or did problems persist following the setting up of the urology unit?

16. Do you think the unit was adequately staffed and properly resourced from its inception? If that is not your view, can you please expand noting the deficiencies as you saw them?

17. Were you aware of any staffing problems within the unit since its inception? If so, please set out the times when you were made aware of such problems, how and by whom.

18. Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?

19. In your view, what was the impact of any staffing problems on, for example, the provision, management and governance of urology services?

20. Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?

21. Has your role changed in terms of governance during your tenure? If so, explain how it has changed with particular reference to urology services, as relevant?

22. Explain your understanding as to how the urology unit and urology services were supported by non-medical staff. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff. If you not have sufficient understanding to address this question, please identify those individuals you say would know.

23. Do you know if there was an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants? How was the administrative workload monitored?

24. Were the concerns of administrative support staff, if any, ever raised with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.

25. Who was in overall charge of the day to day running of the urology unit? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person answered throughout your tenure.

26. What, if any role did you have in staff performance reviews?

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

**Engagement with unit staff**

28. Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.

29. Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

30. During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

**Governance – generally**

31. What was your role regarding the consultants and other clinicians in the unit, including in matters of clinical governance?

32. Who oversaw the clinical governance arrangements of the unit and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately?

33. How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?

34. How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for this overseeing performance metrics?

35. How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?

36. How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?

37. Did those systems or processes change over time? If so, how, by whom and why?

38. How did you ensure that you were appraised of any concerns generally within the unit?

39. How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?

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

41. What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?

42. What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?

43. During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.

44. How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?

45. The Inquiry is keen to learn the process, procedures and personnel who were involved when governance concerns having the potential to impact on patient care and safety arose. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.

46. Did you feel supported in your role by the medical line management hierarchy? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.

**Concerns regarding the urology unit**

47. The Inquiry is keen to understand how, if at all, you, as Assistant Director, liaised with, involved and had meetings with:

    (i) The Chief Executive(s) during your tenure (the inquiry understand these to have been Mairead McAlinden, Paula Clark, Francis Rice, Stephen McNally and Shane Devlin)

(ii) the Medical Director(s) during your tenure (the inquiry understand these to have been Patrick Loughran, John Simpson, Richard Wright, Ahmed Khan and Maria O'Kane),

(iii) the Director(s) of Acute Services during your tenure (the inquiry understand these to have been Gillian Rankin, Debbie Burns, Esther Gishkori, Anita Carroll and Melanie McClements)

(iv) the other Assistant Director, namely Heather Trouton,

(v) the Associate Medical Directors during your tenure (the inquiry understand these to have been Eamon Mackle, Mark Haynes, Stephen Hall, Charlie McAllister and Damian Scullion)

(vi) the Clinical Director(s) during your tenure (the inquiry understand these to have been Robin Brown, Sam Hall, Colin Weir and Ted McNaboe)

(vii) the Head of Service, namely Martina Corrigan, and

(viii) the consultant urologists in post during your tenure.

When answering this question, the Inquiry is interested to understand how you liaised with these individuals in matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (i) specifically with reference to the concerns raised regarding urology services. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc.

48. Following the inception of the urology unit, please describe the main problems you encountered or were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters: -

(a) What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes, records etc., and attendees, and

detail what was discussed and what was planned as a result of these concerns.

(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?

(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not.

(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?

(e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

(f) If you were given assurances by others, how did you test those assurances?

(g) Were the systems and agreements put in place to rectify the problems within urology services successful?

(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.

49. Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -

(a) properly identified,
(b) their extent and impact assessed,
(c) and the potential risk to patients properly considered?

50. What, if any, support was provided to urology staff (other than Mr O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q62 will ask about any support provided to Mr O'Brien).

51. Was the urology department offered any support for quality improvement initiatives during your tenure?

**Mr. O'Brien**

52. Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?

53. What was your role and involvement, if any, in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.

54. When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? Do you now know how long these issues were in existence before coming to your or anyone else's attention?

55. Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.

56. What actions did you or others take or direct to be taken as a result of these concerns? You should include details of any discussions with named others regarding these concerns. Please provide dates and details of any discussions, including any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.

57. Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so:

    (i) what risk assessment did you undertake, and
    (ii) what steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person.

58. If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr O'Brien and others, given the concerns identified.

59. What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?

60. How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed?

61. Did any such agreements and systems which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?

62. What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.

63. How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any

documents referred to. If the concerns raise were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

**Learning**

64. Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why.

65. Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?

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

67. Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

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

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

70. Given the Inquiry's terms of reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

**NOTE:**

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

**UROLOGY SERVICES INQUIRY**

**USI Ref:** Notice 5 of 2022

**Date of Notice:** 30th March 2022

**Witness Statement of: Ronan Carroll**

I, Ronan Carroll, will say as follows:-

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

1. The Southern Trust came into existence in April 2007. I was appointed as Assistant Director for Cancer & Clinical Services in April 2007 to April 2016, job description located in *S21 5 of 2022 – 20070301 doc Number 5 JD AD for CCS*. The services contained within this clinical portfolio included Cancer Services, Radiology Services, Laboratory Services, Anaesthetists, Theatres and Intensive Care (ATICS) and Allied Health Professionals (AHP)

2. In April 2016, Acute Services were restructured under the guidance of Esther Gishkori, Director of Acute Services and my Assistant Director portfolio changed to becoming Assistant Director for ATICS and Surgery and Elective Care (SEC). As AD the responsibility for ATICS continued on as it had been between 2007 and 2016. I now had the additional responsibility for the operational management of SEC. SEC included the following surgical services General Surgery, Urology, Ear Nose and Throat (ENT), Trauma and Orthopaedics (T&O), Ophthalmology and Outpatients. The Surgical services were delivered across three hospital sites; Craigavon, Daisy Hill and South Tyrone Hospital with Outpatient services delivered over five sites; Craigavon, Daisy Hill, South Tyrone, Armagh and Banbridge Hospitals.

3. My role involves me working closely with Medical and non-medical managers in the delivery of services to the population in the Southern Trust. I was responsible for the operational management of all these specialities, ensuring that performance, financial and governance targets and required standards were managed.

4. The urology issues that I became aware of can be divided into three broad categories (all of which, including my role in respect of them, are addressed in more detail below from Question 4 onwards). However, for the purpose of Question 1, I shall offer an overview in the following paragraphs, before going on to provide detailed answers to Question 4 to Question 70.

5. The first issue centres on the performance of the Urology Service concerning those performance standards as detailed in the Integrated Elective Access Protocol (IEAP). As detailed in my response to Question 48 below, the performance issues and challenges for the Urology Service have been present for many years. The reasons for not being able to achieve the IEAP targets are multifactorial and not easily resolved; please see my response to Question 48h below.

6. From 2016 (please see my response to Question 48a below) there have been many meetings, internal and external with the Health and Social Care Board (HSCB), to monitor, discuss, understand and agree actions that could to go some way to reducing the excess waiting times within the Urology Service.

7. From 2016, each year has seen the HSCB allocate non recurrent monies to the Urology Service. These non-recurrent monies have enabled some limited additional outpatient activity; please see table 1 in response to Question 48h. A meaningful reduction in the waiting times and volumes of patients has only been possible with monies being allocated to the Trust by the HSCB to enable a contract with Independent Service (IS) providers being agreed; please see response Question 48(h). With the transfer of Urology new outpatient referrals (red flag and urgent) to the IS, it is anticipated that the waiting times will be reduced significantly to approximately 52 weeks for new urgent referrals and 21 days for red flag referrals if non recurrent monies continue throughout the financial year.

8. The second issue that I became aware of was the workforce challenge for the Urology Service. Similar to the Urology Service performances against the IEAP targets, the workforce issue was, and continues to be, a chronic recurring issue, with the causes being complex and the solutions to fix it to date being unachievable with respect to a full complement of Consultant Urologists and ward-based nursing team. Please see further my responses to Q18 in this regard.

9. The third issue, Mr O'Brien's administrative practices, came to my attention in April 2016 when I became the AD for ATICs/SEC. Mrs Trouton advised that Mr O'Brien had received a letter (the letter dated 23rd March 2016) from Mr Mackle, Associate Medical Director (AMD) and herself. The letter was asking Mr O'Brien for a commitment and an immediate plan to address the issues highlighted in this letter. The letter was dated 23rd March 2016 and in this letter reference was made to four governance issues that were causing concern. The issues were:

   a Untriaged Outpatient Referrral Letters
   b Current Review Backlog up to 29 February 2016
   c Patient Centre letters and recorded outcomes from Clinics
   d Patient Notes at home

10. I acknowledge that I did not take immediate action to deal with the content of this letter. On reflection, after a reasonable period of time (approximately 4-6 weeks) along with the Clinical Director / CD (Mr Weir) we should have communicated with Mr O'Brien to ascertain what plan he had or was proposing to address the issues highlighted in the letter of the 23rd March 2016. By way of explanation, this was at the start of my AD tenure with SEC and I was occupied with understanding all the challenges that were present across all SEC.

11. On the 16th and 23rd of December 2016, I received two separate emails. The first email was from Dr Tracey Boyce (Director of Pharmacy with responsibility for acute governance) to Mrs Esther Gishkori (Director of Acute Services) and myself. Mr Glackin raised three concerns: the first concern was the default triage system, the second concern was patient notes leaving the Trust, and the third concern was the patient letters not being dictated in a timely manner.

12. The second email (23rd December) was from Mr Mark Haynes expressing concern that, following his review of a patient who had been seen privately by Mr O'Brien, this patient had been placed on the waiting list for an operation far sooner than other patients waiting for the same operation on Mr O'Brien's waiting list. I forwarded this email onto Dr Wright (Medical Director) for discussion and possible action.

13. As a result of these emails a series of oversight meetings were held on the 22 December 2016, 10 January 2017 and 26 January 2017. I attended two oversight meetings, 22nd December 2016 and the 10th January 2017. For a list of attendees, please see my response to Question 68 below.

14. The first meeting I attended was on the 22nd December 2016, when I deputised for Mrs Esther Gishkori (Director of Acute Services). Present at this meeting as part of the oversight committee were Dr R Wright (Medical Director) and Mrs Vivienne Toal (Director of Human Resources). Also present was Dr Tracey Boyce (Director of Pharmacy and acute governance lead) and Mr Simon Gibson (Assistant Director in Medical Director's Office).

15. At this meeting Dr Boyce summarised an ongoing SAI relating to a Urology patient who may have a poor clinical outcome due to the lengthy period of time taken by Dr O'Brien to undertake triage of GP referrals. Part of this SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason. It was noted as part of this investigation that Dr O'Brien had been undertaking dictation whilst he was on sick leave.

16. I reported to the Oversight Committee that, between July 2015 and Oct 2016, there were 318 letters not triaged, of which 68 were classified as urgent. The range of the delay was from 4 weeks to 72 weeks. This information came from an email from Mrs Corrigan dated 22 December 2016.

17. The second Oversight committee I attended was on the 10th January 2017. Present were Dr Richard Wright, Medical Director (Chair), Vivienne Toal, Director of HROD, and Esther Gishkori, Director of Acute Services. In attendance also were Simon Gibson, Assistant Director, Medical Director's Office, Siobhan Hynds, Head of Employee Relations, Dr Tracey Boyce, Director of Pharmacy, Acute Governance Lead, and myself

18. At this meeting Dr Wright summarised the progress on this case to date, following a meeting with Mr O'Brien on 30th December 2016, including the following appointments to the investigation:

    a) John Wilkinson as the Non-Executive Director,
    b) Ahmed Khan as the Case Manager,
    c) Colin Weir as the Case Investigator (subsequently replaced by Dr Neta Chada),
    d) Siobhan Hynds as the Head of Employee Relations supporting the investigation.

19. I summarised a meeting held with Mr Weir, Mrs Corrigan, the Urologists and myself. I reported that the Urologists were supportive of working to resolve the position with respect to the un-triaged referral letters. I further updated the Oversight Committee in relation to the three issues identified, plus a fourth issue subsequently identified (all described in more detail below). The information for this update was obtained from undertaking physical searches

and running reports through the various information/data systems.

Untriaged referrals

20. I reported that, from June 2015, there were 783 untriaged referrals, all of which need to be tracked and reviewed to ascertain the status of these patients in relation to the condition for which they were referred. All 4 consultants would be participating in this review

Notes being kept at home

21. I reported that 307 notes were returned by Mr O'Brien from his home; 88 sets of notes were located within Mr O'Brien's office; and 27 sets of notes, tracked to Mr O'Brien, were still missing, going back to 2003. Work was continuing to validate this list of missing notes. It was agreed to allow an additional seven days to track these notes down, in advance of informing the CEx and SIRO, and Information Governance Team.

Undictated outcomes

22. I reported that 668 patients had no outcomes formally dictated from Mr O'Brien's outpatient clinics. They were broken down as follows: 272 from the SWAH clinic and 289 from other clinics. The remaining 107 patients were still being investigated

Private patients

23. I reported that a review of TURP patients identified 9 patients who had been seen privately as outpatients, then had their procedure within the NHS. The waiting times for these patients appeared to be significantly less than for other patients. It would appear that there was an issue of Mr O'Brien scheduling his own patients in a non-chronological manner.

24. As part of the "Maintaining High Professional Standards" Investigation I met with Dr Neta Chada and Mrs Siobhan Hynds (Head of Employee Relations) on Thursday 6th April 2017 to discuss my understanding of the administrative issues with Mr O'Brien's practice. I took no part in this investigation as an AD.

25. As part of Mr O'Brien's return to work action plan (9th February 2017) the four elements of the plan were monitored by the Urology Head of Service (Mrs Martina Corrigan) with the outcome being shared with Dr Khan (Case Manager) and Mrs Siobhan Hynds (Head of Employee Relations). Monitoring continued from February 2017 through to June 2020 (when Mr O'Brien retired) with exception of a 5 month period in 2018. Unfortunately, Mrs Corrigan [redacted] was off work from June to October 2018. During this period the auditing of Mr O'Brien's work plan elements was not continued. This omission was recognised on the 4th October 2018 and monitoring recommenced in November 2018.

26. In September 2019 (email 16th September 2019), as part of the monitoring process, Mrs Corrigan reported to Dr Khan that the volume of Mr O'Brien's undictated clinics had increased. This resulted in emails from Dr O'Kane (Medical Director) of 5th November and 17th November asking for a meeting to be arranged to address three points: (1) describe the management plan, (2) the expectation re compliance and (3) escalation. In an email provided by Mr Haynes (email 22nd November 2109) he provided narrative and context as to how the monitoring was being undertaken. A meeting chaired by Mr Simon Gibson and attended by Mr Gibson, Dr Khan, Mr Haynes, Mrs Corrigan and myself took place. The purpose of this meeting was to review the three points in the email from Dr O'Kane on the 17th November 2019 and provide actions which were listed 1-5 in Mr Gibson's email to Dr O'Kane (24th January 2020).

27. The monitoring of Mr O'Brien's administrative workload as described in the action plan of the 7th February 2017 continued until Mr O'Brien retired in June 2020. Meetings were held internally within the Trust, and between the Trust, externally with the HSCB and with Department of Health, chaired by the (then) Permanent Secretary, Mr Pengelly. Furthermore, as a result of the "Look Back" review an SAI was undertaken, chaired by an independent non Trust employee, Dr Dermot Hughes. This SAI made 11 recommendations, which the Trust is currently in the process of implementing.

**[2] Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below.**

28. All documents relating to this S21 response are cited herein and signpost provided.

**[3] Unless you have specifically addressed the issues in your reply to Question 1 above, please answer the remaining questions in this Notice. If you rely on your answer to Question 1 in answering any of these questions, please specify precisely which paragraphs of your narrative you rely on. Alternatively, you may incorporate the answers to the remaining questions into your narrative and simply refer us to the relevant paragraphs. The key is to address all questions posed. If there are questions that you do not know the answer to, or where someone else is better placed to answer, please explain and provide the name and role of that other person.**

**Your position(s) within the SHSCT**

**[4] Please summarise your qualifications and your occupational history prior to commencing employment with the SHSCT.**

29. Occupational History prior to commencing employment with the SHSCT

a) I starting working in the Health Service on the 19 Jan 1984 as a student nurse at the Belfast Northern College of Nursing. Qualifying April 1987.
b) I commenced employment in the Royal Victoria Hospital in April 1987 as a Staff Nurse.
c) I left the Royal Victoria Hospital and commenced the Renal Nursing Course in April 1988 and completed this course in December 1988.
d) I took up a post in the Belfast City Hospital within Renal Services between January 1989 to December 1989.
e) I left the Belfast City Hospital in January 1990 and took up employment with the Newry & Mourne Trust as a Staff Nurse working in Daisy Hill Hospital.
f) Between Jan 1990 and June 1995 I worked as a Staff Nurse within Daisy Hill Hospital and became the Night Nursing Co-ordinator for 12 months.
g) I then was successful in becoming the Ward Manager initially in the Surgical / High Dependency Ward and then spending 5 years in the hospital's Renal Unit.
h) I then became the Clinical Nurse Manager within the Surgical Directorate in 2002 and finally becoming the Assistant Director for Nursing between 2004 to March 2007.

**Qualifications**

30. Along with my nursing qualification, I have also obtained a number of academic qualifications. I list the following in chronological order:

a) English National Board (ENB) Renal Nursing Course (ENB 136)
b) Diploma in Professional Development in Nursing July 1991 University of Ulster at Jordanstown (UUJ)
c) BSc Professional Development in Nursing July 1993 UUJ
d) Post graduate certificate in Health Service Management November 1994 UUJ
e) MSc Health & Social Services Management June 1997 UUJ
f) Bachelor of Laws August 2004 University of London

**[5] Please set out all posts you have held since commencing employment with the Trust. You should include the dates of each tenure, and your duties and**

**responsibilities in each post. Please provide a copy of all relevant job descriptions and comment on whether the job description is an accurate reflection of your duties and responsibilities in each post.**

31. The Southern Trust came into existence in April 2007. I was appointed as Assistant Director for Cancer & Clinical Services in April 2007 to April 2016, job description located in *S21 5 of 2022 – 20070301 doc number 5 JD AD for CCS*. The services contained within this clinical portfolio included Cancer Services, Radiology Services, Laboratory Services, Anaesthetists, Theatres and Intensive Care (ATICS) and Allied Health Professionals (AHP)

32. I was responsible for the operational management of all these specialities, ensuring that performance, financial and governance targets and required standards were managed. I believe the job description reflected the main responsibilities for this role.

33. In April 2016, Acute Services was restructured under the guidance of Esther Gishkori, Director of Acute Services and my Assistant Director portfolio changed to becoming Assistant Director for ATICS and Surgery and Elective Care (SEC).

34. As AD the responsibility for ATICS continued on as it had been between 2007 and 2016. I now had the new additional responsibility for the operational management of SEC. SEC included the following surgical services General Surgery, Urology, Ear Nose and Throat (ENT), Trauma and Orthopaedics (T&O), Ophthalmology and Outpatients. The Surgical services were delivered across three hospital sites; Craigavon, Daisy Hill and South Tyrone Hospital and Outpatient services was delivered over five sites; Craigavon, Daisy Hill, South Tyrone, Armagh and Banbridge Hospitals.

35. I was not provided with a new or revised job description when I became AD for ATICS and SEC, however, I understood that the roles and responsibilities vis-à-vis SEC would be the same as they had been in my previous position vis-à-vis the services contained within that portfolio. To me with the restructuring of the clinical divisions within Acute Services and the bringing together of ATIC and SEC together, I viewed to this be a better operational fit. I was already responsible for half of this ATICs/SEC Division i.e. ATICS. This was a horizontal move getting to work with a different set of medical and non-medical managers but the responsibilities for SEC would be comparable to ATICs.

36. As a registered nurse, I also have a role in chairing the monthly acute senior nurse meeting. This meeting included all AD's (who were nurses), Head of Services (who were nurses) and Lead Nurses (LN). I also attend the executive Director of Nursing Trust wide meetings. In attendance at this meeting are all the AD who are nurses. This professional role and function has never been reflected in my 2007JD.

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

37. As the AD for CCS (2007 – 2016) and AD for SEC and ATICS (2016 – present) the line management responsibility was and is to ensure that performance, finance and governance are managed.

Directors of Acute Services

38. There have been a number of Directors of Acute Services between the period 2007 to 2022, to whom I directly reported.

39. The following Directors have been listed in both chronological date order and the capacity as an AD Division for which I had responsibility.

Table 1 Directors of Acute Services

| Director | Tenure of post | AD for CCS / ATICS or SEC / ATICS |
|---|---|---|
| Mr Jim McCall | 01/04/2007 - 21/05/2008 | CCS / ATICS |
| Miss Joy Youart | April 2008 – 30/11/2009 | CCS / ATICS |
| Dr Gillian Rankin | 1st December 2009 (Interim Director of Acute Services) 01/03/2011 – 31/03/2013 – Director of Acute Services | CCS / ATICS |
| Mrs Debbie Burns | 01/04/2013 – 31/08/2015 | CCS / ATICS |
| Mrs Esther Gishkori | 17/08/2015 - 30/04/2020 (Sick Leave from 06/06/2019) | CCS / ATICS to April 2016 then SEC / ATICS |
| Mrs Melanie McClements | Interim Director of Acute Services: 07/06/2019 – 31/10/2020 Permanent Director of Acute Services: 01/11/2020 - Present | SEC / ATICS |

Line management reporting structure for CCS

40. As the AD of CCS (2007 – 2016), the following members of staff would have reported directly to me during this timeframe.

a) Head or Service for Cancer Services – Miss Alison Porter (Head of Service) replaced by Mrs Fiona Reddick in 30 June 2012
b) Head or Service for Radiology – Mrs Alexis Davidson replaced by Mrs Jeanette Robinson in 31 March 2013
c) Head or Service for Laboratory – Mr Brian Magee
d) Head or Service for ATICS – Mrs Mary McGeough

e) Head or Service for AHPs – Ms Cathy McElroy
f) Operational Support Lead – Ms Wendy Clayton

41. The management structure describes services and reporting structures pictorially and is located in

*S21 5 of 2022- 20160401 doc RC number 6 Management structure CCS ATICS*

Line management reporting structure for ATICs/SEC

42. As the AD of ATICS and SEC (2016 – present) the following members of staff would have reported directly to me during this time frame

a) Head or Service (HoS) for ATICS – Mrs Mary McGeough replaced by Mrs Helena Murray in July 2017
b) Head or Service for General Surgery – Mrs Amie Nelson
c) Head or Service for Urology, ENT, Ophthalmology and Outpatients – Mrs Martina Corrigan replaced temporarily by Ms Wendy Clayton in October 2020
d) Head or Service for Trauma and Orthopaedics – Mrs Brigeen Kelly
e) Operational Support Lead (OSL) – Ms Wendy Clayton temporarily replaced by Mrs Jane Scott in October 2020

43. The management structure describes services and reporting structures pictorially and is located in:

*S21 5 of 2022- 20220401 doc RC number 6 Management structure SEC ATICS*
*S21 5 of 2022- 20220401 number 6 HOS ENT, Urology, OPD management structure*
*S21 5 of 2022- 20220228 number 6 HOS ENT, Urology, OPD Band 6 and 7 Staff in post*

**[7] With specific reference to *the operation and governance of urology services*, please set out your roles and responsibility and lines of management.**

44. As described in my response to question 6 the lines of management responsibility for Urology Services sits with the Head of Service for Urology reporting directly to me as the AD and I in turn reported directly to the Director of Acute Services as listed in Q6. My role with respect to the operational and governance of Urology service (which overlapped) were to:

a) To work closely with Medical and non-medical managers in the delivery of services to the population in the Southern Trust.
b) To monitor nursing and medical workforces working with the Assistant Directors for Nursing Workforce and Mr Mark Haynes as Associate Medical Director (AMD) now known as Divisional Medical Director (DMD)
c) Responsible for effective financial management and the efficient use of all resources allocated to the Division

d) Responsible for managing, monitoring and escalating each surgical' s specialties performance against the required waiting time access targets for outpatients and inpatient/day cases
e) Modernisation of services and implementation of initiatives when opportunities arise.
f) To ensure systems and processes were in place that enables risks to be identified and managed accordingly. To monitor data, which would identify trends and could identify possible patient safety issues. These trends could include increasing Datix, complaints and / or Serious Adverse Incidents (SAIs),

45. Where risks could not be managed within the Division, the risk would have been escalated to the Director and captured on the Divisional or Directorate Risk Register for example the urology service unable to achieve the performance targets as described in the Integrated Elective Access Protocol (IEAP).

*S21 5 of 2022 – 20160401 excel number 7 April 16 SEC performance risk register*
*S21 5 of 2022 – 20220301 excel number 7 March 22 Divisional risk register*

**[8] It would be helpful for the Inquiry for you to explain how those aspects of your role and responsibilities which were *relevant to the operation and governance of urology services*, differed from and/or overlapped with, for example, the roles of the Medical Director, Clinical Director, Associate Medical Director and Head of Urology Service or with any other role which had governance responsibility.**

46. As the AD with operational responsibility for ATICS and SEC, my role is to ensure that all the specialities (Urology being one) within the Division delivers the best outcomes with respect to performance, finance and governance.
47. I work very closely with the Head of Service for Urology Service discussing these three elements on a monthly basis or as frequently as discussions need to take place or decisions need to be taken in relation to the Urology service.

48. The Medical staff within the Urology service are managed through a medical hierarchical structure, meaning that Consultant Urologists and other medical doctors would report to the Clinical Director upward to the AMD and finally to the Medical Director on professional clinical issues. Medical staff within the Urology Service would attend a monthly specialty meeting which were dedicated to cases being discussed, reviewed, and appropriate actions taken and to be taken (known as Morbidity and Mortality (M&M)). Thereafter a combined Anaesthetics and Surgical M&M is held on a Quarterly basis.

49. There are some collective and shared responsibilities between the AD and DMD, this would be similar for the HOS and CD. Such shared responsibilities are listed at (a) to (n) below. However, the matters at (o) to (u) below are roles within the professional responsibility of the AMD/DMD and the CD.

    a) Staffing and Staff Management

b) Adverse and Serious Adverse Incident Management
c) Litigation and Claims Management
d) Coronial Matters
e) Complaints
f) Patient Safety (Including Infection Prevention and Control)
g) Medications management
h) Research and Development
i) Risk Management / Mitigation and Reduction
j) Learning from Experience
k) Quality Improvement
l) Education, Training and Continuing Professional Development
m) Ensuring Delivery of Effective Evidence-Based Care
n) Patient and Carer Experience and Involvement
o) Professional Performance Management
p) Appraisal and Revalidation
q) Morbidity and Mortality
r) Medical Education in conjunction with DMD/ Dir Med Ed
s) Medical Workforce development
t) Clinical Audit
u) Medical leadership in delivery of MCA and Safeguarding

*S21 5 of 2022- 20220301 question 8 CD General Surgery JD*
*S21 5 of 2022- 20220301 question 8 CD ENT Urology JD*
*S21 5 of 2022- 20210701 question 8 Interim DivMD JD SEC (FINAL)*
*S21 5 of 2022- 20170601 question 8 AMD – SEC job description June 2017*
*S21 5 of 2022- 20151109 question 8 Clinical Director Surgery Elective Care JD*
*S21 5 of 2022- 20220328 question 8 Trust Board Workshop CSCG 28.02.2022*

**Urology services/Urology unit - staffing**

**[9] The Inquiry understands that a regional review of urology service was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. This review was completed in March 2009 and recommended three urology centres, with one based at the Southern Trust - to treat those from the Southern catchment area and the lower third of the western area. As relevant, set out your involvement, if any, in the establishment of the urology unit in the Southern Trust area.**

50. From 2007-2016 I was the Assistant Director for Cancer & Clinical Services and Anaesthetics, Theatres and Intensive Care and I was not directly involved in the regional review and the establishment of Urology unit (other than to ensure 3 session days were provided for theatres to accommodate Urology – refer to my response to Q13).

51. However, as an AD and part of the acute Senior Management Team (SMT) I was aware that the regional review had been undertaken and that a team South was being created. The Director's SMT would have involved themed weekly meetings (week 1 Governance, Week 2 Ad hoc, Week 3 Finance and Human Resources and Week 4 Planning and Reform). As I recall, it would have been at the week 4 meeting where Mrs Heather Trouton (AD SEC at this time) would have provided updates on the implementation plan and progress.

**[10] What, if any, performance indicators were used within the urology unit at its inception?**

52. As these performance indicators would have been discussed and agreed by the project implementation team, which I was not part of, I am unaware of what the indicators were at inception.

**[11] Was the *'Integrated Elective Access Protocol'* published by DOH in April 2008, provided to or disseminated in any way by you or anyone else to urology consultants in the SHSCT? If yes, how and by whom was this done? If not, why not?**

53. The *Integrated Elective Access Protocol* (IEAP) was a regional document published by the Department of Health (DOH). The IEAP was used by all Trusts in Northern Ireland to manage elective services e.g., Outpatients, Inpatient & Day Cases surgery and regional cancer targets. IEAP does reference the red flag cancer pathway targets and is used by the administrative and clerical staff. .

54. The IEAP April 2008 page 15 and updated version in June 2020 page 20 and 21 outlines the regional cancer targets

*Page 15 of S21 5 of 2022 –20080430 doc question 11 Integrated Elective Access Protocol Revised 30apr08*
*Page 20 and 21 of S21 5 of 2022 – 20200601 doc question 11 IEAP June 2020*

55. However, in my role as AD for Cancer performance I would have met with each cancer multidisciplinary team including urology to communicate the new regional cancer guidance, as outlined in '***A guide to cancer waiting times'***. These meetings would have taken place in early 2008. 'A guide to cancer waiting times' was the document used regionally by all Trusts to ensure all patients with a possible cancer diagnosis progressed along the appropriate cancer pathways.

*S21 5 of 2022 – 20080102 doc question 11 A guide to cancer waiting times.*

56. These cancer pathways in Northern Ireland are known as the 31 and 62 days Cancer pathways, both of which would have been applicable to patients with suspect or confirmed urological cancers.

57. I would not have circulated the IEAP or the '***guide to cancer waiting times'*** to Urology Consultants directly, they may have received one or both of these documents from other staff at the time of these roadshow meetings in 2008.

**[12] How, if at all, did the *'Integrated Elective Access Protocol'* (and time limits within it) impact on the management, oversight and governance of urology services? How, if at all, were the time limits for urology services monitored as against the requirements of the protocol? What action, if any, was taken (and by whom) if time limits were not met?**

58. Between 2007 – 2016, I was responsible for the monitoring of the Trust's cancer targets. A Monthly Cancer Access Standard Meeting was held with all Heads of Service and Assistant Directors. The purpose of the meeting was to share the Trust performance against the required cancer targets as described in the IEAP. Actions from these meetings would have been taken forward by the Assistant Director and Head of Urology Services.

59. The Trust would also have met with the Health and Social Care Board (HSCB) to review and discuss our performances against the targets outlined within the IEAP. Unfortunately, the Urology Service was unable to achieve these Cancer targets for several reasons. These reasons included vacant consultants posts, insufficient outpatients slots to accommodate the demand for Red Flag Haematuria (blood in urine) referrals and the corresponding requirement for diagnostic tests in the form of CT and cystoscopy (endoscope into the urinary bladder).

60. Meeting notes and the performance dashboards from April 2012 – March 2016 are referenced below**.**

Table 1 - Urology cancer performance on the 31 and 62 day cancer pathways completed from 2016 to 2022.

| | Cancer 62 day % performance | Cancer 31 day % performance | Total outpatient referrals | Average monthly outpatients referrals | Commissioned outpatient activity per month | Variance of capacity gap |
|---|---|---|---|---|---|---|
| 2016/17 | 80 | 100 | 5121 | 427 | 299 | -128 |
| 2017/18 | 58 | 99.4 | 5965 | 497 | 299 | -198 |
| 2018/19 | 54.8 | 99.3 | 6427 | 536 | 299 | -237 |
| 2019/20 | 42.6 | 98.7 | 6136 | 511 | 299 | -212 |
| 2020/21 | 32.3 | 94.2 | 4484 | 374 | 299 | -75 |
| 2021/22 | 27.4 | 98.15 | 4824 | 402 | 299 | -103 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Average | 49.2 | 98.3 | 5492.8 | 458 | 299 | -159 |

The data for this table is sourced from Business Objects XI (BOXI) query. BOXI is the regional information system.
The table demonstrates that the urology service was unable to achieve the required 62day cancer standard of 95%. This is attributable to the demand for red flag referrals being greater that the capacity within the service to enable patients to have their first definitive treatment by day 62.

*S21 5 of 2022 – 20160401 to 20170331 question 12 Urology cancer 31 and 62 day completed waits*
*S21 5 of 2022 – 20170401 to 20180331 question 12 Urology cancer 31 and 62 day completed waits*
*S21 5 of 2022 – 20180401 to 20190331 question 12 Urology cancer 31 and 62 day completed waits*
*S21 5 of 2022 – 20190401 to 20200331 question 12 Urology cancer 31 and 62 day completed waits*
*S21 5 of 2022 – 20200401 to 20210331 question 12 Urology cancer 31 and 62 day completed waits*
*S21 5 of 2022 – 20210401 to 20220331 question 12 Urology cancer 31 and 62 day completed waits*

61. The Urology performance is discussed at the Urology Cancer MDT Annual General Meeting

*S21 5 of 2022 - 20200101 doc question 12 Urology MDT Business Meeting Jan 2020*

62. By 2016 and becoming responsible for Surgical and Elective Care the performance targets as described in the IEAP and applicable to urology were not being achieved by a significant margin: e.g., the IEAP in 2008 described the performance targets of 9 weeks for outpatients and 13 weeks for inpatient / daycase, and 95% for 62 day cancer target and 98% for 31 day cancer target.

Table 1 - Summary of Urology Access waiting times 2016, 2019 and 2022:

| Specialty | Category | IEAP Target | Waiting time as at 1 April 16 | Waiting time as at 1 April 19 | Waiting time as at 1 April 22 |
|---|---|---|---|---|---|
| Urology | Outpatients | 9 weeks | Red flag = 3.5 wks<br>Urgent = 40 wks<br>Routine = 73 wks | Red flag = 5-7 wks<br>Urgent = 168 wks<br>Routine = 175 wks | Red flag =11 wks<br>Urgent = 312 wks<br>Routine = 319 wks |
| Urology | Inpatient / Daycases | 13 weeks | Urgent = 119 wks<br>Routine = 124 wks | Urgent = 249 wks<br>Routine = 277 wks | Urgent = 399 wks<br>Routine = 398 wks |

63. Recognising that the waiting times as described in the IEAP were being exceeded, several actions were taken:

a) There was a continuous monitoring of the waiting times against targets for Urology Services within the Surgical Division.
b) As the waiting times were far in excess of those targets described in the IEAP the performance target positions were placed on the Directorate Risk Register. The reason for placing it on the risk register was that the solutions required to address the waiting times were greater than that which existed within the Urology Service.
c) At Director level a monthly performance meeting was held with senior members of Trust's Performance team in attendance. At these meetings the waiting times were reviewed and actions taken when possible to address the waiting times. These actions included undertaking 'in-house' additionality. The Urology Service would have been able to undertake in house additionality when it received non recurrent waiting list monies from the HSCB. In-house additionality would have been undertaken by our consultant urologist for outpatient activity, inpatients and or day case activity.
d) The waiting times targets were also addressed by the Trust engaging with the Independent Sector (IS) to undertake agreed volumes of clinical activity. Similar to In-House additionality contracts with the IS could only happen when the Trust received additional non recurrent waiting list monies from the HSCB.

*S21 5 of 2022 - 20160401 to 20220331 Q12 IHA and IS urology funding*

e) Meetings where also held between the Trust and the HSCB at which the waiting times targets were discussed.

Summary of Actions taken:

64. <u>Internal</u>

a) Monthly Performance Heads of Service meeting, attended by the Performance Head of Service for the Southern Trust, examples are located in:
    a. *Relevant to Acute, Document Number 13, 13b, 2016.04.26 Minutes - HOS performance meeting, 2017.03.14 - Minutes - HOS Performance Meeting and 2018.04.26 Minutes - HOS Performance Meeting*
    b. Monthly Performance Acute SMT, attended by the Assistant Director for Performance & Reform
b) Monthly Cancer Performance Meetings
c) Risk register – performance escalated for outpatients, elective and planned waiting times

65. <u>External</u>

a) Health & Social Care Board Performance meetings at which Urology (amongst many other specialties) where discussed. Evidence can be sourced at;
*S21 5 of 2022 –20150501 Qu. 12 Actions Issues register – HSCB SHSCT ED and elect dir mtg*
*S21 5 of 2022 –20160614 Qu 12 Prep and action notes – HSCT SHSCT service issues and perf mtg*
*S21 5 of 2022 –20160921 Qu 12 Internal prep notes – HSCT SHSCT service issues and perf mtg*
*S21 5 of 2022 –20170530 Qu 12 Internal prep notes – HSCT SHSCT service issues and perf mtg*
*S21 5 of 2022 –20170530 Qu 12 Internal prep notes – HSCT SHSCT service issues and perf mtg A1*
*S21 5 of 2022 –20180523 Qu 12 Internal prep notes – HSCT SHSCT service issues and perf mtg*
*S21 5 of 2022 - 20180523 Q12Internal Prep Note - HSCB SHSCT Service Issues and Performance Meeting A1*
*S21 5 of 2022 - 20180523 Q12 Internal Prep Note - HSCB SHSCT Service Issues and Performance Meeting A2*
*S21 5 of 2022 –20200923 Qu 12 Internal prep notes – HSCB SHSCT Service Issues and Performance Meeting*
*S21 5 of 2022 – 20160921 Qu 12 HSCB SHSCT Services issues and perf mtg*
*S21 5 of 2022 – 20160226 Q12 Internal Prep Notes HSCB SHSCT Mtg*

**[13] The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog.**

**I. What is your knowledge of and what was your involvement with this plan?**

66. The Regional Plan published in Jun 2010 and the subsequent Team South Implementation Plan published in November 2010 were both developed at a time when I had no operational management responsibility for Urology Services. I had no involvement in the development or implementation of either plan nor the Trust's plan to deal with any backlog. At the time of the Team South Implementation Plan (2010/2011) I was AD for CCS which included responsibility for theatres and I recall being instructed by Dr Rankin to provide extended operating sessions ( 3 session days within theatres at CAH) to accommodate additional inpatient operating need for Urology. These extended operating days commenced in January 2013 (Tuesday and Wednesday), increasing to thrice weekly in December 2014 (Monday, Tuesday and Wednesday) but ceased in January 2018.

67. This was the extent of my involvement at that time.

**II. How was it implemented, reviewed and its effectiveness assessed?**

68. I assume that Dr Gillian Rankin (Acute Director), Mrs Heather Trouton (AD) and Mr Eamon Mackle (AMD) would have had responsibility for the implementation, review and effectiveness assessment of the plan. I had no role in the Trust's review or effectiveness assessment of the Regional review for Team South in 2010/2011. My only role in the Trust's implementation of the Plan was to provide 3 session days for theatre, which was done.

**III. What was your role in that process?**

69. Please see response to Question 13(II).

**IV. Did the plan achieve its aims in your view? OR Please advise whether or not it is your view that the plan achieved its aims? If so, please expand stating in what way you consider these aims were achieved.**

70. In 2010 when I had responsibility for theatres, I knew that 3 session days for theatres was in operation to accommodate Urology. In April 2016 when assuming role as AD for ATICs /SEC I would not have been aware of the aims of the Regional Review of Urology Services, or Team South Implementation Plan as published in 2010 or whether the targets were being met at that time. Neither the Regional Review of Urology Services nor the Team South Implementation Plan as published in 2010 documentation was shared with me upon my appointment as AD in April 2016. I received both documents for first time on April 29, 2022.

71. However, now having had sight of the Team South Implementation Plan I can confirm that the following elements were in place in April 2016 when I became AD. These included:

a) The main acute elective and non-elective inpatient unit for Team South was in operation at Craigavon Area Hospital
b) Day surgery for Urology was being undertaken at Craigavon and South Tyrone.
c) Outpatient clinics were being held at Craigavon, South Tyrone, Armagh Community Hospital, Banbridge Polyclinic and the Erne Hospital (Daisy Hill had ceased upon retirement of Mr Robin Brown).
d) All outpatient referrals were directed to Craigavon Area Hospital.
e) Suspected cancer referrals were being appropriately marked and recorded.
f) Consultant led sessions were being provided over 42 weeks.
g) Six Consultant Urologists were in place (The Team South Implementation Plan proposed 5)
h) Two CNS were in post (had been in post since 2005).

72. However, now having had sight of the Team South Implementation Plan I can confirm that the following elements were not in place in April 2016 when I became AD. These included:

a) Nurse led/ICATS sessions were not being provided

**[14] Were the issues raised by the *Implementation Plan* reflected in any Trust governance documents or minutes of meetings, and/or the Risk Register? Whose role was to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.**

73. By April 2016 when I was appointed as AD the Implementation group to introduce Team South had ceased. I believe this group ceased to meet in 2011. However, the access waiting times for urology in April 2016 were as follows:

Table 1 Urology Access Waiting Times at April 2016

| Specialty | Category | IEAP Target | Waiting time as at 1 April 16 |
|---|---|---|---|
| Urology | Outpatients | 9 weeks | Red flag = 3.5 wks<br>Urgent = 40 wks<br>Routine = 73 wks |
| Urology | Inpatient / Daycases | 13 weeks | Urgent = 119 wks<br>Routine = 124 wks |

74. These access waiting times were recognised to be far in excess of the IEAP Target and were recorded on the Divisional Performance Risk Register of April 25th 2016 - Item No 3

*S21 5 of 2022- 20160401 question 14 performance risk register*

**[15] To your knowledge, were the issues noted in the Regional Review of Urology Services, Team South Implementation Plan resolved satisfactorily or did problems persist following the setting up of the urology unit?**

75. On recent review (April 29, 2022) I understand the basis of the Plans was to address concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. Given the waiting times in the table above, as of April 2016 when structures within acute services were changed and I became responsible for Urology Services, it was evident that the Urology Services continued to have excessively long waiting times which significantly exceeded the IEAP Targets. The issues, which were highlighted, have continued through to current day.

**[16] Do you think the unit was adequately staffed and properly resourced from its inception? If that is not your view, can you please expand noting the deficiencies as you saw them?**

76. I am unable to respond prior to 2016. In 2016 the Urology Services were funded to have 6 Consultant urologists and at this time all six posts were filled by Mr A O' Brien, Mr M Young, Mr A Glackin, Mr J O'Donoghue, Mr Suresh and Mr M Haynes.

77. Supporting and working very closely with the consultant urologists were the urology services Clinical Nurse Specialists (CNS). Funding at this time were for two (2) and two were in post, Mrs Kate O' Neill and Mrs Jennifer McMahon.

78. Urology in-patient services (emergency and elective) were accommodated on ward 3 South (31 beds). This ward also accommodated ENT Services. The 'normative nurse staffing' (regional nursing workforce tool) compliment for this ward was 47.19 whole time equivalents (WTE). This staffing compliment of 47.19WTE combined trained and untrained staff on a 70/30 percentage split.

79. The Urology Services were staffed to the level funded by the HSCB.

80. Concerning the excessively long waiting times for all Urology Services the staffing resources available were insufficient to meet the demand on the Urology Services. These inadequate resources applied to Consultants and supporting middle grade medical staff, CNS's and operating time. Operating time per consultant was 1 all day in-patients list and 1 day case list weekly both of which were inadequate to meet the demand. However, it should be noted that the physical theatre capacity available would not have been able to accommodate more Urology operating sessions.

81. For 3 South the nursing workforce compliment was sufficient for the commissioned 31 beds. The challenge for 3 South was the number of vacant nursing positions unfilled resulting in an over reliance on nursing agencies providing the nursing staff, both trained and untrained.

**[17] Were you aware of any staffing problems within the unit since its inception? If so, please set out the times when you were made aware of such problems, how and by whom.**

82. While I was not directly involved with the unit until April 2016, as a member of the SMT from 2007 I would have been present at performance meetings wherein it was apparent that demand for urology was unabating and exceeding the capacity available. Over the course of the period post my appointment as AD SEC, a number of additional appointments were made – I refer to my response to Question 18 below.

**[18] Were there periods of time when any posts within the unit remained vacant for a period of time? If yes, please identify the post(s) and provide your**

**opinion of how this impacted on the unit. How were staffing challenges and vacancies within the unit managed and remedied?**

83. In April 2016 all Consultants and CNSs were held by permanent appointments.

84. In late 2018 the Trust secured non recurrent funding to appoint their 7th Consultant urologist. Mr Matthew Tyson was appointed Feb 2019, however, Mr Tyson wished to undertake a fellowship in New Zealand. The secondment was approved and Mr Tyson left in August 2019. While he completed his fellowship in July 2020 with the Covid-19 pandemic he was unable to return to work in the urology service at CAH until October 2021. During the time Mr Tyson was away undertaking his Fellowship, the Urology Service engaged with medical agencies to appoint Locum Urology Consultants.

85. In June 2020 Mr O'Brien retired leaving a vacant consultant urologist position.

86. Unfortunately, despite advertising on 3 occasions the post remains vacant.

87. Currently there are 5 permanent Consultant Urologists constituting 4.3WTEs - Mr Young, Mr Glackin, Mr O'Donoghue, Mr Haynes (0.3WTE to Southern Trust plus 2 days in Belfast HSC Trust) & Mr Tyson - and 2 vacant WTE consultant posts. Mr Young is retiring May 2022, which will reduce the number to 3.3WTE permanent Consultants.

88. Attempts to recruit permanent Consultant urologist into our urology service has not yielded a positive outcome.

89. Reasons for this include that a small urology team (this applies to any medical specialty) leaves the service very vulnerable to workforce gaps. It means the frequency of 'on-call' is increased and whilst this would be reflected in their salary for some prospective consultants this maybe too frequent. The training numbers commissioned by the N. Ireland Medical and Dental Agency (NIMDTA) would appear insufficient to meet the needs of all the urological units in N Ireland. Anecdotally consultants preference is to be within a team that has a full range of allied supporting specialties, e.g., interventional radiology being a big advantage for urology services. Please refer to Slide 19 which details the workforce for each urology Service in each Trust as of current day -

*S21 5 of 2022- 20220401 Q18 Urology Demand Capacity Review Slides*

90. Only 1 x Trust (Western) is fully staffed and not reliant on Locum Consultants with the Southern Trust are particularly impacted with negatives variances across all medical and nursing staff.

91. Again, I believe it is prudent to state that whilst we have been challenged to recruit consultant urologists the Trust is equally challenged to recruit to other medical specialties radiology, pathology, and general surgery to name but a few.

92. Surgeons are attracted to positions that allow them to operate as per their job plans. However, due to regional workforce deficits in nursing and the little to no exposure during their undergraduate training it is exceptionally difficult to attract new registrants into theatre and recovery within the Southern Trust. At the time of writing this submission there are 35WTE registered nurses (band 5) vacant positions.

**Table 1 Advertisements**

| NO. OF TIMES ADVERTISED | DATE ADVERTISED | NORMAL ADVERTISING | APPLICATIONS RECEIVED | ENHANCED ADVERTISING |
|---|---|---|---|---|
| Temporary Consultant Urologist | 24/11/2016 | | No Applicants | |
| Consultant Urologist | 10/01/2017 | | No Applicants | |
| Consultant Urologist | 02/10/2018 | | Mr Matthew Tyson Started post 25/02/2019 | |
| 1 | March 2021 | Social Media Platforms<br>Jobs.hscni.net<br>BMJ website<br>BMJ Journal | 0 | |
| 2 | May 2021 | Social Media Platforms<br>Jobs.hscni.net<br>BMJ website<br>BMJ Journal | 2 (interviewed & not appointable) | |
| 3 | October 2021 | Social Media Platforms<br>Jobs.hscni.net<br>BMJ website | 2 (interviewed & not appointable) | |

| | | | | |
|---|---|---|---|---|
| | | BMJ Journal | | |
| 4 | February 2022 | Social Media Platforms<br>Jobs.hscni.net<br>BMJ website<br>BMJ Journal | 0 | ➢ BMJ website – Top Job |
| 5 | April 2022 | Social Media Platforms<br>Jobs.hscni.net<br>BMJ website<br>BMJ Journal | Closing date: 10 May 2022 | ➢ Irish Medical Times<br>➢ BMJ website enhancements Top Job<br>Premium job<br>Promoted Job<br>Target email to 150 registered candidates<br>CV database search<br>➢ BMJ website in Australia & New Zealand |

**These Consultant Urologist posts have also been shared with all the contracted agencies for the International Medical Recruitment project and a number of non-contracted agencies that deal with permanent / long term recruitment.**

93. For the recent advertisements we made enhancements on the BMJ website which included tagging the BMJ website with Australia and New Zealand. A target email has also been distributed to 150 registered candidates who have requested to be contacted in relation to Urology posts to extend the reach of the recruitment campaign. Enhancements such as expenses associated with

relocation have been detailed in the Job description.

*S21 5 of 2022– 20220503 Q18 Email Consultant Urologists Recent Advertisement*

*S21 5 of 2022- 20220503 Q18 Word Doc CONSULTANT UROLOGIST RECENT ADVERTISING*

94. Please refer to Slide 19 which details the workforce for each urology Service in each Trust as of current day – *located in S21 5 of 2022 S21- Q18 Urology Demand Capacity Review.* Only 1 x Trust (Western) is fully staffed and not reliant on Locum Consultants with the Southern Trust are particularly impacted with negatives variances across all medical and nursing staff.

**Table 2 – Locum recruitments**

| First Name of Doctor filling booking | Surname of Doctor filling booking | Start Date | Expected End Date | Reason for Locum |
|---|---|---|---|---|
| **Thomas** | **Jacob** | 03/01/2017 | 04/01/2019 | Replaced Mr Suresh |
| **Gyorgy** | **Solt** | 15/07/2019 | 13/09/2019 | Replaced Mr Suresh |
| **Tamas** | **Fel** | 01/07/2020 | 04/09/2020 | Mr Tyson on sabbatical |
| **Shawgi** | **Razig Omer** | 21/09/2020 | 30/06/2021 | Backfill AOB |
| **Saifeldin** | **Elamin** | 19/07/2021 | 02/08/2021 | Backlog clearance clinics only |
| **Shawgi** | **Omer** | 16/08/2021 | 30/10/2021 | Backfill AOB |
| **Nasir** | **Khan** | 02/11/2020 | Still in post | Backfill Con 7 |

95. The impact of not having a full complement of Consultant Urologists is that it places greater pressure on the remaining Consultants, non-consultant grades (Urology service has 2 Specialty Doctors) and junior medical staff as the demand for both emergency and elective work remains undiminished. Having Locum medical consultants presents particular challenges in terms of costs and operational limitations e.g. if operating they may no longer be working as locum within the Trust when the patient is due a review appointment.

96. Recognising the considerable pressure the Urology Service was under the Trust have recruited additional junior middle grade doctors (known as Clinical Fellows) from August 2020 and 0.5 whole time equivalent (18 ¾ hours) Physician Associate from 20 September 2021.

97. In 2019, the CNS workforce was increased by one through funding from Macmillan. In 2020, through new HSCB funding CNS posts increased by a further two. The impact of now having 5 x CNS has allowed the CNSs to undertake work previously undertaken by medical staff, e.g., cystoscopy (endoscope into the urinary bladder), allowing patients suspected of having cancer to have their diagnostic tests more timely. As part of the cancer standards it allows patients to be allocated their 'key worker' - which is the CNS.

98. The 5 CNSs and their dates of appointment are as follows:

a) Jenny McMahon 04.07.2005
b) Kate O'Neill 04.07.2005
c) Leanne McCourt 01.03.2019
d) Patricia Thompson 03.08.2020
e) Jason Young 31.08.2020

99. On ward 3 South there were several registered nurse (RN) and Heath Care Assistant (HCA) vacancies. This was and continues to be a chronic problem for several reasons as listed below:

a) The Northern Ireland nursing recruitment challenges has meant there are not enough RNs to allow all wards to have their nursing positions filled.
b) The unrelenting pressure of emergency medical admissions resulted in many medical patients being admitted into the beds on 3South. For some nurses they did not wish to be 'medical' nurses and so left to work in other surgical wards in the hospital.
c) Over several years the Ward lost its Urology/ENT identity and became largely a medical ward.
d) The financial incentive to leave the Health Service and join nursing agencies is very attractive to nurses.
e) Increased numbers of nurses requesting to work flexibly to achieve a better work life balance.

**[19] In your view, what was the <u>impact</u> of any staffing problems on, for example, the provision, management and governance of urology services?**

100. The tables presented in my response to Question 12 demonstrate the increase in waiting times from 2016 to 2022 in 3 year intervals. The factors that have contributed include an increased demand on the service along with an inability to achieve the 7 x Consultants at any time over this 6 year period (funding for the 7th consultant having come in 2022). In fact, the Consultant

levels have decreased to a current level of 4.3WTEs despite multiple recruitment campaigns, with the position expected to deteriorate further with the pending retirement of Mr Young. Not having a full complement of Consultants and ward-based nurses has an impact on the overall Urology service and the staff remaining as the demand for Urology Services both emergency and elective goes undiminished.

101. On 3 South the impact of not having a full complement of permanent staff and an over reliance on locum nurses could be evidenced by poor Nursing Quality Indicators (NQIs) which reflect core aspects of nursing care such as:

a) omitted or delayed medicines,
b) poor compliance with skin bundles (measures which should be implemented for patients who are assessed as being at risk of developing pressures),
c) compliance with NEWS ( **N**ational **E**arly **W**arning **S**core which helps identify patients who may be ill) and
d) an increased number of incident reporting (Datix) year on year

Table 1 DATIX submitted for Ward 3 South over 6 year period.

| **Year** | **Total** |
|---|---|
| Apr16 - Mar 17 | 172 |
| Apr17 - Mar 18 | 203 |
| Apr18 - Mar 19 | 210 |
| Apr19 - Mar 20* | 249 |
| Apr20 - Mar 21* | 321 |
| Apr21 - Mar 22* | 376 |

*Medical Ward

102. Although it must be highlighted that for the last three years approximately 3 South has had to be re-profiled to being a medical ward as a consequence of the COVID-19 pandemic.

*S21 5 of 2022 – 20181201 doc question 19 3 South Risk assessment*

<u>Performance</u>

103. Less staff results in fewer patients being assessed or reviewed within appropriate clinical timeframes:

a) Waiting lists grew in weeks waiting for both outpatients and inpatients / daycases;

b) Number of patients waiting on the total patient target lists grew year on year;
c) Cancer performance – Please see response to Question12;
d) Complaints / MLA queries;
e) In addition, there has been a yearly increase in Datix / incident reporting which is an indicator of more incidents occurring at ward level.

**Table 1 Comparison of Waiting Times per Surgical Specialty in Southern Trust (2016 to 2022)**

| Specialty | | **Waiting time as at 1 April 16** | **Waiting time as at 1 April 19** | **Waiting time as at 1 April 22** |
|---|---|---|---|---|
| Urology | Outpatients | Red flag = 3.5 wks<br>Urgent = 40 wks<br>Routine = 73 wks | Red flag = 5-7 wks<br>Urgent = 168 wks<br>Routine = 175 wks | Red flag =11 wks<br>Urgent = 312 wks<br>Routine = 319 wks |
| Urology | Inpatient / Daycases | Urgent = 119 wks<br>Routine = 124 wks | Urgent = 249 wks<br>Routine = 277 wks | Urgent = 399 wks<br>Routine = 398 wks |
| GSUR | Outpatients | Red flag = 3 wks<br>Urgent = 28wks<br>Routine = 41 wks | Red flag = 4-5 wks<br>Urgent = 78 wks<br>Routine = 129 wks | Red flag = 6-7 wks<br>Urgent = 169 wks<br>Routine = 260wks |
| GSUR | Inpatient / Daycases | Urgent = 56wks<br>Routine = 77 wks | Urgent = 165 wks<br>Routine = 179 wks | Urgent = 161 wks<br>Routine = 175 wks |
| ENT | Outpatients | Red flag = 2 wks<br>Urgent = 17 wks<br>Routine = 41 wks | Red flag = 1-2 wks<br>Urgent = 58 wks<br>Routine = 96 wks | Red flag = 5 wks<br>Urgent = 230 wks<br>Routine = 321 wks |
| ENT | Inpatient / Daycases | Urgent = 9 wks<br>Routine = 32 wks | Urgent =249 wks<br>Routine = 131 wks | Urgent = 393 wks<br>Routine = 261 wks |
| Orthopaedics | Outpatients | Urgent = 44 wks<br>Routine = 59 wks | Urgent = 94 wks<br>Routine = 125 wks | Urgent = 185 wks<br>Routine = 310 wks |
| Orthopaedics | Inpatient / Daycases | Urgent = 26 wks<br>Routine = 88 wks | Urgent = 186 wks<br>Routine = 165 wks | Urgent = 453 wks<br>Routine = 465 wks |

**Table 2 Patient Review Backlog for all Surgical Specialties**

| **TOTAL RBL** | | | |
|---|---|---|---|
| **SPEC** | **Apr-16** | **Apr-19** | **Apr-22** |
| **Urology** | 2021<br>June 2013 | 2711<br>April 2015 | 1368<br>July 2013 |
| **General Surgery** | 2839<br>December 2012 | 3520<br>April 2016 | 3253<br>March 2017 |
| **ENT** | 979<br>August 2013 | 2499<br>March 2016 | 1301<br>August 2017 |
| **Ortho** | 738<br>April 2014 | 844<br>May 2014 | 283<br>January 2017 |

**Table 3 Urology OPD Demand v activity v Commissioned Volumes**

| | Average monthly outpatients referrals | Average monthly outpatients activity | Commissioned outpatient activity per month |
|---|---|---|---|
| 2017/18 | 497 | 316 | 299 |
| 2018/19 | 536 | 321 | 299 |
| 2019/20 | 511 | 251 | 299 |
| 2020/21 | 374 | 143 | 299 |
| 2021/22 | 402 | 155 | 299 |
| Average | 458 | 237 | 299 |

104. When one is considering Urology performance it is prudent to note that the challenges were common to multiple surgical specialties with a common theme being demand outstripping capacity, which in the last 2 years has been further negatively impacted by the challenges presented by the COVID-19 pandemic in particular on all elective activity. Nonetheless, focussing on Urology, while demand has increased my view is that there is no doubt that not having a full complement of an appropriate workforce and infrastructure (theatres) to better meet that increased demand has resulted in a yearly increase in patients waiting to be seen and treated within the Urology service.

**[20] Did staffing posts, roles, duties and responsibilities change in the unit during your tenure? If so, how and why?**

105. In 2019 funding for a 6th consultant post was achieved.

106. In 2022 funding for a 7th consultant post was achieved.

107. In 2019 funding for a 3rd CNS was achieved.

108. In 2020 funding for a 4th & 5th CNS was achieved.

109. In September 2021 recruitment of 0.5 whole time equivalent (18 ¾ hours) Physician Associate (PA) was achieved. The role of the PA is to support

Junior Medical staff by undertaking certain tasks such as patient assessment and admission and preparing documentation to enable prompt discharge.

110. Most recently in November 2021 Consultants job plans have been reviewed and updated to reflect additional responsibilities associated with ensuring higher degree of governance was achieved within the urology service

a) Patient safety lead – Mr O Donoghue 0.485PA
b) Standards and Guidelines lead – Mr Tyson 0.5PA
c) Quality Improvement lead - Mr Tyson 0.5PA
d) Cancer MDM lead – Mr Glackin 1.0PA
e) Rota Co-ordination lead – Mr Young 0.5PA

*S21 5 of 2022 – 20211101 to 20220531 Q20 Urology consultant job plans*
*S21 5 of 2022 – 20220601 Q20 Urology consultant job plans*
*S21 5 of 2022 – 20210401 Q20JP overview AG*
*S21 5 of 2022 – 20210401 Q20JP overview JOD*
*S21 5 of 2022 – 20211025 Q20JP overview MT*
*S21 5 of 2022 – 20211101 Q20JP overview MH*
*S21 5 of 2022 – 20211101 Q20JP overview MY*

111. In 2019 a Clinical Sister (Band 6) was appointed to have responsibility for the day to day running of the Thorndale Unit. This allowed the CNS's to concentrate on working both independently and alongside the medical staff to enable patients to be reviewed and progress to be made along the urology benign and cancer pathways.

112. In 2019 a Nursing Practice Educator (Band 7) was appointed for surgical wards, with an initial emphasis being placed on 3South.

113. This senior clinical nursing post was to enable new RN's and overseas RN's to be better supported in the preceptorship period (initial 6 months after qualifying) and the early years after qualifying

**[21] Has your role changed in terms of governance during your tenure? If so, explain how it has changed with particular reference to urology services, as relevant?**

114. My role with respect to governance has not changed either formally or informally, rather I can assert that it has been increasingly challenging since April 2016 with significant increases in clinical demand against a backdrop of pressures associated with not having a full complement of staff throughout the urology service and infrastructure.

115. My role has been to ensure urology services best meet the needs of patients through having the urology staff work within the systems and

processes in place to enable all the required standards associated with governance to be achieved: For example;

a) Securing learnings from complaints and incident reporting system (Datix) and having a process in place that enables the early identification of serious risk and initiating the serious adverse incident system.
b) Placing intractable challenges such as performance for the urology service on the risk register
c) Through having our acute performance meetings and highlighting the Urology performance status to the Trust's SMT and the HSCB this enabled additional resources and funding to help address the very long waiting times associated with the urology service.
d) Engaging with the HSCB for additional funding to increase the Consultant headcount from 5 to 7 and CNS headcount from 2 to 5 (albeit acknowledge that re Consultants we have not achieved the funded complement of 7 at any time).
e) Appointing a new education nursing resource in the form to the Practice Educator.
f) Immediately acting on the governance concerns expressed by Mr Glackin in his 2016 email to Tracey Boyce and the email from Mr Haynes in 2016 to myself (both referred to in further detail in my response to Question 48 below).

**[22] Explain your understanding as to how the urology unit and urology services were supported by non-medical staff. In particular the Inquiry is concerned to understand the degree of administrative support and staff allocation provided to the medical and nursing staff. If you not have sufficient understanding to address this question, please identify those individuals you say would know.**

116. From 2007 to 2014, the administrative staff (clerical and secretarial) were managed within each Division's portfolio of staff. However, in 2014, this changed and all these staff were realigned to the Functional Services Division. The AD for Functional Services is Mrs Anita Carroll.

**[23] Do you know if there was an expectation that administration staff would work collectively within the unit or were particular administration staff allocated to particular consultants? How was the administrative workload monitored?**

117. It would be my view that administration staff need to work collectively. By that I mean they would cover the work that needed to be completed if other administration staff were unavailable, for whatever reason e.g. sick leave or annual leave.

118. It is my understanding and experience that each consultant is assigned their 'own' personal secretary, as an essential component in their role being as

effective as it needs to be is that the secretary understands how the consultant works from an administrative perspective.

119. I received the SEC backlog report from Mrs Anita Carroll's team. This report provides a high level summary of:

a) Dictation still outstanding per consultant
b) Typing to be complete by the secretary
c) Outstanding filing

*S21 5 of 2022 – 20210931 question 23 Backlog report all specialities monthly total*
*S21 5 of 2022 – 20211230 question 23 Backlog report all specialities monthly total*
*S21 5 of 2022 – 20220330 question 23 Backlog report all specialities monthly total*

120. These SEC backlog reports are issued monthly and have been since at least 2013, to my knowledge, to ADs, Heads of Service and Consultants. I was not informed by the AD, Heather Trouton, that these reports could be or were being used to monitor the Secretarial staff workload and throughput or the Consultants', including Mr O'Brien's, administrative practices. It is only in recent years that these have been used as a tool to monitor both the Secretarial staff and the Consultants' administrative workload. I was not aware that these reports had flagged up any concerns prior to April 2016. In April 2016 this report would have been unfamiliar to me as I would not have used the report within CCS and I was not actively reviewing it at the start of my tenure. In February 2017 when Mr O'Brien returned to work his administrative practices, as detailed in the action plan, were being monitored by Mrs Corrigan.

**[24] Were the concerns of administrative support staff, if any, ever raised with you? If so, set out when those concerns were raised, what those concerns were, who raised them with you and what, if anything, you did in response.**

121. I do not recall any concerns in regard to the administrative support to the urology consultants. What was raised with me very recently (14th April 2022) was a request from the Urology Consultants to have a urology specialty scheduler appointed. This request is currently being progressed.

*S21 5 of 2022 – 20220601 question 14 Urology Team Meeting NOTES 14/04/2022*
*S21 5 of 2022 –20220414 question 14 Urology Team Meeting NOTES 14.04.2022 A1*
*S21 5 of 2022 - 20220414 question 14 Urology Team Meeting NOTES 14.04.2022 A2*

**[25] Who was in overall charge of the day to day running of the urology unit? To whom did that person answer, if not you? Give the names and job titles for each of the persons in charge of the overall day to day running of the unit and to whom that person answered throughout your tenure.**

122. On a day to day basis the Head of Service for Urology was responsible for the running of the urology service Mrs Martina Corrigan 2016- October 2020 then Ms Wendy Clayton October 2020 to present. Both these staff reported directly to myself.

a) In the urology unit the Outpatient Clinical Sister Dolores Campbell reports to Joanna Percival, Outpatient Manager
b) On the ward 3 South the ward sisters were Caroline Caddell, Gayle Magill and then Laura White. The ward sister reports to their Lead Nurse, in turn they have been Mrs Gillian Henry then Mrs Sarah Ward and currently Mrs Paula McKay
c) CNS's – all 5 x CNS's report to the Lead Nurse, Mrs Gillian Henry then Mrs Sarah Ward and currently Mrs Paula McKay
d) Medical Staff (Consultants, staff grade and Doctors in Training) report up through the medical management lines for clinical and professional issues to Mr Young as the Urology lead then Mr McNaboe as the CD and Mr Haynes as AMD. Mr Haynes has become the Divisional Medical Director (DMD) for Quality Improvement (QI) and Mr Haynes's Operational DMD position has been filled by Mr McNaboe.

**[26] What, if any role did you have in staff performance reviews?**

123. As Assistant Director I have undertaken performance reviews of those staff have reported directly to me, namely, Mrs. Martina Corrigan and Ms Wendy Clayton.

124. These reviews included a review of mandatory training as applicable to their role, a review of the previous year and the objectives set and then agreed objectives for the incoming year.

a) With April 2016 being my first year with responsibility for SEC I did not undertake performance review as I was new to managing Mrs Corrigan and unable to provide an assessment of her performance
b) Attached is PDP 2017 for Martina Corrigan
c) During 2018 Martina Corrigan went on Personal Information redacted by the USI leave from June and November- no performance review was undertaken
d) Attached is PDP 2019 for Martina Corrigan
e) With the Covid-19 Pandemic, I did not undertake any performance reviews for the year 2020. I can confirm that the Trust's appraisal percentage for staff on Agenda for Change Terms and Conditions (AfC) for the years 2019 – 2021 was as follows - April 2019 60%, March 2020 58%, and March 2021 39%. AfC terms apply to all staff excluding Medical staff. These percentages show that many appraisals across the Trust were not being undertaken during the Pandemic.
f) Attached is PDP 2021 for Wendy Clayton

*S21 5 of 2022 – 20210613 doc question 26 KSF 21.22 signed WC*
*S21 5 of 2022 – 20190627 question 26 KSF 19.20 signed MC*
*S21 5 of 2022 –20170825 question 26 KSF 17.18 signed MC*

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

125. I was subject to a yearly Personal Development Plan (PDP) with my Director. The format was a review of mandatory training as applicable to my role, to review the previous year's objectives and then to agree the incoming year's objectives. I also include the Divisional Work Plan which describes agreed work plans for every speciality contained with the ATICs/SEC division.

*S21 5 of 2022 – 20190601 question 27 over ATIC SEC performance workplan*
*S21 5 of 2022 – 20190903 question 27 AD PDP 19.20*
*S21 5 of 2022 – 20190903 question 27 AD PDP 19.20 work plan A1*
*S21 5 of 2022 – 20210613 question 27 AD PDP 21.22*
*Attached embedded in 21.22 PDP is the same work plan for 19.20*

**Engagement with unit staff**

**[28] Describe how you engaged with all staff within the unit. It would be helpful if you could indicate the level of your involvement, as well as the kinds of issues which you were involved with or responsible for within urology services, on a day to day, week to week and month to month basis. You might explain the level of your involvement in percentage terms, over periods of time, if that assists.**

126. In my role as Assistant Director, I engaged and spoke with Mrs Corrigan and Ms Clayton on a regular basis daily or every other day on operational matters, e.g. staffing challenges/shortages.

127. Monthly, I would have a meeting (1:1) with the Urology Head of Service to review Urology and ENT services. At this meeting, which was themed, together we would discuss operational issues, performance, sickness, recruitment, service improvement, finance, training, governance and other. This meeting would last for approximately 1hour

128. The following documents are the record of 1:1 meetings:

*S21 5 of 2022 – 20180621 Q28 Head of Service 1 to 1*
*S21 5 of 2022 – 20190228 Q28 Head of Service 1 to 1*
*S21 5 of 2022 – 20210309 Q28 Head of Service 1 to 1*

129. I also held a weekly Divisional Business meeting that was themed (Week 1 Governance, Week 2 Ad hoc, Week 3 Finance and HR and Week 4 Performance). Present at these meetings were all the Heads of Service, Lead Nurses, Operational Support Lead and, when possible, the AMDs. This meeting would last approximately 1.50 hours.

130. For support to the entire Urology team I was part of the senior managers group to meet with the urology team. These meetings were held with the Chief Executive (Shane Devlin), Medical Director (Dr Maria O'Kane) and Director of Acute Services (Melanie McClements) and the urology team.

*S21 5 of 2022 – 20201215 Q28 Urology team group minutes (15 Dec 2020)*
*S21 5 of 2022 – 20201208 Q28 Urology team group minutes (15 Dec 2020)*
*S21 5 of 2022 – 20210216 Q28 Urology team group minutes 16.02.2021*
*S21 5 of 2022 - 20210216 Q28 Urology Team Group Minutes 16.02.2021 A1*
*S21 5 of 2022 – 20210112 Q28 Urology team group minutes A1*

131. I visited the wards and departments and spoke with ward sisters and CNSs, 2 to 3 times per annum. These walk around meetings were general in nature and mostly focused on the busyness, pressures and everyday challenges they faced.

132. However, these visits could not be accommodated safely during Covid - 19 and were suspended.

133. During the height of the Covid19 Pandemic ranging from approximately December 2019 through January 2022, a great deal of my time was directed towards the increased requirement to provide additional intensive care beds in CAH to meet the regional critical care expansion plan. In order to release the nursing staff approximately 80-90% of all elective activity was stopped and staff redeployed to intensive care which expanded from 7 to 16 intensive care beds.

134. Within Acute Services, we had a role known as the Assistant Director of the Week (ADoW). When you were rostered to be the ADoW this role involved deputising for the Director if she was unavailable e.g., on annual leave and overseeing the patient flow function, chairing daily bed flow meetings and endeavouring to have beds or a plan for beds before leaving the hospital at 6pm. The ADoW was for each AD one full working week every 6weeks.

135. Along with the ADoW role each AD partook in the on-call rota which involved being available on the out of hours period to provide advice or guidance to the onsite staff. The frequency of this commitment was one night weekly (16hrs) or one full day if rostered at the weekend (24hrs)

136. Notwithstanding the above narrative, I have remained accessible to anyone who needs to communicate with me either face to face, via phone or via email.

137. Due to the number of specialities and service areas within ATICs/ SEC, attending meetings and attending to 150+ emails daily the allocation time to urology services would be between 5-10% of my working week.

**[29] Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.**

138. As the AD I hold monthly one to one (1-1) meetings with the urology Head of Service Mrs Corrigan and later Ms Clayton. The meeting lasted 1-1.50hrs.

139. The Urology Head of Service held a weekly/Monthly operational specialty meeting with all the members of the urology multi-disciplinary team. This meeting chaired by the Head of Service discussed items such as urology performance in respect to waiting times, service improvements, complaints and any SAI, staffing challenges and recruitment updates. I attended no more than once each year. My presence at the meeting was primarily to listen and answer questions that were asked off myself.

140. As part of all surgical specialties using theatres, a monthly 'Theatre Users' group was held. Mr Young represented urology on this group.

*S21 5 of 2022 – 20161201 Q29 THUGs notes*
*S21 5 of 2022 – 20170302 Q29 THUGs notes*
*S21 5 of 2022 – 20181206 Q29 THUGs notes*
*S21 5 of 2022 – 20190404 Q29 THUGs notes*

**[30] During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.**

141. My view was that the medical managers and operational managers worked well together.

142. Regularly (2-3 weekly) I would have observed urology consultants meet with Mrs Corrigan and Ms Clayton.

143. I am aware that the Head of Service met with Mr Young as the Clinical Lead for Urology. They would plan the rota at the beginning of each month for outpatients & theatres.

144. Their Head of Service would also have chaired their specialty meeting and would have endeavoured to address issues / challenges they may have had, e.g. operational issues such as triaging, clinic numbers, gaps in the rota, progressing with any initiatives.

145. Initiatives such as the redesign of the stone treatment service was clinically led but Mrs Corrigan contributed to the proposal paper and was a member of the core team – as evidenced below.

*S21 5 of 2022 – 20180101 Q51 Proposal for ADEPT Management project in SHSCT*

**Governance – generally**

**[31] What was your role regarding the consultants and other clinicians in the unit, including in matters of clinical governance?**

146. My role and responsibility as the AD was to interact with the AMD (Mr Haynes, appointment date October 2017). I believe I have a responsibility along with Mr Haynes to create an environment across all of SEC that promoted governance.

147. Consultants and other junior doctors in the first instance reported and discussed matters with Mr Young (Clinical Lead) and Mr Haynes as the AMD. Following this interaction if required they would communicate and have discussions with their Head of Service.

148. Essential elements of clinical governance such as Appraisals, medical revalidation and the management of poor or underperforming doctors were managed within the medical management sphere and very often through the Medical Director's office. A monthly Morbidity and Mortality (M&M) meeting was held. The chair of this meeting changed but it was always a senior clinician.

149. I had a role in the early identification of risks and concerns and responsibility to ensure Mr Young (Clinical Lead) or Mr Haynes were aware of any complaints involving dissatisfaction with medical care or a particular doctor and the matter investigated and action taken.

150. When clinical incidents occurred and in the formal identification of risks, the Trust has a process for incident reporting through the 'Datix' reporting system. On a regular basis, usually weekly, the AMD for ATICs, AMD or CD for SEC, governance managers and myself would meet to screen those Datix reports that were scored as being high. The outcome of this screening process was that either no further action was required, or the incident could sent to the specialty M&M for review or the incident met the threshold for a Serious Adverse Incident (SAI) and a SAI review would be undertaken.

151. Where opportunities arose to improve services to benefit patients for example through supporting staff's attendance at courses I would have approved those. In addition, where service redesign was merited I would have approved such reviews also.

152. Clinical governance concerns progressed from the specialty to myself and the AMD, via the Head of Service and CD/Clinical Lead.

*S21 5 of 2022 – 20141106 doc question 31 working draft SHSCT incident mgmt. procedure*
*S21 5 of 2022 – 20190501 doc question 31 HSC-SQSD-05-19 Early Alert System*

**[32] Who oversaw the clinical governance arrangements of the unit and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately?**

153. The responsibility for Clinical Governance arrangements for the Urology unit resides with the Clinical Lead (Mr Young) and Head of Service (previously Martina Corrigan and currently Wendy Clayton). As the Head of Service reported to myself as AD, I assured myself that clinical governance issues were being raised appropriately as follows:

154. For the Urology Service clinical governance was overseen at various levels.

155. For the nursing staff, which would have involved 3South and the CNSs working within the Thorndale Unit and each Ward /Department sister, any governance concerns would have been raised to their Lead Nurses and then escalated as necessary to the Urology Head of Service and then to myself as the AD. I, in turn, would escalate to the Director of Acute Services and the Executive Director of Nursing.

156. For the medical staff governance concerns would have been raised by individual consultants to their Clinical Lead and then escalated as necessary to the Clinical Director, AMD and then to myself.

157. There are several forums where clinical governance issues can be, and were, discussed.

a) Monthly Urology patient safety meetings chaired by the Head of Service which have the urology medical staff, CNSs and ward sister present.
b) Monthly Governance ATICs/SEC Business meeting chaired by myself and which have all the Head of Service, Lead Nurses and (when possible) the AMDs present.
c) Monthly Governance Acute SMT meetings chaired by Director and which have other ADs working in Acute Services along with senior governance managers present.
d) Monthly Acute Clinical Governance meetings chaired by Director and which have all AMDs, CDs and ADs present
e) Fortnightly Standards & Guidelines meetings chaired by Director & AD with Standard and guideline managers present.
f) Weekly ATICs/SEC Datix Screening meetings with AD, ATICs AMD, SEC ATICs and governance managers present.

158. For the meetings described in numbers 2, 3 and 4 a similar agenda template would have be used to structure the meetings.

159. As the AD the cumulative effect of these meetings and the information that flowed from them provided assurance to me as to the clinical governance position for Urology Services.

160. The series of meetings listed above represented the formal systems in place to provide clinical governance assurance.

**[33] How did you oversee the quality of services in urology? If not you, who was responsible for this and how did they provide you with assurances regarding the quality of services?**

161. As the AD I monitored the quality of the Urology Service in several ways. Central to this was the close working relationships with Mr Haynes (AMD for SEC), Mrs Corrigan (Head of Urology) and the Lead Nurses. The quality of urology services has multiple component parts of relevance (considered below), not least the complement and competence of the entire urology team including clinical and non-clinical staff.

Workforce

162. Considering the clinical staff, the difficulties experienced in recruiting and retaining Senior Consultants in particular in the and building of a cohesive team working transparently, cooperatively and professionally was an important factor in the ability to deliver a quality service:

163. In April 2016 on assuming the role of AD SEC and ATICs, I was aware that the Urology service had a complement of Consultant Urologists (6) in post with a locum (Mr Jacobs) subsequently commencing in January 2017 for a 2 year period through to January 2019 after Mr Suresh left.

164. In 2019 we appointed a 7th Consultant (Mr Matthew Tyson) – who then left on Fellowship to New Zealand.

165. A series of locum Consultants (7) filled positions, some for short periods (1 or 2 months) and some longer, as illustrated in the table below, and hence the Consultancy team was in a constant state of flux over the period 2019 to current date.

**Table 1 – Locum Consultant Urologists**

| First Name of Doctor filling booking | Surname of Doctor filling booking | Start Date | Expected End Date | Reason for Locum |
|---|---|---|---|---|
| **Thomas** | **Jacob** | 03/01/2017 | 04/01/2019 | Mr Suresh leaving |
| **Gyorgy** | **Solt** | 15/07/2019 | 13/09/2019 | Mr Tyson on sabbatical |

| | | | | |
|---|---|---|---|---|
| **Tamas** | **Fel** | 01/07/2020 | 04/09/2020 | Mr Tyson on sabbatical |
| **Shawgi** | **Razig Omer** | 21/09/2020 | 30/06/2021 | Backfill AOB |
| **Saifeldin** | **Elamin** | 19/07/2021 | 02/08/2021 | Backlog clearance clinics only |
| **Shawgi** | **Omer** | 16/08/2021 | 30/10/2021 | Backfill AOB |
| **Nasir** | **Khan** | 02/11/2020 | Still in post | Backfill Con 7 |

166. Furthermore, Specialist Nurses who play a central role in the provision of urology services for a period were limited to 2 only up to 2019 due to funding, thereafter between 2019 and 2020 three more CNS were successfully recruited to the Urology Service.

167. On ward 3 South, where there were challenges in respect of having vacant RNs positions, this situation was described in the 3South Risk Assessment paper. This was escalated to the Director of Acute Services and the Executive Director of Nursing (December 2018), with a summary of the control measures put in place and recommendations to maintain patient safety and enhance the quality of service provided. Please see my response to Question 19 for the 3 South paper.

Performance Metric

168. The Urology Service was not achieving the performance standard as out lined in the IEAP for a very long time. On assuming operational responsibility for Urology in April 2016 the performance targets for OPD where 8 times longer and In-patient/Day Case 9 times longer than the required performance targets (I refer to table within my response to Q19).

169. This under performance was recorded on the Directorate Risk Register (I refer to my response to Q7) as the solutions to address or manage this underperformance required HSCB involvement.

170. For several years 'in-house' additionality (hours above their JDs) was undertaken by some of the Consultants to address those patients awaiting urgent OPD appointments. Unfortunately, there were no non-recurrent monies made available to address those patients awaiting routine OPD appointments.

171. Independent Sector contracts were initiated in 2016 allowing patients to have their care and treatment.

Cancer performance

172. Unfortunately, the Urology Service was unable to achieve these Cancer targets for several reasons. These reasons included vacant consultant posts, insufficient outpatients slots to accommodate the demand for Red Flag Haematuria (blood in urine) referrals and the corresponding requirement for

diagnostic tests in the form of CT and cystoscopy (endoscope into the urinary bladder), and insufficient urology operating sessions. Monitoring on urology's cancer performance (all cancers) was through a combination of HSCB, Corporate, Acute Director and SEC meetings.

Governance

173. There was a continuous monitoring of the indicators such as the volume and type of Datix submitted. From the submission of a Datix for those scored high a screening process was in place involving senior clinicians and myself to determine if further action and investigation needed to take place, that is, was the threshold for a SAI achieved. Complaints volume and type were monitored with the expectation that trends could be identified and actioned. Data monitored included the following:

174. The quality of the Urology Service was also achieved through the continuous reviewing of data and the constant communication between key clinicians, managers and myself. Data monitoring included the following;

a) Performance metrics (further described in my response to Q34)
b) Incidence of complaints
c) Volume and nature of the SAI. Included below are the volume of SAI across SEC from 2016-2022
*S21 5 of 2022 – 20220506 doc question 33 Email SAI's by Specialty - listed by Datix Number and Final Report date (year)*
*S21 5 of 2022 – 20220506 doc question 33 Spreadsheet SAI's by Specialty - listed by Datix Number and Final Report date (year)*
d) Litigation
e) Staff turnover

Table 1 Summary of SEC/ATIC formal complaints and the urology percentage of the total

| Date | Number | Urology only | % Urology complaints |
|---|---|---|---|
| **Apr 16 - Mar 17** | 101 | 6 | 6% |
| **Apr 17 - Mar 18** | 106 | 7 | 7% |
| **Apr 18 - Mar 19** | 99 | 9 | 9% |
| **Apr 19 - Mar 20** | 109 | 16 | 15% |
| **Apr 20 - Mar 21** | 43 | 10 | 23% |
| **Apr 21 - Mar 22** | 75 | 11 | 15% |

**[34] How, if at all, did you oversee the performance metrics in urology? If not you, who was responsible for this overseeing performance metrics?**

175. For the Urology Service I had responsibility to manage Performance metrics which I did through my direct reports. Within the SEC the operational support lead (OSL) Wendy Clayton (2016 to 2020), currently Jane Scott, had a key role in monitoring the performance of the Urology Service and working very closely with the Head of Urology (Martina Corrigan – 2016 to 2020).

176. The Urology Service had their performance measured through the monitoring of waiting times and patient volumes on the 31/62 day cancer pathways, awaiting first and review outpatients appointments and waiting inpatient and day case surgeries/treatments.

177. At the weekly business meeting, the 4th Tuesday of each month was dedicated to reporting, reviewing, monitoring of all the elements of performance. In attendance at this meeting was a senior manager from the Trust's Performance Team (usually an Assistant Director and/or a Head of Service).

178. The Director (Esther Gishkori 2015 to 2020, Melanie McClements 2021 to current date) held a similar monthly performance meeting where Urology performance would have been discussed

179. The Trust, represented by the Director of Acute Services (Esther Gishkori or Melanie McClements), myself from Acute Services and the Corporate Performance Team (as described above) would then meet with the Health and Social Care Board (HSCB) to review the performance of commissioned services including urology & cancer.

**[35] How did you assure yourself regarding patient risk and safety in urology services in general? What systems were in place to assure you that appropriate standards were being met and maintained?**

180. I relied on such metrics as described to my responses to questions 33 and 34. Other systems or methods used and relied upon were as follows:

a) The urology specialty patient safety meeting and issues that arose from same.
b) The M&M process which urology services followed, ensuring patients were discussed in a multi-disciplinary meeting for understanding and learning.
c) Datix (clinical incident report system) and any that reached the threshold for further investigation to be undertaken, e.g. Serious Adverse Incidents (SAIs).
d) The volume and content of patients complaints particularly those citing clinical or care concerns.
e) For patients being cared for on our wards I reviewed the outcomes from the Nursing Quality Indicators (NQI).
f) Also, I worked closely with the Lead Nurses and Ward Sister with regard to the management of the nursing workforce on 3 South.

g) The Practice Educator was appointed to support new nursing registrants

**[36] How could issues of concern relating to urology services be brought to your attention? The Inquiry is interested in both internal concerns, as well as concerns emanating from outside the unit, such as from patients. What systems or processes were in place for dealing with concerns raised? What is your view of the efficacy of those systems?**

181. Through meetings with my direct reports, Mrs Corrigan and Mrs Clayton and Jane Scott compliance with performance targets and performance indicators were discussed, hence, I could readily identify and determine if any action needed to be taken including escalation upwards.

Internal Concerns

182. Staff with internal concerns could bring their concerns to my attention through a variety of ways, several of which were formal systems for logging concerns:

a) Staff would regularly use the Trust's internal incident reporting system (Datix) to raise their concerns. For example, nursing staff would complete a Datix to raise concerns regarding low nurse staffing levels at ward level.
*S21 5 of 2022 – 20220504 Q36 Email 3S Datix*
*S21 5 of 2022 - 20220504 Q36 email 3S Datix A1*
b) The urology specialty meeting was another opportunity for the urology multidisciplinary team to raise concerns.
c) Emails directly to myself were also used to raise an awareness of a concern.
d) The weekly Business meeting was used by the Urology Head of Service or Lead Nurses to express their concerns on such things as performance targets or workforce challenges.
e) Audits flagging concerns. These audits could have included those undertaken as part of the patient safety report.

*S21 5 of 2022 – 20190401 Q36 Acute Governance Patient Safety Report April 2019*
*S21 5 of 2022 – 20190901 Q36 Acute Governance Patient Safety Report Sept 2019*
*S21 5 of 2022 – 20200301 Q36 Acute Governance Patient Safety Report March 2020*
*S21 5 of 2022 – 20200701 Q36 Acute Governance Patient Safety Report July 2020*
*S21 5 of 2022 – 20201001 Q36 Acute Governance Patient Safety Report Oct 2020*
*S21 5 of 2022 – 20210101 Q36 Acute Governance Report Jan21 (2)*
*S21 5 of 2022 – 20210801 Q36 Acute Governance Report Aug21*
*S21 5 of 2022 – 20211101 Q36 Acute Governance Report Nov21*

External Concerns

183. Patients or their local representatives (e.g. MLA's) could register their dissatisfaction through the complaints system. For external concerns, many patients complaints were directed at the very long waiting times for their outpatient's appointment, outpatient review or operation. Unfortunately, with the resources available the ability of the Urology Service to reduce the waiting times was restricted and limited.

184. Please see further my response to question 33 and Table 1 in this regard.

Efficacy of the systems.

185. Within urology services, in order to achieve good governance, systems and processes were devised and implemented. However, no system is fool-proof and all rely heavily on full transparency, with deviations being recognised and declared by all staff as appropriate so as to better understand the reason for the occurrence and to implement corrective actions to enhance and improve the system. Those systems for recording patient data rely on accurate and timely entries from many individuals, health professionals and administrative staff all of whom are fallible. Within urology there were systems and processes for raising concerns. However, they rely on those staff in positions of authority ensuring that all the elements of good governance are not only in place but employed, utilised, monitored and applied equally across all staff as applicable to their role.

186. Below, I consider the efficacy in the context of the concerns that arose in relation to Mr O'Brien.

187. Triaging of Referrals: Reflecting on recent events within Urology it is apparent that a number of patients were recorded on the patient administration system but had not been triaged with all of those attributed to a single Consultant, thus the patients default status remained per GP referral. In 2014 a process was put into place in relation to triaging referrals which undermined the safety net principle of triaging (I refer to my response to response to Question 42 in this regard). On reflection this was a flawed process and has since been revised to ensure all referrals are triaged and returned to the Referral Booking Centre. I was not aware of the untriaged referrals within urology assigned to Mr O'Brien until a review was undertaken in December 2016/January 2017 as a consequence of concerns raised by Mr Glackin in December 2016. So, on one view the systems could be considered effective, in so far as once a concern was raised this triggered an investigation/review which then revealed a number of discrepancies in untriaged referrals, so I could state that this exemplifies the efficacy of the system. However, I would acknowledge and accept that these discrepancies were unearthed following review and not as a matter of routine monitoring. Hence the system from 2014 was undermining and has since ceased.

*S21 5 of 2022 – Q36 20170509 email urology e-triage*

188. Case note tracking: Again reflecting on recent events it is apparent from the sheer volume of urology patient notes located within the Consultant's office and outside the Trust premises in his home, that is indicative of reconciliation processes within medical records that need reviewing. Medical Records staff apparently have no mechanism for tracking the location or number of patients records assigned to an individual member of staff.

189. Undictated Clinics: Once again reflecting on recent events it is apparent that secretarial staff within Urology were aware that one Consultant regularly had large volumes of undictated clinics and failed to escalate this to their Line Management, thus acquiescing in the poor practices.

190. Private Patients: An Audit undertaken by Internal Audit of Business Services Organisation (BSO) in 2020/2021 reported significant issues in the Trust's management and monitoring of compliance with private patients guidance in particular the change of status process and their ability to monitor that patient's transferring from private to NHS care are treated in an equitable manner.

191. Viewing the systems for raising concerns I believe that any member of the urology MDT who had a concern could have brought their concern to my attention through whatever means they believed were the most appropriate.

192. I also believed with the large operational portfolios carried by Heads of Service that each operational Division within Acute Services should have had a governance risk manager whose role it is to manage and progress complaints, the recommendations from SAI's, and keep live the risk register on behalf of the Division. The role in the form of the operational support lead (OSL) is already in place for performance and works successfully. Please see further my answer to Question 69 below.

**[37] Did those systems or processes change over time? If so, how, by whom and why?**

193. The system and processes I have referred to in my response to Question 35 and Question 36 have not changed since April 2016 when I was appointed.

**[38] How did you ensure that you were appraised of any concerns generally within the unit?**

194. I ensured that I was appraised of any concerns that needed to be escalated to me not only through the systems referred to in my response to Question 36 but also by ensuring I was personally accessible such that anyone with a concern or concerns regarding patient safety could have brought this to my attention. My manner is such that I encourage open dialogue. Whilst I was 'based' in, DHH I attended CAH every Tuesday and Thursday and the office I used was directly next to my Heads of Service office. My secretary was based in CAH and she had full access to my diary.

195. If a concern was brought to my attention, through whatever means, I would have determined the severity of the concern mainly through initial conversations with HoS, LN, AMD, CD or specialty leads. Actions taken included escalating to the Director of Acute Service and Medical Director.

This process was employed in December 2016 when upon receiving communication from Mr Glackin and Mr Haynes expressing separate clinical concerns about the possibility of untriaged referrals (new GP referrals requiring to be reviewed to determine their appropriateness) and private patients being afforded an advantage over NHS patients with the Urology Service, with reference to Mr O'Brien.

196. Furthermore, I ensured I was appraised through an oversight of complaints and datix that were completed and deemed to be of significance that warrant action.

**[39] How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?**

197. I ensured that governance systems were adequate by personally understanding the elements that make up governance and I ensured in the following ways that;

a) All clinical staff within the Urology service would have been familiar with the metrics used to determine or measure clinical practices and governance:
b) All clinical staff would have had access to the systems to raise any concerns they held through their management lines verbally or in writing and I was also aware that the doctors and nurses were bound by their respective codes of conduct which mandates concerns to be raised:
c) There were multiple meetings at which staff (please see my response to Question 32), who had clinical governance concerns, had the opportunity to raise their concerns, (please see my responses to Question 36 and Question 38):
d) A review of patient safety reports was conducted on a monthly basis by the Director of Acute Services and, as AD, I then cascaded that report to Head of Service and Lead Nurses in ATICS/SEC (please see the evidence at Question 36).

198. When I became AD in April 2016 I was aware that Mr O'Brien had been issued with a letter of concern in respect of his administrative processes (please see my answer to Question 1). I was also aware that there were concerns with respect to the workforce within the urology service. i.e. Medical and 3South (please see my response to Question 18 and Question 19) and the ongoing challenges in regard to achieving the waiting times (please see my response to Question 48).

199. In December 2016 when the emails from Mr Glackin and Mr Haynes were received, with the actions that emanated from these emails (please see response to Question 40) evidencing that non red flags referrals were untriaged, that excessive volumes of patients notes were in Mr O' Brien's office

and also outside the hospital, that there were undictated clinics, and that there were issues with private patients being afforded more timely operations than Mr O'Brien's other NHS patients, all of these were concerning to me.

200. In particular, I was also concerned that the volumes had gotten so high without concerns being raised.

201. While my concerns were heightened in relation to the evidence revealed following the 2016/2017 review of the 4 elements relating to Mr O'Brien's practices carried out by Mrs Corrigan and reported to me, (thus highlighting governance gaps in relation to this single Consultant), I was confident that the administrative practices of the other Urology Consultants were in keeping with the Trusts Governance systems and processes. This confidence was borne out of the fact that the RBC were not reporting any issues with returns and the Head of Service Mrs Corrigan, was also not reporting any issues per see regarding Mr Glackin, Mr Young, Mr O'Donaghue, Mr Haynes or Mr Suresh.

202. Subsequent concerns that arose in 2020 in relation to patients not being added to the Waiting Lists by Mr O'Brien had to my knowledge, never been raised as an administrative issue previously, and suggests a failure in the reconciliation of patient outcomes as the failsafe should have been the secretarial staff who process outcomes and is normal secretarial practice. If this additional poor practice by Mr O'Brien had been escalated by the Secretarial staff that 5th element could have been addressed and added to the monitoring plan being conducted by Head of Services, Mrs Martina Corrigan.

*S21 5 of 2022 – 20200128 Q39 Good-medical-practice – English pdf*
*S21 5 of 2022 – 20181010 Q39 NMC code pdf*

**[40] How, if at all, were any concerns raised or identified by you or others reflected in Trust governance documents, such as Governance meeting minutes or notes, or in the Risk Register? Please provide any documents referred to.**

203. The Urology Service's inability to meet the performance targets as described in the IEAP would have resulted in this underperformance being recording on the Directorate Risk register (along with a number of other surgical specialties). These performance concerns would also have been captured in the Trust's internal performance reports and meetings between Acute Services and our Performance Team. Please see response to answer Question 12.

204. In March 2016, Mrs Heather Trouton (AD) and Mr Eamon Mackle (AMD) communicated concerns relating to administrative practices of Mr O'Brien (Consultant Urologist) in a letter dated Mar 23rd 2016 followed up by a meeting attended by Mr O'Brien, Mr Mackle and Martina Corrigan (Head of Service). There are minutes/notes from Oversight Committee meetings held on Sep 13th 2016, Oct 12th 2016 and Dec 22nd 2016 which further considered the previously identified concerns. The Oversight Committee noted that the concerns relating to Mr O'Brien's administrative practices namely, untriaged letters, outpatient

review backlog, taking patient notes home and recording outcomes of consultations and discharges persisted.

205. Mr Glackin (Consultant Urologist) expressed clinical concerns in a letter (Dec 15th 2016) attached to an email to Dr Boyce (Acute Governance Lead) which was escalated to myself and Esther Gishkori (Director of Acute Services). Mr Glackin was expressing 3 concerns in his letter. The first concern was the default triage system, the second concern was patients notes leaving the Trust and the third concern was the patients letters not being dictated in a timely manner. Furthermore, Mr Haynes (Consultant Urologist) also expressed clinical concerns in an email (Dec 22nd 2016) sent to myself and subsequently shared with Dr Wright (Medical Director). Mr Haynes email entitled 'Management of PP's / non chronological listing' expressed concerns that a patient seen privately by Mr O'Brien had his operation quicker than other patient's under the care of Mr O'Brien.

206. These new concerns which were discussed at two further Oversight Committee Meetings (Jan 10th 2017 and Jan 26th 2017) brought about an additional course of action that resulted in a 'Maintaining High Professional Standards' review (conducted by Dr Neta Chada), a Case Managers Determination report (conducted by Dr Khan), an overarching SAI in which the care of 5 patients were reviewed (Dr Johnson) and an internal audit into Mr O'Brien's compliance with the 'Private Patient Work' (Internal Audit Team).

207. In addition the nursing concerns on ward 3 South were raised to me by the Lead Nurse (Mrs Gillian Henry). These concerns resulted in a paper being written showing why and how this ward was not performing as well as it should have been. The paper offered actions that could be taken to mitigate risk and also offered solutions.

*S21 5 of 2022 –20160913 Q68 Action Note Oversight committee*
*S21 5 of 2022 – 20161012 Q68 Action Note Oversight committee*
*S21 5 of 2022 – 20161222 Q55 Action note Oversight committee*
*S21 5 of 2022 – 20170110 Q55 Action note Oversight committee*
*S21 5 of 2022 – 20170126 Q63 Action note oversight committee*
*S21 5 of 2022 – 20160905 Q40 Private patient letter*
*S21 5 of 2022 – 20161215 Q40 Letter SAI Panels Concerns*
*S21 5 of 2022 – 20161216 Q40 Email Concerns raised by an SAI Panel*
*S21 5 of 2022 – 20161223 Q40 Email Management of PP's - Non Chronological Listing*
*S21 5 of 2022 – 40. 20181201 doc question 19 3 South Risk assessment*

**[41] What systems were in place for collecting patient data in the unit? How did those systems help identify concerns, if at all?**

208. Systems used to collect and record patient's data took several formats.

a) For urology patients admitted into the hospital either electively or as an emergency, their admission is recorded by the medical staff into the patient's medical notes and for the nursing staff it is recorded into the patient's nursing notes. To respond to a complaint, datix or as part of a serious adverse incident review, both sets of notes (medical and nursing) are retrospectively to review medical management and care. Reviewing notes is important in helping to determine if care and treatments were appropriate.

b) Within Nursing, nursing quarterly indicators (NQI's) were undertaken by the Lead Nurses and Ward Sisters. These NQI's reviewed aspects of nursing care that were viewed as being components of safe care. For 3 South NQI audits did highlight deficits between 2016 and 2018 – these were detailed in the paper referenced in the response to Questions 40.

c) All GP referrals are recorded on the Trust Patient Administration system (PAS).

d) All cancer referrals (red flag referrals) from GP's or other consultants are recorded on the regional Cancer Patient Pathway System (CAPP). The Trust has a procedure governing how referrals are received, recorded onto the system, sent for triage and an escalation process if referrals do not return to the Referral and Booking Centre (RBC) within the stated time frames.

e) Clinical Incidents that happened on a ward or department are recorded on the clinical incident reporting system (Datix). Those datix which were initially classified as high or greater, would be 'screened' weekly to determine what further action was required. Actions could include non-action or an SAI if required.

209. In regards to concerns, a, b and e systems would assist the urology service to identifying clinical issues or concerns. Concerns c and d would enable non red flag and red Flag referrals to be processed, triaged and escalated.

210. The Datix system did assist with identifying nursing concerns with regard to staffing deficits in 3South

**[42] What is your view of the efficacy of those systems? Did those systems change over time and, if so, what were the changes?**

211. My view is that the patient data recording systems rely on accurate and timely entries from many individuals, health professionals and administrative staff who are fallible. The efficacy of the system is also dependent on trends and areas of concern being identified. The patient data collecting systems as listed in Question 41 did not change over time.

212. When in April 2016 and becoming the AD for SEC, I was aware that in 2014 a process was put in place that enabled referrals that had not been returned and therefore triaged, to be recorded on PAS in accordance with the

GP's assessment of the referral acuity, i.e., if the GP sent a routine referral into the RBC and it went untriaged the routine classification remained. Contained within this process the opportunity to review the GP referral and upgrade to urgent or red flag status, if deemed necessary, was removed. With hindsight, this was a flawed process and has since been revised to ensure all referrals are triaged and returned to the RBC (March 2017). The default system I believe prevented the RBC or operational ADs having sight on the 'nil' returns from Mr O'Brien.

213. NQIs are an effective mechanism and are used in all acute hospitals in Northern Ireland and that in operation within ward 3 South was efficacious in highlighting concerns in Nursing care.

214. In other hospitals in N Ireland the medical and nursing notes are electronic whereas within the Southern Trust our medical and nursing notes remain on paper. Possibly, I do not know, having patient notes held electronically enables issues and trends to be identified through a system search function.

215. The Datix system did enable clinical issues to be raised and my view is that for the nursing staff in 3 South (please see response to Question 32) this worked.

**[43] During your tenure, how well do you think performance objectives were set for consultant medical staff and for specialty teams? Please explain your answer by reference to any performance objectives relevant to urology during your time, providing documentation or sign-posting the Inquiry to any relevant documentation.**

216. The operational performance targets set for consultants and the urology specialty team were clearly set out and described in the 2008 Integrated Elective Access Targets (IEAP) i.e. OPD waiting times, inpatient/day case waiting times and cancer 31/62days pathways.

217. The reality was that IEAP performance targets were unachievable as the demand into the service was greater than the demand contained with the consultants JP's (please see response to Question 19). So the Urology Service would have their performance monitored against the commissioned Service Baseline Agreement (SBA) levels (Service Baseline Agreement (SBA) levels from 2012/13 to 2018/19. The SBA was the amount of clinical activity the HSCB would expect to be delivered over a 12 month period. In April 2016 the Urology team's performance against the SBA were not being achieved. There was a realisation that with the lengthening waiting lists, the HSCB performance currency of SBA should be changed to what capacity the Urology (and for all other medical specialties being monitored by the HSCB) could provide. The measurement for clinical activities outcome became known as Trajectories (2017)

218. Within the Consultant 'Job Plans' each consultant would agree the number and amount of clinical activity they would undertake annually.

219. The Job Plan was made up from what is referred to as programmed activities (PA) and supporting professional activity (SPA) with each PA & SPA being 4 hours duration or 3hours if it involves working 'out of hours' e.g. after 5pm or weekends. A typical JP would have included OPD clinics, day case operating, in-patient operating, emergency and ward work, out of hours work and sessions.

220. For each OPD PA a certain number of patients would be appointed to the clinic. However, the total capacity from all the Consultants job plans was not sufficient to meet the incoming referral demand. This resulted in the number of patients on the waiting list growing along with the time they spent on the list.

221. These objectives were discussed at the Monthly Performance HOS meetings

222. Evidence of regional HSCB meetings as per Question 12 submission

*S21 5 of 2022 – 20170628 Q43 HSCB Performance Management Framework – Performance Improvement trajectories. pdf*

**[44] How well did you think the cycle of job planning and appraisal worked and explain why you hold that view?**

223. As the AD and the budget holder for ATIC/SEC I was the either the 2nd or 3rd person in the 3 person sign off process depending on whether the Consultant having their job plan undertaken was a medical manager or not. The Job Planning process for a Consultant lay with the CD, then the DMD and then myself as AD. The Job Planning process for the Clinical Director (CD) lay with the DMD and then myself as AD and then the Director of Acute Services.

224. Apart from signing off a consultant's Job Plan this process was the responsibility of the consultant's medical line manager with regard to agreeing the content of the Job Plan.

225. Appraisal was part of a consultant's revalidation process and again appraisals were managed through the medial management lines.

226. For years 2017/18 and 2018/19 the Job planning process was poor, attributed in part in my opinion, to the fact that the Clinical Director was solely responsible for the Job planning and appraisal process for both General Surgery and Urology with inadequate time allocated to the CD to complete this aspect of the role. There was a recognition that this needed to improve, such that a Deputy Medical Director with responsibility for workforce and Job

planning was appointed and over the course of the last three years 2019/20 and 2020/21 and 2021/22 the Job Planning has been stronger.

*S21 5 of 2022 – 20160101 to 20200101 doc question 44 Urology appraisals*
*S21 5 of 2022 – 20160101 to 20200101 doc question 44 Urology JPs*

**[45] The Inquiry is keen to learn the process, procedures and personnel who were involved <u>when</u> governance concerns having the potential to impact on patient care and safety <u>arose</u>. Please provide an explanation of that process during your tenure, including the name(s) and role of those involved, how things were escalated and how concerns were recorded, dealt with and monitored. Please identify the documentation the Inquiry might refer to in order to see examples of concerns being dealt with in this way during your tenure.**

227. During my tenure (April 2016 onward) the following processes, procedures and personal were involved with governance concerns within the Trust.

228. If the concern was raised through the Incident Reporting System (Datix) then a screening meeting would occur. This screening team would have been Dr Damian Scullion (AMD ATICS), Mr Mark Haynes (AMD SEC) and Mr Ted McNaboe (Clinical Director). The purpose of this screening meeting was to determine had the incident reached the threshold for further action, review and or Serious Adverse Incident investigation (SAI) to be the outcome (the criteria is listed in the Trust's Incident reporting procedure. If a SAI was the outcome, a review team would be formed, comprised of a chair (always a clinician) and other key medical and nursing staff. This review team would undertake a review into the incident and then report back.

229. If the incident on the early information available was viewed to be of serious significance a discussion with the Director of Acute Services and the AD for Clinical governance would take place and a decision taken as to whether an 'Early Alert' form would be sent to the HSCB and the DHPSS. This form would be drafted by the Head of Service for Acute Governance and approved by myself and the Director of Acute Services

230. The SAI Review and the recommendations would be tabled at the monthly acute governance meeting which was chaired by the Director of Acute Services. At this meeting would be other acute AMD, CDs and AD who would critique the SAI review accepting or rejecting the finding and recommendations.

*S21 5 of 2022– 20190501 doc question 45 HSC-SQSD-05-19 Early Alert System*
*S21 5 of 2022 – 20220504 Q45 Email Early Alert System 2010*
*S21 5 of 2022 – 20141001 doc question 45 Incident reporting procedure*
*S21 5 of 2022 – 20190501 doc question 45 Risk management strategy*

<u>Incident 1</u>

231. It is apparent that in relation to Mr O'Brien there were long standing concerns re his administrative practices for a significant period of time, including that before my tenure (which I was aware of), coupled with an apparent inability to deal with him as a difficult colleague in a robust and consistent manner. To my knowledge, this culminated in Mr O'Brien being issued with a letter (March 23rd 2016) by Mrs Heather Trouton and Mr Mackle (AMD) specifying concerns in relation to Mr O'Brien's administrative practices and asking that he provide a plan to address the issues highlighted

232. On assuming the role of AD in April 2016 I was made aware by Mrs Heather Trouton that this letter had been issued to Mr O'Brien. This was at the start of my AD tenure with SEC and I was occupied with understanding all the challenges that were present across all SEC and did not follow up re seeking Mr O'Brien's plan, nor did Mr O'Brien offer this plan.

233. Thereafter, at an Oversight Committee Meeting held on September 13th 2016, attended by Medical Director (Dr Wright), Acute Director Esther Gishkori and HR Director (Vivienne Toal) wherein Mr O'Brien's administrative practices were discussed, at that meeting it was noted that no action plan had been provided by Mr O'Brien, despite the request in March 2016, and the same concerns continued to exist almost 6 months later. It was stated that a preliminary investigation had already taken place on paper. The actions emanating from that meeting included, a letter to be drafted and presented by Colin Weir (CD) and myself (AD) to Mr O'Brien, highlighting the Trust's intention to proceed with an investigation under MHPS if within a 4 week timescale the 4 main areas causing concern (i.e., untriaged letters, outpatient review backlog, taking patient notes home and recording outcomes of consultations and discharges), had not been addressed.

234. As I recall following a meeting with Mrs Gishkori where Dr McAllister and myself were present, Dr McAllister and Mr Weir (CD) wished to 'work locally' with Mr O'Brien to see could this style improve Mr O'Brien's administrative practices. Mrs Gishkori wrote to Dr Wright (Medical Director) and Mrs Toal (HR Director) asking for a postponement of the actions detailed from the Oversight Committee 13th September for 3 months; with Dr Wright in turn asking to see the plan and how progress would be monitored.

235. A list of actions were proposed by Mr Weir and supported by Dr McAllister. In my email reply of the 22nd September 2016 I offered some operational suggestion against a number of points

236. A further Oversight Committee Meeting was held on October 12th 2016, attended by Medical Director (Dr Wright), Acute Director (Esther Gishkori) and HR Director (Vivienne Toal) wherein it was reported that Mr O'Brien had not been told of the concerns following the previous Oversight Committee of September 13th 2016. At that meeting it concluded that the concerns regarding his administrative practices highlighted by the Oversight Committee would be formally discussed with Mr O'Brien on his return from his

period of [redacted] and this would be kept under review by the Oversight Committee.

Incident 2

237. On 16th and 23rd of December 2016 I received two emails. The first came from Dr Tracey Boyce who was the Director Pharmacy but had a lead role for acute governance. The second email came from Mr Mark Haynes.

238. Both emails raised separate concerns about various aspects of Mr O'Brien's practice. Along with myself the first email was sent to Mrs Esther Gishkori (Director of Acute Services). I escalated the 2nd email to Dr Richard Wright (Medical Director) for his attention. (Please see my response to Question 40 for more detail on the content of these emails) The first email from Dr Boyce detailed concerns prompted by Mr Glackin as Chair of the SAI

239. Both of these emails brought about Oversight committee meetings on 22nd December, 10th January 2017 and 23rd January 2017 (two of which I attended, 22nd December 2016 and 10th January 2017). At these meetings the incidents (un-triaged referrals, undictated clinic outcomes, excess patient notes off site and in hospital office and private patients) were discussed and action agreed (please see my response to Question 49). An investigation under 'Maintaining High Professional Standards' investigation was undertaken by Dr Chada and the report sent to the Case Manager (Dr Khan) with a decision by the Case Manager not to refer Mr O'Brien to the General Medical Council (GMC) and to monitor his progress and his compliance through an action plan.

**Senior staff involved (2016/2017)**

| **Title** | **Personnel/Names** |
|---|---|
| Director of Acute Services<br>Assistant Director | Mrs Esther Gishkori<br>Mr R Carroll |
| Medical Director<br>Associate Medical Director<br>Associate Medical Director<br>Clinical Director<br>Associate Medical Director | Dr Richard Wright<br>Dr A Khan<br>Dr C McAllister<br>Mr C Weir<br>Dr N Chada |
| Acute Governance | Dr T Boyce |
| Director of Human Resources | Mrs Vivienne Toal |

Incident 3

240. An email sent by Mr Haynes in June 2020, with regard to patients who Mr O'Brien wished to have scheduled for surgery and the realisation that these patients were not on the Trust's Waiting Lists, gave rise to the Trust's 'Look Back' review.

241. This email was sent to Dr O'Kane, Mrs McClements, Mrs Corrigan and myself. In addition Oversight Committee meetings were held, starting in June 2020 and continuing to the current day initially on a weekly basis, (later, moving to monthly basis), to assess the nature and scope of the issues

identified in the "Look Back" review. Meetings were held between the Trust (Dr Maria O'Kane - Medical Director, Dr Damian Gormley - Deputy Medical Director, Mr Mark Haynes – Associate Medical Director, Melanie McClements - Acute Services Director, Martina Corrigan – Head of Services, myself as Assistant Director and Jane McKimm – Communications), and HSCB. In addition, the Trust Chief Executive (Shane Devlin) and Medical Director (Dr Maria O'Kane) met with Department of Health, chaired by the Permanent Secretary, Mr Pengelly. Furthermore, as a result of the "Look Back" review an SAI was undertaken, chaired by an independent non Trust employee, Dr Dermot Hughes. This SAI made 11 recommendations which the Trust is currently in the process of implementing.

*S21 5 of 2022 – 20200611 email Patients to be added to Urgent Bookable List*

242. Urology Advisory Group minutes

*S21 5 of 2022 – 20211101 Q45 UAG Minutes*
*S21 5 of 2022 – 20211125 Q45 UAG Minutes*
*S21 5 of 2022 – 20220106 Q45 UAG Minutes*
*S21 5 of 2022 – 20220217 Q45 UAG Minutes*
*S21 5 of 2022 – 20220303 Q45 UAG Minutes*
*S21 5 of 2022 – 20220331 Q45 UAG Minutes*
*S21 5 of 2022 – 20220414 Q45 UAG Minutes*
*S21 5 of 2022 – 20220428 Q45 UAG Minutes*

243. Lookback Steering Group Minutes

*S21 5 of 2022 – 202200411 Q45 Lookback Steering Group Minutes*
*S21 5 of 2022 – 20220509 Q45 Lookback Steering Group Minutes*
*S21 5 of 2022 – 20220328 Q45 Lookback Steering Group Minutes*
*S21 5 of 2022 – 20220314 Q45 Lookback Steering Group Minutes*
*S21 5 of 2022 – 20220228 Q45 Minutes of lookback meeting*
*S21 5 of 2022 – 20220214 Q45 minutes of lookback meeting*
*S21 5 of 2022 – 20220131 Q45 minutes of lookback meeting*
*S21 5 of 2022 – 20220117 Q45 minutes of lookback meeting*
*S21 5 of 2022 – 20220106 Q45 Lookback Steering Group Minutes*
*S21 5 of 2022 – 20211220 Q45 Lookback Steering Group Minutes*
*S21 5 of 2022 – 20211206 Q45 Lookback Steering Group Minutes*
*S21 5 of 2022 – 20211122 Q45 Lookback Steering Group Minutes*
*S21 5 of 2022 – 20211115 Q45 Lookback Steering Group Minutes*
*S21 5 of 2022 – 20211111 Q45 Lookback Steering Group Minutes*

**[46] Did you feel supported in your role by the medical line management hierarchy? Whether your answer is yes or no, please explain by way of examples, in particular regarding urology.**

244. Yes I have, and continue to have, the support of the medical managers. I had a strong professional relationship with Mr Mark Haynes who

was the Associate Medical Director (AMD). Mr Haynes moved in January 2022 to become the Division Medical director for Quality Improvement

245. Mr Haynes and I discussed all the surgical services on a regular basis however, this was informally face to face or on the telephone and not documented. The following are sample emails communication between Mr Haynes and myself on operational matters across all surgery over several years. I continue to have a strong professional relationship with Mr Ted McNaboe who is now the current Divisional Medical Director (DMD

*S21 5 of 2022 - 20170613 Email Q46 Proof read, comment*
*S21 5 of 2022 - 20170615 Q46 100*
*S21 5 of 2022 - 20180418 Q45 Letter of Concern*
*S21 5 of 2022 - 20181024 Q24 Update on CW*
*S21 5 of 2022 - 20190117 Q46 An idea*
*S21 5 of 2022 - 20190609 Q46 My Job Plan*
*S21 5 of 2022 - 20190612 Q46 GP Concerns regrading Red Flag referral*

**Concerns regarding the urology unit**

**[47] The Inquiry is keen to understand how, if at all, you, as Assistant Director, liaised with, involved and had meetings with:**

**(i) The Chief Executive(s) during your tenure (the inquiry understand these to have been Mairead McAlinden, Paula Clark, Francis Rice, Stephen McNally and Shane Devlin**)

246. During my tenure as AD I did not liaise directly with any of the Trust's Chief executives with exception of meetings I attended in relation to Mr Aidan O'Brien wherein Mr Shane Devin, Trust Chief Executive, was present as Chair.

247. I attended other meetings where each of the above Chief Executives (except for Mairead McAlinden and Paula Clarke) were present, no more than once or twice a year and these were meetings centred on the overall Trust's performance. At this meeting our Director (please see response to Question 6) and my peer AD colleagues would have been present also.

**(ii) the Medical Director(s) during your tenure (the inquiry understand these to have been Patrick Loughran, John Simpson, Richard Wright, Ahmed Khan and Maria O'Kane),**

248. I do not recall having meetings with Dr Loughran or Dr Simpson.

249. I did meet Dr Wright as part of his induction week with the Trust. I then was present as part of the initial investigation into several aspects of Mr

O'Brien's practice in end of December 2016 and start of 2017. Dr Wright was present at these meetings.

250. I received emails from Dr Khan (18th October 2018). Another email on the 17th September 2019 and attended a meeting organised by Simon Gibson at which Dr Khan, Mr Haynes, Mrs Corrigan were present (21st January 2020). These communications were in regard Mr O'Brien's compliance with the action plan:

*S21 5 of 2022 - 20200124 Q47ii Email for response Request AOB Meeting*

251. Since her appointment (December 2018) I have been in many meetings with Dr O'Kane as part of the lookback process into Mr O'Brien's care between January 2019 and June 2020. I also attended meetings where Dr O'Kane was present in relation to management of the COVID-19 pandemic and bed pressures in acute services.

**(iii) the Director(s) of Acute Services during your tenure (the inquiry understand these to have been Gillian Rankin, Debbie Burns, Esther Gishkori, Anita Carroll and Melanie McClements)**

252. As an Assistant Director and with the Director being my direct line manager, I would have liaised, been involved and had meetings with the Director of Acute Services several times a week. These meetings would have been formal and informal talking through a range of operational issues and concerns.

**iv) the other Assistant Director, namely Heather Trouton,**

253. As we were both AD and part of the Senior Management team we would have communicated and been part of regular acute SMT meetings. As the Assistant Director for CCS between 2007 – 2016 I would have liaised with Heather Trouton in regard to the Cancer performance of the urology service.

254. In 2016 resulting from the restructuring of Acute Services I became the AD for ATICS / SEC. I would have again communicated with Heather Trouton with respect to receiving an update on surgical services one of which being urology.

**v) the Associate Medical Directors during your tenure (the inquiry understand these to have been Eamon Mackle, Mark Haynes, Stephen Hall, Charlie McAllister and Damian Scullion)**

255. I have had a strong professional relationship with all the Associate Medical Directors during my tenure in particular Mr Haynes who moved only

recently in January 2022 to become the Division Medical director for Quality Improvement.

256. Mr Haynes (initially as CD May 2016 and then as AMD Oct 2017) and I discussed surgical services on a regular basis however this was informally face to face or on the telephone and not documented. (2016-2022)

257. Dr Hall was the AMD for Cancer and Clinical services from 2007 and 2016. I would have met Dr Hall weekly where we would have discussed the business of the Division. We also had a monthly Divisional Governance meeting with Dr Hall chaired.

258. Dr McAllister was the AMD for ATIC from approximately 2010-2016 and for short time the AMD for ATICs/SEC. Meetings with Dr McAllister were more informal and we did not have formal diarised meetings.

259. Mr Mackle stepped down as the AMD for SEC very shortly after I started as AD for SEC. Dr McAllister undertook the role of AMD for both ATIC and SEC for a short while, but he too stood down from this post early into my tenure as AD for SEC.

260. Dr Scullion replaced Dr McAllister as the AMD for ATICs. Similar to Dr McAllister meetings with Dr Scullion were informal relating to anaesthetics and as matters arose that needed discussion and decisions.

261. Dr Hall

*S21 5 of 2022 – 20220407 Q47v Notes of meeting CCS meeting 07.04.11*
*S21 5 of 2022 – 20120216 Q47v Notes of meeting CCS meeting 16.02.12*
*S21 5 of 2022 – 20111013 Q47v Notes of meeting CCS meeting 13.10.11*
*S21 5 of 2022 – 20110210 Q47v Notes of meeting CCS meeting 10.02.11*
*S21 5 of 2022 - 20101007 Q47v Notes of meeting CCS meeting 07.10.10*

262. Dr McAllister

*S21 5 of 2022 – 20160822 Q47v email confidential AOB.*
*S21 5 of 2022 – 20160831 Q47v email* [redacted]
*S21 5 of 2022 – 20160921 Q47v E meeting re Mr O'Brien*

263. Dr Scullion

*S21 5 of 2022 – 20170224 Q47v email regional urology proposal*
*S21 5 of 2022 – 20190906 Q47v email allocation letter update*
*S21 5 of 2022 – 20200925 Q47v email Emergency general surgery*
*S21 5 of 2022 – 20200925 Q47v email Emergency general surgery A1*

264. Meetings notes

*S21 5 of 2022 – 20181206 Q47v Notes of Thugs Meeting*

*S21 5 of 2022 – 20190502 Q47v NOTES Thugs*
*S21 5 of 2022 – 20190419 Q47v April 19 ATICs NOTES Business Meeting*

**vi) the Clinical Director(s) during your tenure (the inquiry understand these to have been Robin Brown, Sam Hall, Colin Weir and Ted McNaboe)**

265. I did not interact with either Mr Brown or Mr Hall in a managerial capacity, they both had ceased being CD's by April 2016. During my tenure as AD for ATICS/SEC Mr Weir was the CD for General Surgery and Mr McNaboe was CD for Urology/ENT. CD's would normally liaise and communicate with their Head of Service. My interaction with Mr Weir and Mr McNaboe would have been infrequent approximately once or twice monthly and usually it was when I would come upon a meeting between them and their Head of Service

**vii) the Head of Service, namely Martina Corrigan, and**

266. I had very regular contact and communication with Mrs Corrigan. Communication would have taken the form of standing meetings e.g HOS 1:1 and informal communication held either in her office or via phone, email or zoom. Mrs Corrigan was the HoS when I came to SEC in April 2016 and she remained until October 2020. There would have been 1000's of email during this time period. The following are but a very small sample of emails between Mrs Corrigan and myself divided into sections; general urology and the second are related to Mr O'Brien. These emails have been uploaded as Discovery in Section 21 No 2a of 2021.

267. General Urology
*S21 5 of 2022 - 20160616 Q47 vii OPD Project*
*S21 5 of 2022 - 20161016 Q47 vii Discharge lounge*
*S21 5 of 2022 - 20170118 Q47 vii capital Requisition not raised*
*S21 5 of 2022 - 20180110 Q47 vii Urology Registrar foir tonight*
*S21 5 of 2022 - 20180608 Q47 vii Urology Waiting list*
*S21 5 of 2022 - 20181220 Q47 vii Thorndale*
*S21 5 of 2022 - 20190322 Q47 vii Service improvement post*
*S21 5 of 2022 - 20190909 Q47 vii Trus Ultrasound*
*S21 5 of 2022 - 20200220 Q47 vii Update regarding Fermanagh Urology patients*
*S21 5 of 2022 - 20190926 Q47 (vii) Complaint* Personal Information redacted

268. Mr O'Brien emails
*S21 5 of 2022 – 20161222 Q47vii email Urology missing triage*
*S21 5 of 2022 - 20161222 Q47vii email Urology missing triage A1*
*S21 5 of 2022 - 20161223 Q47vii email Backlog report no clinic outcomes as per 15.12.16*
*S21 5 of 2022-20161223 Q47vii email Backlog report no clinic outcomes as per 15.12.16 A1*

*S21 5 of 2022 - 20161228 Q47vii email Audit of charts re AOB*
*S21 5 of 2022 - 20170106 Q47 vii email TURP audit*
*S21 5 of 2022 - 20170110 Q47vii untriaged as of 10 january 2017*
*S21 5 of 2022 - 20170110 Q47vii email Confidential confirmation of further oversight mtg re AOB 10.1*
*S21 5 of 2022 - 20170110 Q47vii email Confidential confirmation of further oversight mtg re AOB 10.1 A1*
*S21 5 of 2022 - 20170110 Q47vii email Confidential confirmation of further oversight mtg re AOB 10.1 A2*
*S21 5 of 2022 – 20170110 Q47vii email Confidential confirmation of further oversight mtg re AOB 10.1 A3*
*S21 5 of 2022 – 20170110 Q47vii email Confidential confirmation of further oversight mtg re AOB 10.1 A4*
*S21 5 of 2022 – 20170113 Q47vii email audit of charts for AOB*
*S21 5 of 2022 – 20170116 Q47vii email outstanding charts for AOB*
*S21 5 of 2022 – 20170116 Q47vii email outstanding charts for AOB A1*
*S21 5 of 2022 – 20170124 Q47vii email action note 22 Dec AOB action plan MC 24 Jan 17*
*S21 5 of 2022 - 20170124 Q47vii email action note 22 Dec AOB action plan MC 24 Jan 17 A1*
*S21 5 of 2022 – 20170124 Q47vii email strictly private and confid. AOB*
*S21 5 of 2022 –20170208 Q47vii email Return to work action plan Feb 17*
*S21 5 of 2022 – 20170208 Q47vii email Return to work action plan Feb 17 A1*
*S21 5 of 2022 – 20170209 Q47vii email return to action plan Feb 17*
*S21 5 of 2022 – 20170303 Q47vii email urology etriage*
*S21 5 of 2022 – 20170313 Q47vii email AOB*
*S21 5 of 2022 – 20170313 Q47vii email wrong notes sent through earlier mtg with AOB Weir 9.3.17*
*S21 5 of 2022 – 20170313 Q47vii email wrong notes sent through earlier mtg with AOB Weir 9.3.17 A1*
*S21 5 of 2022 – 137. 20200124 Q47ii Email for response Request AOB Meeting*
*S21 5 of 2022 - 20181123 Q47vii Email AOB Action Plan*

**viii) the consultant urologists in post during your tenure.**

269. I did not liaise or communicate with consultant urologist on a formal basis. The communication channels would have been via Martina Corrigan and Wendy Clayton their Head of Service and through their Clinical Lead and Clinical Director or AMD/DMD. However, I have always operated a policy of being available to them to discuss understand and resolve any issues. An issue that I would have spoken to Mr Young concerned gaps in the medical workforce. Mr Glackin re the introduction of the Phlebotomy hub.

*S21 5 of 2022 - 20200626 S47 viii – Phlebotomy Hub*

**When answering this question, the Inquiry is interested to understand how you liaised with these individuals in matters of concern regarding urology governance generally, and in particular those governance concerns with the potential to impact on patient care and safety. In providing your answer, please set out in detail the precise nature of how your roles interacted on matters (i) of governance generally, and (i) specifically with reference to the concerns raised regarding urology services. Where not previously provided, you should include all relevant documentation, dates of meetings, actions taken, etc.**

270. There are several forums where clinical governance issues can be and were discussed.

a) Monthly Urology patient safety meetings Chaired by the Head of Service and which has the urology medical staff, CNS's and ward sister present.
b) Monthly Governance ATICs/SEC Business meeting Chaired by myself and which has all the Head of Service, Lead Nurses and when possible the AMD's present.
c) Monthly Governance Acute SMT chaired by Director and which has other AD working in Acute Services along with senior governance managers
d) Monthly Acute Clinical Governance chaired by Director and which have all AMD, CD's and AD's present
e) Fortnightly Standards & Guidelines chaired by Director & AD with Standard and guideline managers
f) Weekly ATICs/SEC Datix Screening meetings with AD, ATICs AMD, SEC ATICs and governance managers

271. During my tenure as AD I did not liaise directly with any of the Trust's Chief Executives or any of Medical Directors on general urology governance as per my response to Question 47(i) and Question 47 (ii).

272. During my tenure as AD I liaised directly with the Director of Acute Services, (Esther Gishkori and Melanie McClements) on matters that pertained to general urology governance in relation to performance and workforce as per my response to Question 47(iii).

273. With regard to general urology governance issues, as the outgoing AD for SEC I recall having a brief handover meeting with Mrs Heather Trouton re all the surgical specialties with at most a high level summary of performance and workforce issues as per my response to Question 47 (iv).

274. While Mr McAllister was temporarily AMD for ATICS/SEC (April 2016 to September 2016) during my initial appointment as AD for ATICS/SEC, I do not

recall having any discussions with Mr McAllister on general urology governance. My primary liaison on general urology governance was with Mr Haynes upon his appointment as AMD for ATICS/SEC and discussions centred on matters relating to performance and workforce as per my response to Question 47(v).

275. While Mr Weir was already CD for urology prior to my appointment as AD for ATICS/SEC, I do not recall having any discussions with Mr Weir on general urology governance as per my response to Question 47(vi). Mr Weir would have communicated with the Head of Service for Urology, Mrs Martina Corrigan.

276. Mrs Corrigan had been the Head of Service for Urology for several years prior to my appointment in April 2016 as AD for ATICS/SEC and she remained as Head of Service until October 2020, after which Ms Clayton was appointed as Head of Service for Urology. I had a lot of communication with both Mrs Corrigan and latterly Ms Clayton on general urology governance with meetings typically monthly on areas such as workforce gaps at consultant and junior doctor level and nursing staff, plus waiting times as per my response to Question 47(vii).

277. During my tenure as AD I did not liaise directly with any of the Consultant Urologists on general urology governance as per my response to Question 47(viii).

278. With regard to urology clinical governance issues involving the potential to impact on patient care and safety, I would have liaised with Mrs Corrigan, (Head of Service for Urology), Lead Nurses and Ward sister in 3 South to address the concerns and challenges brought about due to having a depleted nursing workforce and having an over reliance on agency nursing staff. Potential safety issues such as these would then have been escalated to the Director of Acute Services Mrs Esther Gishkori and Mrs Heather Trouton as the Executive Director of Nursing (e.g., 3 South Risk Assessment Paper).

279. In relation to Incident 1, as detailed in my response to Question 45 I was present at a meeting with Mrs Gishkori (Director of Acute Services) and Dr McAllister (AMD for ATICs/SEC) in relation to Mr O'Brien wherein the decision following a September 16th 2016 Oversight Committee Meeting was to manage Mr O'Brien locally.

280. In relation to Incident 2, considering specific governance concerns in relation to Mr O'Brien with the potential to impact on patient care and safety, in December 2016, Mr Glackins' and Mr Haynes' respective emails (see response to Question 40) expressing the potential for patient safety concerns as a result of Mr O'Brien administrative practices, brought me into contact with the Medical Director Dr Wright as I escalated Mr Haynes email to Dr Wright. Additionally Dr Boyce escalated Mr Glackin's email to Mrs Gishkori and myself. This resulted in a course of action including 3 Oversight Committee meetings in 22nd December 2016, 10th January 2017 and 23rd January 2017 (please refer to my response to Question 55). I attended the 22nd December 2016 and 10th January 2017 Oversight Committee meetings. Also present was Dr Wright (MD) and Vivienne Toal (Director of HR). At these meetings the incidents (un-triaged referrals, undictated clinic outcomes, excess patient notes off site and in hospital office and private patients) were discussed and action agreed (please see my response to Question 49). An investigation under 'Maintaining High Professional Standards' was then undertaken by Dr Chada and the report sent to the Case Manager (Dr Khan). Thereafter, I had some contact with Dr Khan in late 2018 (AMD in Children and Young Persons Programme Of Care within the Trust), and December 2019 in relation to the monitoring of Mr O'Brien's adherence to the management action plan. (please refer to my response to Question 47 (ii).

281. In relation to Incident 3, considering specific governance concerns in relation to Mr O'Brien with the potential to impact on patient care and safety, I attended meetings at which Mr Shane Devin, Trust Chief Executive, was present as Chair in December 2021. The purpose of these meeting was to have a collective memory of what decisions had been made over time with regard to Mr O Brien.

282. I also attended a series of Oversight Meetings detailed in response to Question 45 at which Dr O'Kane (MD), Mr Haynes (AMD for SEC), Mr McNaboe (CD), Mrs McClements (Director of Acute Services), and Mrs Corrigan (Head of Services for Urology) and subsequently Ms Clayton (Head of Services for Urology) as part of the "Look Back" review.

**[48] Following the inception of the urology unit, please describe the main problems you encountered or were brought to your attention in respect of urology services? Without prejudice to the generality of this request, please address the following specific matters:**

**(a) What were the concerns raised with you, who raised them and what, if any, actions did you or others (please name) take or direct to be taken as a result of those concerns? Please provide details of all meetings, including dates, notes,**

**records etc., and attendees, and detail what was discussed and what was planned as a result of these concerns.**

283. Excluding the issues that were raised with regard to Mr O'Brien, which I shall address in Question 52 – Question 62, the issue I quickly became aware of was Urology performance targets. This was raised by the Mrs Corrigan (Head of Service) and Wendy Clayton (OSL – please see response to Question 19 and Question 34)

284. The Urology Service was not achieving the performance standard as out lined in the IEAP for a very long time. On assuming operational responsibility for Urology in April 2016 the performance targets for OPD where 8 times longer and In-patient/Day Case 9 times longer than the required performance targets (refer to IEAP Targets presented in Table within response to Question 12).

285. This Performance position for the urology service had been registered within the Trust (refer to response to Question 7) as the solutions to address or manage this underperformance required HSCB involvement and at the performance meeting with the Health and Social Care Board (HSCB) through the Trust's corporate performance team.

Table 1 Summary of Urology Access waiting times 2016, 2019 and 2022:

| Specialty | | **Waiting time as at 1 April 16** | **Waiting time as at 1 April 19** | **Waiting time as at 1 April 22** |
|---|---|---|---|---|
| Urology | Outpatients | Red flag = 3.5 wks<br>Urgent = 40 wks<br>Routine = 73 wks | Red flag = 5-7 wks<br>Urgent = 168 wks<br>Routine = 175 wks | Red flag =11 wks<br>Urgent = 312 wks<br>Routine = 319 wks |
| Urology | Inpatient / Daycases | Urgent = 119 wks<br>Routine = 124 wks | Urgent = 249 wks<br>Routine = 277 wks | Urgent = 399 wks<br>Routine = 398 wks |

286. Those in attendance at the HSCB performance meetings included, the Directors of Commissioning (I believe the HSCB Directors in 2016 were Mr Dean Sullivan and Mr Michael Bloomfield), Director and Assistant Director of Performance and Reform (Mrs Paula Clarke and Mrs Lesley Leeman), Director Acute Services (Esther Gishkori), other Acute Assistant Directors (as the meeting would be for all acute commissioned services, not just Urology) and myself.

287. From 2016 to 2022 the senior personnel at the HSCB have changed along with the Director of Acute Services (now Melanie McClements) but the performances challenges and the gap between demand and capacity have remained.

*S21 5 of 2022 – 25. 20150501 Qu. 12 Actions Issues register – HSCB SHSCT ED and elect dir mtg*

*S21 5 of 2022 –20160614 Qu 12 Prep and action notes – HSCT SHSCT service issues and perf mtg*
*S21 5 of 2022 – 34. 20160921 Qu 12 Internal prep notes – HSCT SHSCT service issues and perf mtg*
*S21 5 of 2022 – 28. 20170530 Qu 12 Internal prep notes – HSCT SHSCT service issues and perf mtg*
*S21 5 of 2022 – 29. 20170530 Qu 12 Internal prep notes – HSCT SHSCT service issues and perf mtg A1*
*S21 5 of 2022 – 31. 20180523 Qu 12 Internal prep notes – HSCT SHSCT service issues and perf mtg*
*S21 5 of 2022 – 33. 20200923 Q12 Actions Issues Register - HSCB SHSCT Service Issues and Performance Meeting*
*S21 5 of 2022 –20160921 Qu 12 HSCB SHSCT Services issues and perf mtg*

**(b) What steps were taken (if any) to risk assess the potential impact of the concerns once known?**

288. To my knowledge there is no specific risk assessment forms or processes that the Trust or the HSCB complete to determine the level of risk associated with excessive waiting time for urology (or any medical specialty waiting list). However, the Trust, in consultation with HSCB, has carried on an annual basis some in house additionality, validation exercise as referenced in section 48h below and in recent contracts with the Independent Sector (see 48h below).

**(c) Did you consider that any concerns which were raised may have impacted on patient care and safety? If so, what steps, if any, did you take to mitigate against this? If not, why not.**

289. The waiting times for urology services were unfortunately not the only surgical services which had excessive waiting times (possible applied to all acute hospital specialties) (please see tables provided in response to Question 19). It was recognised that the waiting times could impact on patient care and safety, and steps taken in response included the following

a) Patient risk is recognised hence its placement on the Risk Register.
b) Trust SMT and Trust board are advised monthly as to the position for all services including Urology
c) Then GP's are furnished with a monthly elective access waiting time report which detail waiting times for OPD's and IN/DC's
d) The appointment of additional CNS's in 2019 and 2020 assisted with workload and enabling nurse lead clinics for such conditions as urinary incontinence and also for cancer patients to have the CNS as their key worker. However, addition of CNS did not impact on waiting times.
e) Despite several recruitment campaigns to secure additional Consultant Urologists the Trust has been unsuccessful.

**(d) If applicable, explain any systems and agreements put in place to address these concerns. Who was involved in monitoring and implementing these systems and agreements?**

290. In 2012/13 the waiting times targets were performance managed through a monthly benchmarking exercise to see had the urology service achieved their SBA volumes (level of commissioned activity agreed by the HSCB). In 2017 SBA was replaced by performance trajectories. Trajectories are clinical outputs for a service based on the resources the service has available to them e.g., 1 consultant working 42weeks annually undertaking one OPD clinic weekly times 8 patients equals a trajectory of 336 new outpatients annually

291. For the Trust's SMT and Trust Board this performance monitoring function is undertaken by the Corporate Performance Team.

292. Within the Acute Services the Director holds a monthly performance meeting and in attendance are our Corporate performance colleagues, acute AD's including myself and our OSL's.

293. As the operational AD for Surgery I too hold a monthly performance meeting with my Heads of Service and OSL to monitor and escalate all the waiting times for urology (and all surgical specialties).

294. As referred to in Part H of this question the allocation of non-recurrent monies assisted with some limited in-house additional work being undertaken.

**(e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?**

295. I assured myself by holding a monthly performance meeting at which a senior member (Head of Service Mrs Lynn Lappin) of the Corporate Performance team was present and reviewing the performance data and reports.

*S21 5 of 2022 –20191030 Q48 SCSCT Delivery of Core (OP) TRAJ v Actual Oct 19*
*S21 5 of 2022 –20191030 Q48 SCSCT Delivery of Core (IPDC) TRAJ v Actual Oct 19*

**(f) If you were given assurances by others, how did you test those assurances?**

296. I did not test the assurances given to me as the assurance and data provided were from a senior experienced Head of Performance, Head of Service (for urology and OSL who were more experienced and competent than I in using the Trust's information and data systems to gain information and compile reports. Nonetheless, I would have been able to identify trends to determine was the information and assurance provided correct.

**(g) Were the systems and agreements put in place to rectify the problems within urology services successful?**

297. The continuous monitoring of the Urology performance was successful in so far as the systems were able to highlight and predict waiting times and volumes of patients to be seen. Rectifying the performance problems for and within the elective limb of the urology service would and does require major transformational change in terms of modern infrastructure, health care workforce and running parallel to addressing and better managing the demand into the urology service. The urology service have been unable to have a full consultant complement, non-recurrent in house additionality has made very little difference to waiting time improvement and whilst the CNS are a welcome investment their role is to support patients through their pathway.

**(h) If yes, by what performance indicators/data/metrics did you measure that success? If not, please explain.**

298. The performances indicators measured predicted outcomes as explained in Question 48d for the urology service for both OPD and IN/DC activity. In 2019/20 the Urology Trajectories were OPD Amber (-7% (-143 under what we had predicted)) and IN/DC Green +19% (+473 above what was predicted by Oct 2019).

299. From Question 19 it was established that commissioned activity for the urology services was insufficient to meet the demand

300. Operationally the ability of the Urology service (all surgical specialties) to address their excessive waiting times and volume of patients waiting has been hampered internally by several major obstacles;

a) Having limited consultant urologists who are willing to undertake additional work,
b) Consultants reaching their pension thresholds per year and unwilling to undertake additional work which could leave them financially disadvantaged,
c) As most of the additional work is undertaken at the weekend it requires having sufficient theatre and recovery nurses available and willing to work and be recompensed via the Agenda for Change terms and conditions. There are currently 35 whole time equivalents (WTE) which is -17% of the nursing registrants workforce vacant
d) The perennial challenge of having sufficient inpatient beds available and ring fenced to accommodate patients following their surgery.

301. For several years ‘in-house’ additionality (hours above their JDs) was undertaken by some of the Consultants to address those patients awaiting urgent OPD appointments. Unfortunately, there were no non-recurrent monies or investment made available to address those patients awaiting routine OPD appointments. The ‘IHA Urology Attendances’ highlights the volume of in-house

undertaken between 2016 to 2022. The volumes are small relative to the volumes waiting and have little impact on the overall patient waiting times.

Table 1 In house additionality (IHA) Urology Attendances

| | 2016/2017 | 2017/2018 | 2018/2019 | 2019/2020 | 2020/2021 | 2021/2022 |
|---|---|---|---|---|---|---|
| Virtual Reviews | 0 | 0 | 9 | 102 | 8 | 83 |
| Face to Face Reviews | 132 | 41 | 62 | 113 | 8 | 30 |
| Virtual News | | | 0 | 18 | 0 | 0 |
| Mega Clinic (Pre Assessment) | 0 | 0 | 0 | 0 | 0 | 36 |
| Face to Face New | 128 | 0 | 48 | 141 | 0 | 0 |
| Elective Daycase stones | 7 | 0 | 5 | 3 | 0 | 0 |
| Elective Inpatients | 12 | 0 | 0 | 0 | 0 | 0 |
| Consultant led Validation | 0 | 140 | 0 | 0 | 0 | 0 |
| | | | | | | |

302. Independent Sector contracts were initiated at the end of 2021/22 allowing patients to have their care and treatment with an independent care provider. At the time of writing this submission the impact of this contract is yet to be realised however it would be the expectation that with the contract the volumes that new outpatient waiting times will decrease from 319 weeks to approximately 52 weeks by the end of the financial year if non-recurrent funding continues.

303. Independent Sector Urology Attendances

Table 2

| | 2021/22 Q4 (Jan to March 22 as funded by SPPG) | 2022/23 (anticipated volumes) Q1 only (April to June 22 as funded by SPPG at this stage) |
|---|---|---|
| Hermitage - Regional Contract | 23 | 90 |
| 352 New outpatient contract activity - Regional contract from 2022/23 | 808 | 1200* |

304. *Please note from 2022/23 the IS New Urology outpatient contract is a regional contract held by the Southern Trust, this means that other Trusts are able to transfer new urology referrals to the IS if required ie not all of the patient volumes relate to the Southern Trust. This is being regionally monitored and allocated by Strategic Planning and Performance Group (SPPG), previously known by HSCB. For Quarter 1 (April – June 2022) the Southern Trust have approximately 75% (800) share of the volumes. However, there is no guarantee that the non-recurrent funding will continue into Question 2-4 (July

2022 to March 2023) or that the Southern Trust will continue to have this level of access to the volumes in the contract.

305. To further assist the urology service in managing the demand and waiting times a validation process has been gone through for patient on the review backlog (January 2022). The first part of the process is known as administrative, that is, to see is the patient alive, do they still want the appointment or have they been seen privately or in another Trust. When the administrative process is complete, the consultant's then undertake clinical validation, that is, does the patients still need to have their review appointment. This validation exercise has yielded this outcome for the volume of patient awaiting a review urology appointment. The waiting time has changed little as the Urology longest patient waiting are assigned to Mr O'Brien.

Table 3

| TOTAL Review Back Log | | | |
|---|---|---|---|
| **SPEC** | **Apr-16** | **Apr-19** | **Apr-22** |
| **Urology** | 2021<br>June 2013 | 2711<br>April 2013 | 1368<br>July 2013 |
| **General Surgery** | 2839<br>December 2012 | 3520<br>April 2016 | 3253<br>March 2017 |
| **ENT** | 979<br>August 2013 | 2499<br>March 2016 | 1301<br>August 2017 |
| **Ortho** | 738<br>April 2014 | 844<br>May 2014 | 283<br>January 2017 |

**[49] Having regard to the issues of concern within urology services which were raised with you or which you were aware of, including deficiencies in practice, explain (giving reasons for your answer) whether you consider that these issues of concern were -**

**(a) properly identified, -**

306. For the issue of concern namely Urology performance this was identified properly. The reason I believe this were properly identified is because Urology performance is a fundamental indicator in regard to being able to provide a safe service. In regard to Urology performance this challenge had been known within the Trust, HSCB and DHPSS for many years with available solutions being limited.

**(b) their extent and impact assessed,**

307. The extent and the impact of excessively long patient waiting lists were recognised within the Trust, HSCB and DHPSS. A formal assessment on the impact of the urology waiting lists on patients was not conducted other than to place the risk on the Risk Register. However, the Trust in consultation with HSCB has carried on an annual basis some in house additionality, validation exercise as referenced in section 48h above and in recent contracts with the Independent Sector (see 48h above).

**(c) and the potential risk to patients properly considered?**

308. Similar to my response to 48 (b) there was no formal assessment or process that considered the level of patient risk.

**[50] What, if any, support was provided to urology staff (other than Mr O'Brien) by you and the Trust, given any of the concerns identified? Did you engage with other Trust staff to discuss support options, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not. (Q62 will ask about any support provided to Mr O'Brien).**

309. Following the submission of the 3 South Risk Assessment paper (referred to my response to Question 19) the Trust accepted the need to have a Nursing Practice Educator appointed (PE).

310. The role of the PE is to teach, supervise, support and mentor new nursing registrants as they transition from student to registrant. PE's enhance and improve standards of education within the clinical environments and help maintain the quality of practice placements for students nurses also.

311. The Nursing staff at ward level and CNS's continued to be supported by their ward sister, Lead Nurse and Head of Service.

312. Medical staff were supported by their CD and AMD.

313. Consultants were remunerated for undertaking the work associated with the untriaged referrals (783 referrals).

314. Human Resources or Occupational Health services were not offered at this stage as the issue was confined to Mr O' Brien.

315. For support to the entire Urology team I was part of the senior managers group to meet with the urology team. These meetings were held with the Chief Executive (Shane Devlin), Medical Director (Dr Maria O'Kane) and Director of Acute Services (Melanie McClements) and the urology team. Please also see response to Question 28 engagements between the staff and evidence.

**[51] Was the urology department offered any support for quality improvement initiatives during your tenure?**

316. The Urology Service was supported in a number of quality improvement initiatives during my tenure

317. 2018/19 - Southern Trust Stone Treatment Centre - Extracorporeal Shockwave Lithotripsy (ESWL)

318. ESWL is a method of using shockwaves applied to the back of a patient to treat kidney stones and ureteric stones (ureter is the pipe which drains urine from the kidney to the bladder). ESWL is undertaken with pain relief and no anaesthetic is needed unless the patient is a child, and is most commonly conducted as a day case. The alternative for stone treatment is ureteroscopy and percutaneous nephrolithotomy (PCNL), both of which require general anaesthetic and are conducted in a theatre setting

319. There is a proposal to expand the Urology Service into the Daisy Hill site, in the first instance this is to include Outpatients, day cases and some suitable inpatients this is dependent on all 7 consultant posts being filled.

*S21 5 of 2022 – 73. 20180101 Q51 Proposal for ADEPT Management project in SHSCT*
*S21 5 of 2022 – 20180101 Q51 ADEPT Project Stone presentation finance mtg Jan – final*
*S21 5 of 2022 – 20180101 Q51 Stone centre quality improvement Team doc*

**Mr. O'Brien**
**[52] Please set out your role and responsibilities in relation to Mr. O'Brien. How often would you have had contact with him on a daily, weekly, monthly basis over the years (your answer may be expressed in percentage terms over periods of time if that assists)?**

320. Responsibility for Mr O'Brien was professionally through Mr Young, Mr McNaboe and Mr Haynes and operationally through the Head of Service for Urology, Mrs Corrigan who reported to myself as AD.

321. I do not recall meeting or communicating directly with Mr O'Brien during my tenure.

**[53] What was your role and involvement, if any, in the formulation and agreement of Mr. O'Brien's job plan(s)? If you engaged with him and his job plan(s) please set out those details in full.**

322. The job planning process is undertaken through the Medical management line. I did not engage with Mr O'Brien in the formulation of his Job Plan.

**[54] When and in what context did you first become aware of issues of concern regarding Mr. O'Brien? Do you now know how long these issues were in existence before coming to your or anyone else's attention?**

I would have been aware as far back as 2007-2008 in my role as AD for CCS that Mr O'Brien presented challenges for the RBC and Mrs Corrigan with regard to obtaining referrals back for onward processing, particularly 'Red flag' Referrals, as this delayed patients starting on their cancer pathway. Not only did I ask Mrs Corrigan to do whatever she could to address this issue as the AD for CCS I escalated my concerns to Mrs Trouton so as to ensure Mr O'Brien complied with the triaging rules. Any further action I would have assumed lay with Mr O'Brien's managers within SEC. Through being an AD I was aware that Dr Gillian Rankin and Mrs Debbie Burns had had conversations with Mr O'Brien during their tenures. I recall in approximately 2008 when I met with each cancer multidisciplinary team including urology to communicate the new regional cancer guidance. Mr O'Brien said he didn't agree with the Cancer Standards and he would continue to practice as he had always practiced. I had transferred from the legacy Newry and Mourne Trust to the Southern Trust in June 2007. This was my first time meeting Mr O Brien, I had no prior knowledge of him. I do not recall everyone who was present at the meeting but the Head of Cancer Services (Alison Porter) and the Operational Support Lead (Wendy Clayton) would have accompanied me. Mr O'Brien's comment at the time did not raise concerns with me as I understood that the Cancer Standards and the processes involved to achieve the required outcome (i.e., 31/62 days) were new to everyone, that is, to the clinical teams and administrative teams alike. When we met with other clinical teams we were not always received with applause and there would have been clinicians who grumbled, but who did adhere. Throughout my career and working with medical staff it was never my experience that a doctor would wilfully not adhere to guidance that would benefit patients. Therefore, as I recall I viewed Mr O'Brien's comment as that of a clinician who was slow to change. In 2008 this was a big change. I knew the patient pathway involved a tracking element which ensured patients were tracked/managed to their first definitive treatment and there was an escalation process embedded into this new system.

*S21 5 of 2022 – 20121008 Q54 Red Flag Triage*
*S21 5 of 2022 – 20121102 Q54 email Urology RF Referrals breaching 72hr triage target*
*S21 5 of 2022 – 20121105 Q54 email Urology RF Referrals breaching 72hr triage target*
*S21 5 of 2022 – 20130214 Q54 Update Required for Cancer and Clinical team*
*S21 5 of 2022 – 20130219 Q54 Urology Referral*
*S21 5 of 2022 – 20130409 Q54 urology late triage*
*S21 5 of 2022 – 20130417 Q54 Urology Late Triage*
*S21 5 of 2022 – 20130705 Q54 Late Urology Triage*
*S21 5 of 2022 – 20140219 Q54 Cancer Performance*
*S21 5 of 2022 – 20140821 Q54 Cancer AD Urology RF Process*
*S21 5 of 2022 – 20150128 Q54 Urology MDM*
*S21 5 of 2022 – 20150130 Q54 Missing Urology Referrals*
*S21 5 of 2022 – 20150202 Q54 Red Flag Triage*

*S21 5 of 2022 – 20150415 Q54 Outstanding Red Flag Urology referral*
*S21 5 of 2022 – 20150526 Q54 email Outstanding referrals*
*S21 5 of 2022 – 20150701 Q54 Urology Late Triage Escalation*
*S21 5 of 2022 – 20151120 Q54 Missing Urology RF Referral Triage*
*S21 5 of 2022 – 20160106 Q54 email urgent action required urology referrals not back from triage*
*S21 5 of 2022 – 20160107 Q54 email DATIX* [redacted]
*S21 5 of 2022 – 20160218 Q54 email urology ref not back from triage*
*S21 5 of 2022 – 20160301 Q54 Triage*
*S21 5 of 2022 – 20160310 Q54 email Triage*

323. When I became the AD for SEC in April 2016 Heather Trouton (AD) had made me aware that Mr O'Brien had been issued with a letter from Mr Mackle and herself with regard to administrative aspects of his practice.

324. Prior to Mrs Trouton advising that Mr O'Brien had received a letter I would not have been aware of the issues regarding undictated clinics, patients' notes and private patients.

325. I became fully aware of the magnitude of these administrative issues in late December 2016 and into January 2017.

**[55] Please detail all discussions (including meetings) in which you were involved which considered concerns about Mr. O'Brien, whether with Mr. O'Brien or with others (please name). You should set out in detail the content and nature of those discussions, when those discussions were held, and who else was involved in those discussions at any stage.**

326. Prior to April 2016 while, I was not involved in any discussions or meetings centering on Mr O'Brien's administrative practices. I was aware from 2007-2008 in my role as AD for CCS through escalation reports that Mr O'Brien presented challenges for the RBC and Mrs Corrigan as Head of Services.

327. As described in my answer to Question 54 I was aware that they were delays in receiving referrals back from Mr O'Brien. I do not recall being part of any meeting or discussion to have this addressed and resolved.

328. From April 2016 I have not had discussions directly with Mr O' Brien with regard to concerns

329. It is apparent that in relation to Mr O'Brien there were long standing concerns re his administrative practices for a significant period of time, including that before my tenure (which I was aware of), coupled with an apparent inability to deal with him as a difficult colleague in a robust and consistent manner. To my knowledge, this culminated in Mr O'Brien being issued with a letter (March 23rd 2016) by Mrs Heather Trouton and Mr Mackle (AMD) specifying concerns in relation to Mr O'Brien's administrative practices and asking that he provide a plan to address the issues highlighted

330. On assuming the role of AD in April 2016 I was made aware by Mrs Heather Trouton (AD) that Mr O'Brien had been issued with the letter mentioned above. On receiving this information I did not take any further action as I understood Mr O'Brien had been asked to provide a plan to address the issues. (Please see my response to Question 68)

331. Thereafter, at an Oversight Committee Meeting took place on September 13th 2016, attended by Medical Director (Dr Wright), Acute Director Esther Gishkori and HR Director (Vivienne Toal) wherein Mr O'Brien's administrative practices were discussed. It was stated that a preliminary investigation had already taken place on paper. The actions emanating from that meeting included, a letter to be drafted and presented by Colin Weir (CD) and myself (AD) to Mr O'Brien, highlighting the Trust's intention to proceed with an investigation under MHPS if within a 4 week timescale the 4 main areas causing concern i.e. untriaged letters, outpatient review backlog, taking patient notes home and recording outcomes of consultations and discharges, had not been addressed.

332. As I recall it was following a meeting with Mrs. Gishkori and Dr McAllister that the actions of the 13th September were not progressed. Please see my response to Question 45 for more detail and the emails re Dr McAllister at Question 47v

333. A further Oversight Committee Meeting was held on October 12th 2016 which I did not attend

334. I later attended two oversight meetings.

(1) The first meeting I attended was on the 22nd December 2016 when I deputised for Mrs Esther Gishkori (Director of Acute Services). Present at this meeting as part of the oversight committee where Dr R Wright (Medical Director) and Mrs Vivienne Toal (Director of Human Resources). Also present was Dr Tracey Boyce (Director of Pharmacy and acute governance lead) and Mr Simon Gibson (Assistant Director in Medical Director's Office).

*S21 5 of 2022 – 93. 2016122 Q55 Action Note Oversight committee*

335. At this meeting, Dr Boyce summarised an ongoing SAI relating to a Urology patient who may have a poor clinical outcome due to the lengthy period of time taken by Dr O'Brien to undertake triage of GP referrals. Part of this SAI also identified an additional patient who may also have had an unnecessary delay in their treatment for the same reason. It was noted as part of this investigation that Dr O'Brien had been undertaking dictation whilst he was on sick leave.

336. I reported to the Oversight Committee that, between July 2015 and Oct 2016, there were 318 letters not triaged, of which 68 were classified as urgent. The range of the delay was from 4 weeks to 72 weeks.

(2) The second Oversight committee I attended was on the 10th January 2017

*S21 5 of 2022 – 94. 20170110 Q55 Action Note Oversight committee*

337. Present were Dr Richard Wright, Medical Director (Chair), Vivienne Toal, Director of HROD and Esther Gishkori, Director of Acute
In attendance also were Simon Gibson, Assistant Director, Medical Director's Office, Siobhan Hynds, Head of Employee Relations
Tracey Boyce, Director of Pharmacy, Acute Governance Lead and myself

338. At this meeting Dr Wright summarised the progress on this case to date, following the meeting with Mr O'Brien on 30th December 2016, including the following appointments to the investigation:

a) John Wilkinson as the Non-Executive Director
b) Ahmed Khan as the Case Manager
c) Colin Weir as the Case Investigator
d) Siobhan Hynds as the Head of Employee Relations supporting the investigation

339. I summarised the meeting that had taken place between Mrs Corrigan, Mr Weir, the Urologists and myself. I reported that the Urologists were supportive of working to resolve the position. I further updated the Oversight Committee in relation to the three issues identified, plus a fourth issue subsequently identified. The information for this update was obtained from undertaking physical searches, running reports through the various information/data system.

*S21 5 of 2022 – 20170103 Q55 Email Confidential AOB*

<u>Issue one - Untriaged referrals</u>

340. I reported that, from June 2015, there are 783 untriaged referrals, all of which need to be tracked and reviewed to ascertain the status of these patients in relation to the condition for which they were referred. All 4 consultants would be participating in this review

<u>Issue two – Notes being kept at home</u>

341. I reported that 307 notes were returned by Mr O'Brien from his home. 88 sets of notes located within Mr O'Brien's office.

342. 27 sets of notes, tracked to Mr O'Brien, were still missing, going back to 2003. Work was continuing to validate this list of missing notes. It was agreed to allow an additional seven days to track these notes down, in advance of informing the CEx and SIRO, and Information Governance Team.

<u>Issue three – undictated outcomes</u>

343. I reported that 668 patients have no outcomes formally dictated from Mr O'Brien's outpatient clinics.

344. 272 From the SWAH clinic

345. 289 From other clinics.

346. The remaining 107 patients were still being investigated

Issue four – private patients

347. I reported that a review of TURP patients identified 9 patients who had been seen privately as outpatients, then had their procedure within the NHS. The waiting times for these patients appear to be significantly less than for other patients. It would appear that there is an issue of Mr O'Brien scheduling his own patients in non-chronological manner.

(3) The third meeting which was part of the "Maintaining High Professional Standards" Investigation I met with Dr Neta Chada and Mrs Siobhan Hynds on Thursday 6th April 2017 to discuss my understanding of the administrative issues with Mr O'Brien's practice. I took no part in this investigation as an AD.

**[56] What actions did you or others take or direct to be taken as a result of these concerns? You should include details of any discussions with named others regarding these concerns. Please provide dates and details of any discussions, including any action plans, meeting notes, records, minutes, emails, documents, etc., as appropriate.**

348. Prior to April 2016 I had no awareness of any previous actions that had been placed on Mr O'Brien. Between April 2016 and December 2016 as stated previously I took no action with regard to the letter issued to Mr O'Brien, nor did Mr O'Brien come forward with his plan.

349. Action from the Oversight Committee Meeting of 22nd December 2016 included the following actions:

a) Untriaged Referrals: A written action plan to address this issue, with a clear timeline, would be submitted to the Oversight Committee by 10th January 2017: Lead: Ronan Carroll/Colin Weir
b) Casenote tracking: Casenote tracking was to be undertaken to quantify the volume of notes tracked to Dr O'Brien, and whether these are located in his office. Lead: Ronan Carroll
c) Undictated Clinics: A written action plan to address this issue, with a clear timeline would be submitted to the Oversight Committee on 10th January 2017: Lead: Ronan Carroll/Colin Weir
d) IR1's (this is the name of the Datix incident reporting form) and Complaints: It was agreed to consider any previous IR1's and complaints to identify whether there were any historical concerns raised. Action: Tracey Boyce

*S21 5 of 2022 - 20170106 Q56 outstanding notes on PAS as of 6 jan 17*
*S21 5 of 2022 – 20170127 Q56 Email Upgrade Red Flags.*
*S21 5 of 2022 – 20170124 Q56 Email Action note - 22nd December - AOB Action plan MC 24 January 2017*
*S21 5 of 2022 – 20170124 Q56 Action note - 22nd December - AOB Action plan MC 24 January 2017*
*S21 5 of 2022 – 20170208 updated missing notes as per 16 jan 17 updated*
*S21 5 of 2022 – 20170208 Email - updated missing notes as per 16 jan 17 updated*

350. Actions from the Oversight Committee Meeting 10th January 2017

Issue one - Untriaged referrals

a) I was to engage with all 4 consultants to commence reviewing those referrrals which had yet to be triaged.

Issue Two - Notes

b) I was to endeavour to locate missing notes.
c) Mrs Siobhan Hynds on behalf of Dr Khan would draft a letter on behalf of Dr Khan to Mr O'Brien, informing him who the NED was and, if necessary, asking him whether the 27 sets of notes were still at his house.

Issue Three – Undictated Outcomes

d) I was tasked to continue to complete the work associated with the undictated clinics

Issue Four - Private Patients

e) It was recognised that I would continue to lead the operational team in working through the issues identified to reach clear outcomes for all patients. It was agreed by the Oversight Committee that this work would be recognised at WLI rates, with consultants undertaking additional 4 hour sessions to progress the issues identified.

351. As part of the Investigation under the Maintaining High Professional Standards Framework into Mr O'Brien I met with Dr Neta Chada and Mrs Siobhan Hynds on April 6th 2017 –

*S21 5 of 2022 – 20170406 Q56 Dr Chada Witness statement*

352. My understanding is that Dr Khan met with Mr O'Brien on his return to work in February 2017 and a monitoring action plan put in place with the monitoring being delegated to Mrs Martina Corrigan – Head of Service. This monitoring action plan continued through to June 2020 at which time Mr O'Brien retired.

*S21 5 of 2022 – 20181123 Q56 Email AOB Action Plan*

353. I attended a meeting organised by Simon Gibson at which Dr Khan, Mr Haynes, Mrs Corrigan were present (21 January 2020). This meeting was in regard Mr O'Brien's compliance with the action plan which had been identified in September 2019 by Mrs Corrigan as being non-complaint with the action plan. In particular the meeting focused on a critique of the typing backlog template.

354. Please see response and email evidence in Question 47ii

**[57] Did you consider that any concerns raised regarding Mr O'Brien may have impacted on patient care and safety? If so:**

355. Considering the concerns detailed in the letter of the 23rd March 2016 on reflection myself (AD) and Mr Weir (CD) should have followed up directly with Mr O'Brien earlier to press for his action plan, as described in response Question 68, as the four elements may have impacted on patient care and safety.

356. On obtaining, the emails from Dr Boyce and Mr Haynes (please refer to response to Question 45) I recognised that this was a potential patient safety concern. My concerns were confirmed following the searches into the 4 elements and I had an appreciation of the magnitude of the various aspect of Mr O'Brien's administrative practices.

**(i) what risk assessment did you undertake, and**

357. When the extent of the administrative backlogs were identified and this enabled Mrs Corrigan, Oversight committee and myself to ascertain the extent and potential impact of the problem, I worked with the urology HoS to compile a report detailing the volumes of patients and/or notes for each of the four elements.

358. In terms of continuing risk from November 2016 to February 2017, Mr O'Brien was on Personal Information redacted by the USI leave and then exclusion leave. On his return to work in February 2017 all urology clinical activity had been allocated to other urology consultants until the end of March 2017. On return to work Mr O Brien's administrative work was being monitored by Mrs Corrigan.

359. The 783 untriaged referrals had by the end of January 2017 been triaged. The notes from home had been returned to the Trust and the notes in the office had been returned to medical records the 1st week in January 2017. The Undictated clinics were completed on return to work in February as Mrs Corrigan had not scheduled Mr O'Brien into any clinics until the end of July 2017.

*S21 5 of 2022 – 20170608 Q47vii undictated clinics*

360. The 783 untriaged patient referrals were screened by the Urology Consultants (not Mr O'Brien) and through this risk assessment 30 patients were identified as requiring upgrading to Red Flag Status. From that list of 30 patients, 5 patients in the period January 2016 to September 2016 were subject of an overarching SAI as reflected in the SAI report 69120 chaired by Dr Johnston.

**(ii) what steps did you take to mitigate against this? If none, please explain. If you consider someone else was responsible for carrying out a risk assessment or taking further steps, please explain why and identify that person.**

361. The steps taken included:

a) Having the 738 patient referrals triaged by the consultant urologists. This task was completed end of January 2017 (All the patients had initially been referred into the Trust as non-red flag referrals and not triaged).
b) To have all the patients notes removed from Mr O'Brien's office and to have all the notes outside of the hospital returned
c) To have the backlog of clinics outcomes typed
d) To review the number of patients having had a transurethral resection of prostate (TURP) over the previous 12mths to see had they been seen privately by Mr O Brien

**[58] If applicable, please detail your knowledge of any agreed way forward which was reached between you and Mr. O'Brien, or between you and others in relation to Mr. O'Brien, or between Mr O'Brien and others, given the concerns identified.**

362. I did not have any conversations or discussions directly with Mr O Brien. The Medical Director (Dr Wright) and Dr Khan had these discussions with Mr O'Brien. My understanding was Mr O'Brien was to comply with all elements of the action plan. This action plan detailed Mr O'Brien to return to his full job role as per his job plan and to include safeguards and monitoring around the 4 main issues of concerns under investigation. An urgent job plan review would be undertaken to consider any workload pressures to ensure appropriate supports could be put in place. The actions emanating from the plan are summarised as follows

363. Strict Compliance with the Trust's policies and procedures in relation to

a) Triaging of referrals
b) Contemporaneous note taking
c) Storage of medical notes

d) Private patients

*S21 5 of 2022 – 20170209 Q58 Returned to work Action Plan / Monitoring Arrangements*

**[59] What, if any, metrics were used in monitoring and assessing the effectiveness of the agreed way forward or any measures introduced to address the concerns? How did these measures differ from what existed before?**

364. The metrics were the four elements of the action plan implemented from February 2017. The process by which assurance was given was through Mrs Corrigan's monitoring of compliance with the Action Plan from February 2017 through June 2020. Initially this monitoring was weekly but Dr Khan, as the Case Manager, had requested this was changed to monthly in November 2018, but Mrs Corrigan continued to monitor weekly until she went off for surgery in June 2018.

*S21 5 of 2022 – 20170508 Q59 MHPS Case Update.*
*S21 5 of 2022 – 188. 20181123 Q59 email AOB Action plan*

365. I am unaware what previous metrics or processes had been utilised, prior to 2016, that would or did enable concerns surrounding Mr O'Brien's administrative processes to be addressed.

366. Mrs Corrigan, on completion of her auditing of the 4 elements forwarded the outcome for each monitoring period to Dr Khan (Case Manager) and Mrs Siobhan Hynds (Head of Employee Relations).

**[60] How did you assure yourself that any systems and agreements put in place to address concerns (if this was done) were sufficiently robust and comprehensive and were working as anticipated? What methods of review were used? Against what standards were methods assessed?**

367. I assured myself by knowing that Mrs Corrigan is a very experienced Head of Service with an administrative background enabling her to run reports on the various Trust's systems. The process agreed was to have these four elements monitored monthly by the Urology Head of Service with confirmation of compliance being sent via email to Dr Khan as the Case Manager.

368. Other than the short period when Mrs Corrigan was off work, monitoring of these four elements was conducted. When Mrs Corrigan went on from Personal information redacted by the USI leave from June – November 2018 the continuance of Mr O'Brien's monitoring ceased temporarily. As Mrs Corrigan's Line Manager I should have delegated this monitoring responsibility to another HOS, as HOS do share workloads in the short term). However as Mrs Corrigan's Personal Information redacted by the USI was only expected to be 1-2 months provision for an alternate monitor was overlooked. I would also comment that neither Dr Khan nor Mrs

Hynds, as the receivers of the regular audit outcomes, reminded me that they had not received the audits during this time.

**[61] Did any such agreements and systems which were put in place operate to remedy the concerns? If yes, please explain. If not, why do you think that was the case? What in your view could have been done differently?**

369. The system of monitoring the 4 elements of the action plan did have the required result to the point that Dr Khan instructed Mrs Corrigan that he should only receive the email report by exception.

370. In my view all employees need to be held to the same standard of practice. Mr O'Brien as an employee and a senior Doctor needed to comply with the same Trust systems and processes his colleagues complied with. I appreciate that individuals may need support and help on occasion and whilst I was aware that Mr O'Brien's administrative practices were problematic at no time did Mr O'Brien indicate to me directly or indirectly through another member of staff that he required assistance to undertake the full range of his duties. I was not aware he required help.

371. The action plan when set up was effective in the elements it was set up to monitor. The other aspects of Mr O'Brien's practice as articulated in Dr Hughes SAI report were not monitored as at that time January 2017 – June 2020 (approximately) I was unaware of these clinical concerns.

**[62] What support was provided by you and the Trust specifically to Mr. O'Brien given the concerns identified by him and others? Did you engage with other Trust staff to discuss support option, such as, for example, Human Resources? If yes, please explain in full. If not, please explain why not.**

372. I am advised and it is recorded in Dr Chada's investigation report that at a point in 2014 Mr Young assisted Mr O'Brien by doing his triage work when Mr O'Brien had raised the issue about competing work and other professional priorities and indicating he could not get triage completed.

373. During my tenure as AD of ATICS/EC, from April 2016 onwards, Mr O Brien did not raise any concerns directly with me or through another member of staff on his behalf.

374. When on Personal Information redacted by the USI leave (November 2016 – February 2017) Mr O'Brien was provided with support by way of being referred to occupational health in January 2017.

375. The un-triaged 783 non red flag referrals which had initially been sent to Mr O'Brien were subsequently triaged by the other urology consultants.

376. On return to work in February 2017 Mr O'Brien was issued with an action plan and a Head of Service Mrs Corrigan monitored in a supporting capacity his adherence to that plan. Mr O'Brien was also provided with time to undertake

clinical validation of his reviews, his inpatient and day case lists. I am unaware if Mr O'Brien received additional secretarial support. Mr O'Brien had 0.8WTE secretary.

377. Mr O'Brien's outpatient clinic template (each consultant has a template which describes the number of patients that can be booked into this clinic) was set at a lower number of patients per clinic. I have been unable to get the outpatient clinic templates but table one illustrates the activity for each consultant from April 2016 to March 2020 and it can be noted that Mr O'Brien's Outpatient Activity was the lowest amongst his peers.

Table 1 April 2016 to March 2020 Outpatient activity

| Consultant of Clinic Name | New Atts | Follow up Atts | Total Atts |
|---|---|---|---|
| GLACKIN A.J MR | 1643 | 3240 | 4883 |
| HAYNES M D MR | 1786 | 2005 | 3791 |
| JACOB T MR | 1695 | 1642 | 3337 |
| O'BRIEN A MR | 1093 | 2048 | 3141 |
| O'DONOGHUE J P MR | 1788 | 1983 | 3771 |
| YOUNG M MR | 2189 | 2797 | 4986 |

**[63] How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raise were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.**

378. From April 2016, I was aware of the concerns regarding the performance standards and these are captured on the Trust's performance risk register (Please see my response to Question 7 and Question 48 in this regard.

379. The letter of the 23rd March 2016 captured administrative concerns specifically in regard to Mr O'Brien's practice.

380. On the 23rd September 2016 and 12th October 2016 Oversight committee meetings (which I did not attend) referred to concerns with Mr O'Brien's administrative practices

381. The concerns raised by Mr Glackin and Mr Haynes were then captured throughout a series of Oversight meeting 22nd December 2016, 10th January 2017 and the 26th January 2017. Please see the following evidence

*S21 5 of 2022 – 91. 20160913 Q68 Action Note Oversight committee*

*S21 5 of 2022 – 92. 20161012 Q68 Action Note Oversight committee*
*S21 5 of 2022 – 93. 20161222 Q55 Action Note Oversight committee*
*S21 5 of 2022 – 94. 20170110 Q55 Action Note Oversight committee*
*S21 5 of 2022 – 95. 20170126 Q63 Action Note Oversight committee*

382. Dr Chada's investigation and Dr Khan's outcome report were documents also emanating from concerns raised by Mr Glackin and Haynes.

383. Dr Johnston's SAI (Personal Information redacted by USI) 22nd May 2022 is a document that also flowed from the concerns initially raised by Mr Glackin and Haynes.

**Learning**

**[64] Are you now aware of governance concerns arising out of the provision of urology services, which you were not aware of during your tenure? Identify any governance concerns which fall into this category and state whether you could and should have been made aware and why.**

384. I am now aware of the following:

385. Mr Haynes' email in June 2020 with regard to patients who Mr O'Brien wished to have scheduled for surgery, and the realisation that these patients were not on the Trust's Waiting Lists, gave rise to the Trust's 'Look Back' review. Any waiting list within the Urology Service (or any service within the Trust) that is dependent on a paper 'add to the waiting list' form being completed by a clinician, and this patient form being acted upon by their secretary to actually add the patient onto the electronic waiting list, may be vulnerable to human error. In 2017 this aspect of Mr O'Brien's administrative practice was not identified as being a concern, so accordingly was not reviewed. Whether this should have been detected earlier is difficult to say as, to my knowledge, it had never been raised before as being an administrative issue in respect of Mr O'Brien.

386. As a result of the SAI report on the review under the chairmanship of Dr Dermot Hughes, it was highlighted that Assurance Audits within Urology MDT were limited. Clinicians should have been completing these Assurance Audits or informing the Chair of the MDT that they were not being undertaken, communicating same through the medical management structure and in turn escalating to myself or the cancer management team. The 11 recommendations from this SAI review while focused on Urology, are currently being progressed through a Task and Finish Group comprising all Cancer MDTs and not only Urology. As the AD for CCS (2007-2016) Urology underwent peer review in 2015. The report made no reference to deficiencies in clinical audit. However with currently implementing the 11 recommendations it is evident that each MDT is deficient in audit capacity to undertake necessary audits, e.g. from monitoring qouracy to patient survival rates.

*S21 5 of 2022 – 20150616 Q64 Final Report for Urology 2015.*

387. Furthermore, I am now aware as a result of the same SAI report that 9 patients within Urology MDT under the care of Mr O'Brien only were being excluded from having an assigned CNS. The CNS should have been making their Lead Nurse aware of their exclusion who would in turn have escalated to myself. All other Urologists throughout had engaged an assigned CNS to each of their patients and this practice continues currently within the Urology MDT.

**[65] Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?**

388. There have been many challenges over the last 6 years not least with regard to ensuring a full complement of staff and consistent manpower levels for both medical and nursing professions exacerbated by the increased demand on the Urology service with the consequential impact on patient waiting times for outpatient appointments and inpatient/day case surgery. Unfortunately this scenario would not be uncommon, as referenced where appropriate within this S21 submission, for several medical and surgical specialties within the Southern Trust's Acute Services.

389. There is a Governance system to ensure that all the elements are complied with and monitored to provide assurance that the service is operating effectively and safely. However, that required full engagement and compliance from all employees within the Urology Service. When it is identified that practices are neither optimum nor in keeping with Best Practice, this requires understanding and managed plans to address plus a willingness and courage to confront difficult colleagues to ensure patient safety is paramount. It is clearly evident in the case of Mr O'Brien that for too long he was permitted, as described by Dr Chada to "do things his own way", and would have benefitted from closer supervision and management. Mr O'Brien appeared not to have been a team player and it is evident that he did not work to the Trust's expectations or requirements.

390. I do believe that Mr O'Brien's status as being the senior surgeon was a factor in staff accepting his administrative way of working with allowances being permitted.

**[66] What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and the unit, and regarding the concerns involving Mr. O'Brien in particular?**

391. On reflection, in addition to the response to Question 65, an additional clear learning is that the informal default triage (IDT) introduced, I believe, in 2014 simply enabled Mr O'Brien to continue with his own administrative practices that were not in keeping with regional guidance. Furthermore, despite a number of attempts to encourage Mr O'Brien to comply, he failed to do so. Within Urology and indeed any clinical service, where the accuracy of a system is not fully electronic (similar to the regional radiology information system, where an electronic referral must be completed if a clinician wants a radiology

test) and is dependent on a form being completed by a clinician and then that form having to be inputted onto the appropriate system, there exists a risk. The more steps and staff involved in the process, the greater the risk of human errors occurring.

392. From an administrative perspective there needs to be more checks and balances *in situ* with administrative staff empowered to raise and escalate concerns with ease, e.g., each clinic must have a clinic outcome (10 patients attended, 10 patients have outcomes) and this outcome is entered onto the Northern Ireland Electronic Care Record (NIECR) by the clinician.

393. Overall, I would hold the view that there is learning to be had in that if one aspect of a clinician's practice is viewed to be below the required standard, (in this case, administrative practices for elective work), then the clinician's whole practice should be considered by appropriate clinicians and managers to ensure there are no other deficiencies in practice/s that are not visible and which others are therefore unaware of.

**[67] Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.**

394. While workforce has been a challenge over the last 6 years, a series of recruitment campaigns were carried out in an effort to improve/resolve staffing levels for both medical and nursing professions with low levels of success. Consequently, a full complement of staff had not been attained. This necessitated and created a dependence on locums for both medical and nursing positions. Furthermore the Urology Services were also constrained in terms of available theatre capacity to accommodate their elective operating need which resulted in increased waiting times. As a result, where patients could not have their surgery electively in a timely manner they increasingly present to the emergency department for assessment and possible admission. I do not believe for these aspects there were failures to engage with the problem and efforts were made to find solutions at the highest levels with the health service in N. Ireland.

395. Despite the above challenges presented to the Urology Service a recurring problem was a failure to consistently and robustly manage Mr O'Brien to the same standard as his peers in the delivery of the service. However, Mr O'Brien's lack of accountability as a senior medical professional and lack of insight as to the serious consequence of his actions and omissions, in particular his lack of transparency in making any manager (medical or non-medical) aware that he was not now following the triage process, cannot be overlooked. I note that this view was also expressed in the investigations and reports undertaken by Dr Johnstone, Dr Chada and Dr Khan.

396. Other than the letter issued to Mr O'Brien on 23rd March 2016, I am unaware what previous efforts were made by Mrs Trouton and Mr Mackle, as the AD and AMD for surgery, to better manage Mr O 'Brien. I do not know what efforts were made by all the previous Directors of Acute Services, Medical Directors and Chief Executives during their tenures to manage Mr O'Brien.

397. What I can say is that, from December 2016 when I had a greater realisation as to the magnitude of Mr O'Brien's failings in administrative practices, I escalated immediately and a course of actions followed as described in earlier responses, which carried through to Mr O'Brien's retirement.

398. I feel that, post December 2016, there has been a high degree of engagement in relation to the issues associated specifically with Mr O'Brien's practices. These ranged from meetings with Mr O'Brien, a management action plan put in place for him to follow, monitoring of Mr O'Brien by Mrs Corrigan and Dr Khan from Febuary 2017 to June 2020, investigation by Dr Chada (commencing March 2017 through April 2018(, and Dr Khan's decision on receipt of the Dr Chada's report not to refer Mr O'Brien to GMC but rather to manage him through local measures. Furthermore, two SAIs were undertaken by external chairpersons, Dr Johnston and Dr Hughes and the most recent "Look-Back" review, which is still ongoing, are examples of purposeful engagement with the problems in urology.

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

399. Reflecting on my own mistakes I acknowledge that after a reasonable period of time (approximately 4 – 6 weeks) along with CD (Mr Weir) we should have communicated with Mr O'Brien to ascertain what plan he had or was proposing to address the issues highlighted in the letter of the 23rd March 2016. This was at the start of my AD tenure with SEC and I was occupied with understanding all the challenges that were present across all SEC.

400. It is apparent that, in relation to Mr O'Brien, there were concerns re his administrative practices for a significant period of time, including that period before my tenure (which I was aware of), coupled with an apparent inability to deal with him as a difficult colleague in a robust and consistent manner.

401. When Mrs Corrigan went on Personal Information redacted by the UOI leave June – November 2018, the continuance of Mr O'Brien's monitoring ceased temporally. This was my mistake as Mrs Corrigan's role was shared between two other HoS as initially Mrs Corrigan's convalescence was only expected to be 1-2 months. Whilst I accept I had a responsibility to audit and send the outcome as per the agreed

process to Dr Khan and Mrs Hynds, Dr Khan and/or Mrs Hynds as the receivers of the audit outcome could similarly have reminded me of its absence earlier.

402. When in December 2016 I became aware of Mr Glackin's email and having received Mr Haynes email directly I quickly escalated to my superiors and rapid action was taken including oversight committee meetings, an Investigation using the 'Maintaining High Professional Standard' Framework and a SAI review chaired by Dr Johnston all of which resulted in Mr O'Brien's closer supervision and monitoring. But as we are now aware there are other elements of Mr O'Brien's practice, as reflected in Dr Hughes SAI (February 2021), which were not identified or escalated at this stage.

403. In retrospect and reflecting, I would hold the view that the decision made on 13 September 2016 by the oversight committee to meet with and advise Mr O'Brien (during the week commencing 19th September 2016) of the Trust's intention to proceed with a formal investigation under MHPS should have been acted upon. The meeting would have included advising Mr O'Brien of a 4 week timescale to address the 4 main areas of his practice that were causing concern. I say this because, had these decisions been actioned the formal process would have commenced approximately 4 months earlier than it did in 2017 and the magnitude of what was discovered in late 2016 / early 2017would likely have been known to the Trust 4 months earlier. It also would have meant that the 5 patients who were the subject of a SAI chaired by Dr Johnston ([redacted]) would have been triaged much earlier than what was the case.

*S21 5 of 2022 – 91. 20160913 Q68 Action Note Oversight committee*
*S21 5 of 2022 – 92. 20161012 Q68 Action Note Oversight committee*

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

404. In the light of this public inquiry having to take place, it is difficult to state that the Trust's governance arrangements were fully fit for purpose, I accept mistakes were made by myself and possibly others. However, I am also reminded that all the circumstances that have brought us to this point have involved one clinician who had a very long history of 'doing his own thing'.

405. Governance arrangements are only fit for purpose if they monitor and audit the right things along with total reliance upon those staff in positions of authority ensuring that all the elements of good governance are not only in place but employed, utilised, monitored and audited and applied equally across all staff as applicable to their role.

406. Where individual staff fall short in that regard, as I believe was the case with Mr O'Brien over time, in the interests of patient safety the individual must be managed but must have personnel responsibility also, especially where they hold positions on Professional Registers. I respectfully concur with the

recommendation succinctly put by Dr Johnson in the Root Cause Analysis that "*The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with difficult colleagues and difficult issues, ensuring patient safety problems uncovered anywhere can make their way to the Medical Director and Chief Executives Table. This needs to be open and transparent with patients safety issues taking precedence over seniority, reputation and influence." (The underlined is my emphasis)*

407. Given the breath of specialties contained within ATICs/SEC, the clinically high risk areas contained with the Division (Theatres, Intensive Care, Pre-operative assessment, General Surgery, Urology, ENT, ENT, Trauma and Orthopaedics, in-patient wards and outpatients clinics), an annual budget of £66m, and approximately 1000 staff, I have held the view for a substantial period of time that the governance resource allocated to the ATICS/SEC Division were inadequate.

408. I have repeatedly asked over a number of years for governance officers to be appointed to each Clinical Division across acute (ATICS-SEC, Medicine and Unscheduled Care, Integrated Maternity and Women's Health & Cancer and Clinical Services. This dedicated resources would have the primary role of ensuring all aspects of governance, e.g., recommendations from complaints and SAI's, were progressed, embedded and audited. Within ATICs/SEC this governance role is too important and cannot be an "add on" to the Head of Service. Each Head of Service is battling deteriorating performance targets, endeavouring to rebuild elective series in the wake of the devastation brought by the pandemic to elective surgical services, workforce gaps (medical and nursing) across all specialties, whilst ensuring their service remains in budget or at best to minimise their specialty's overspend. To date these Governance officers have not been appointed.

409. I would also go so far as to say that, along with Divisional Governance officers, we need governance auditors who would and should bring a high degree of independent assurance with respect to key aspects of governance.

*S21 5 of 2022 – 20220405 Q69 email B5 governance posts*
*S21 5 of 2022 – 20211001 Q69 email governance post and live database*
*S21 5 of 2022 – 20211001 Q69 email governance post and live database A1*
*S21 5 of 2022 – 20180315 Q69 email governance structure in acute services*
*S21 5 of 2022 – 20180624 Q69 email Acute governance structure*
*S21 5 of 2022 – 20180624 Q69 email Acute governance structure org chart A1*
*S21 5 of 2022 – 20180624 Q69 email Acute governance structure proposal discussion A2*

410. I would suggest the Trust needs to review its Governance structures and decide;

a) Whether Governance needs more resourcing, to which my answer is yes.
b) Whether a centralised corporate controlled model is preferable to a Directorate/Programme of Care model with feedback back to the centre.

c) From a governance perspective there is also learning to be obtained by having clarity between medical and non-medical managers in regard to who is responsible for Clinical Governance and all the elements that make up this umbrella term.

411. Central to Clinical Governance and therefore patient safety is how management is structured, professional management *vs* general management. I have had experience pre The Review of Public Administration in the legacy Newry and Mourne Trust in Daisy Hill Hospital where the Medical Director and the Executive Director of Nursing had clear operational and professional responsibility for all medical staff and nursing staff. There is strength in this model as one clear line of reporting.

412. General management where health professionals report to an operational manager (who may or may not be a health professional) and then have line (often dotted) to a professional manager can be confusing. With experience of having worked in both systems, I hold the view that the health professionals reporting to one manager, both operationally & professionally, is a better model. I would suggest that in health care every operational decision or issue has a professional consequence or impact, which can be positive or negative.

413. To strengthen Clinical Governance medical managers need more time in their Job Plan's allocated to being managers. The current allocation of 2PAs is insufficient. I appreciate that many clinicians do not wish to be managers, or if they do, they only want to be a very part-time one, but management and governance are too important not to have the correct resource allocated to these functions. Having medical managers with greater amounts of management time allows for greater structure in the Division as there would be time to meet frequently to discuss, review and plan the Division's business.

**[70] Given the Inquiry's terms of reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?**

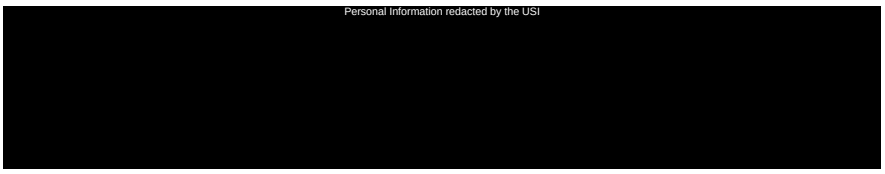
414. I believe that I have addressed all questions to assist the Inquiry honestly and fully to the best of my ability.

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

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

**Statement of Truth**

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

Signed: __ 

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Date: _____16.05.2022_____

**S21 5 of 2022**

**Witness statement of: Ronan Carroll**

**Table of Attachments**

| Attachment | Document Name |
|---|---|
| 1 | 20070301 doc Number 5 JD AD for CCS |
| 2 | 20160401 doc RC number 6 Management structure CCS ATICS |
| 3 | 20220401 doc RC number 6 Management structure SEC ATICS |
| 4 | 20220401 number 6 HOS ENT, Urology, OPD management structure |
| 5 | 20220228 number 6 HOS ENT, Urology, OPD Band 6 and 7 Staff in post |
| 6 | 20160401 excel number 7 April 16 Performance Risk register |
| 7 | 20220301 excel number 7 March 22 Divisional risk register |
| 8 | 20220301 question 8 CD General Surgery JD |
| 9 | 20220301 question 8 CD ENT Urology JD |
| 10 | 20210701 question 8 Interim DivMD JD SEC (FINAL) |
| 11 | 20170601 question 8 AMD – SEC job description June 2017 |
| 12 | 20151109 question 8 Clinical Director Surgery Elective Care JD |
| 13 | 20220328 question 8 Trust Board Workshop CSCG 28.02.2022 |
| 14 | 20080430 doc question 11 Integrated Elective Access Protocol Revised 30apr08 |
| 15 | 20200601 doc question 11 IEAP June 2020 |
| 16 | 20080102 doc question 11 A guide to cancer waiting times |
| 17 | 20160401 to 20170331 question 12 Urology cancer 31 and 62 day completed waits |
| 18 | 20170401 to 20180331 question 12 Urology cancer 31 and 62 day completed waits |
| 19 | 20180401 to 20190331 question 12 Urology cancer 31 and 62 day completed waits |
| 20 | 20190401 to 20200331 question 12 Urology cancer 31 and 62 day completed waits |
| 21 | 20200401 to 20210331 question 12 Urology cancer 31 and 62 day completed waits |
| 22 | 20210401 to 20220331 question 12 Urology cancer 31 and 62 day completed waits |
| 23 | 20200101 doc question 12 Urology MDT Business Meeting Jan 2020 |
| 24 | 20160401 to 20220331 Q12 IHA and IS urology funding |
| 25 | 20150501 Qu 12 Actions Issues Register - HSCB SHSCT ED and Elective Directors Meeting |
| 26 | 20160614 Qu 12 Prep and action notes – HSCT SHSCT service issues and perf mtg |
| 27 | 20160921 Qu 12 Internal prep notes – HSCT SHSCT service issues and perf mtg |
| 28 | 20170530 Qu 12 Internal prep notes – HSCT SHSCT service issues and perf mtg |
| 29 | 20170530 Qu 12 Internal prep notes – HSCT SHSCT service issues and perf mtg A1 |
| 30 | 20180523 Qu 12 Internal prep notes – HSCT SHSCT service issues and perf mtg |
| 31 | 20180523 Q12Internal Prep Note - HSCB SHSCT Service Issues and Performance Meeting A1 |
| 32 | 20180523 Q12 Internal Prep Note - HSCB SHSCT Service Issues and Performance Meeting A2 |
| 33 | 20200923 Q12 Actions Issues Register - HSCB SHSCT Service Issues and Performance Meeting |
| 34 | 20160921 Q12 Internal Prep Notes - HSCB SHSCT Service Issues and Performance Meeting |
| 35 | 20160226 Q12 Internal Prep Notes HSCB SHSCT Mtg |
| 36 | 20160401 question 14 performance risk register |
| 37 | 20220401 – Q18 Urology Demand Capacity Review Slides |
| 38 | 20220503 Q18 Email Consultant Urologists Recent Advertisement |
| 39 | 20220503 Q18 Word Doc CONSULTANT UROLOGIST RECENT ADVERTISING |
| 40 | 20181201 doc question 19 3 South Risk assessment |
| 41 | 20211101 to 20220531 Q20 Urology consultant job plans |
| 42 | 20220601 Q20 Urology consultant job plans |

| Attachment | Document Name |
|---|---|
| 43 | 20210401 Q20 JP overview AG |
| 44 | 20210401 Q20 JP overview JOD |
| 45 | 20211025 Q20 JP overview MT |
| 46 | 20211101 Q20 JP overview MH |
| 47 | 20211101 Q20 JP overview MY |
| 48 | 20210931 question 23 Backlog report all specialities monthly total |
| 49 | 20211230 question 23 Backlog report all specialities monthly total |
| 50 | 20220331 question 23 Backlog report all specialities monthly total |
| 51 | 51. 20220414 question 14 Urology Team Meeting NOTES 14.04.2022 |
| 52 | 52. 20220414 question 14 Urology Team Meeting NOTES 14.04.2022 A1 |
| 53 | 53. 20220414 question 14 Urology Team Meeting NOTES 14.04.2022 A2 |
| 54 | 20210613 doc question 26 KSF 21.22 signed WC |
| 55 | 20190627 question 26 KSF 19.20 signed MC |
| 56 | 20170825 question 26 KSF 17.18 signed MC |
| 57 | 20190601 question 27 over ATIC SEC performance workplan |
| 58 | 20190903 question 27 AD PDP 19.20 |
| 59 | 20190903 question 27 AD PDP 19.20 work plan A1 |
| 60 | 20210613 question 27 AD PDP 21.22 |
| 61 | 20180621 Q28 Head of Service 1 to 1 |
| 62 | 20190228 Q28 Head of Service 1 to 1 |
| 63 | 20210309 Q28 Head of Service 1 to 1 |
| 64 | 20201215 Q28 Urology Team Group-Minutes( 15 Dec 2020) |
| 65 | 20201208 Q28 Urology Team Group-Minutes( 15 Dec 2020) |
| 66 | 20210216 Q28 Urology team group minutes |
| 67 | 20210216 Q28 Urology Team Group Minutes 16.02.2021 A1 |
| 68 | 20210112 Q28 Urology team group minutes A1 |
| 69 | 20161201 Q29 THUGs notes |
| 70 | 20170302 Q29 THUGs notes |
| 71 | 20181206 Q29 THUGs notes |
| 72 | 20190404 Q29 THUGs notes |
| 73 | 20180101 Q51 Proposal for ADEPT Management project in SHSCT |
| 74 | 20141106 doc question 31 working draft SHSCT incident mgmt. procedure |
| 75 | 20190501 doc question 31 HSC-SQSD-05-19 Early Alert System |
| 76 | 20220506 doc question 33 Email SAI's by Specialty - listed by Datix Number and Final Report date (year) |
| 77 | 20220506 doc question 33 Spreadsheet SAI's by Specialty - listed by Datix Number and Final Report date (year) |
| 78 | 20220504 Q36 Email 3S Datix |
| 79 | 20220504 Q36 email 3S Datix A1 |
| 80 | 20190401 Q36 Acute Governance Patient Safety Report April 2019 |
| 81 | 20190901 Q36 Acute Governance Patient Safety Report Sept 2019 |
| 82 | 20200301 Q36 Acute Governance Patient Safety Report March 2020 |
| 83 | 20200701 Q36 Acute Governance Patient Safety Report July 2020 |
| 84 | 20201001 Q36 Acute Governance Patient Safety Report Oct 2020 |
| 85 | 20210101 Q36 Acute Governance Report Jan21 (2) |
| 86 | 20210801 Q36 Acute Governance Report Aug21 |
| 87 | 20211101 Q36 Acute Governance Report Nov21 |
| 88 | 20170509 question 36 email urology e-triage |
| 89 | 20200128 Q39 Good-medical-practice – English pdf |

| Attachment | Document Name |
|---|---|
| 90 | 20181010 Q39 NMC code pdf |
| 91 | 20160913 Q68 Action Note Oversight committee |
| 92 | 20161012 Q68 Action Note Oversight committee |
| 93 | 20161222 Q55 Action note Oversight committee |
| 94 | 20170110 Q55 Action note Oversight committee |
| 95 | 20170126 Q63 Action note oversight committee |
| 96 | 20160905 Q40 Private patient letter |
| 97 | 20161215 Q40 Letter SAI Panels Concerns |
| 98 | 20161216 Q40 Email Concerns raised by an SAI Panel |
| 99 | 20161223 Q40 Email Management of PP's - Non Chronological Listing |
| 100 | 20170628 Q43 HSCB Performance Management Framework – Performance Improvement trajectories. pdf |
| 101 | 20160101 to 20200101 doc question 44 Urology appraisals |
| 102 | 20160101 to 20200101 doc question 44 Urology JPs |
| 103 | 20190501 doc question 45 HSC-SQSD-05-19 Early Alert System |
| 104 | 20220504 Q45 Email Early Alert System 2010 |
| 105 | 20141001 doc question 45 Incident reporting procedure |
| 106 | 20190901 doc question 45 Risk management strategy |
| 107 | 20200611 email Patients to be added to Urgent Bookable List |
| 108 | 20211101 Q45 UAG Minutes |
| 109 | 20211125 Q45 UAG Minutes |
| 110 | 20220106 Q45 UAG Minutes |
| 111 | 20220217 Q45 UAG Minutes |
| 112 | 20220303 Q45 UAG Minutes |
| 113 | 20220331 Q45 UAG Minutes |
| 114 | 20220414 Q45 UAG Minutes |
| 115 | 20220428 Q45 UAG Minutes |
| 116 | 202200411 Q45 Lookback Steering Group Minutes |
| 117 | 20220509 Q45 Lookback Steering Group Minutes |
| 118 | 20220328 Q45 Lookback Steering Group Minutes |
| 119 | 20220314 Q45 Lookback Steering Group Minutes |
| 120 | 20220228 Q45 Minutes of lookback meeting |
| 121 | 20220214 Q45 minutes of lookback meeting |
| 122 | 20220131 Q45 minutes of lookback meeting |
| 123 | 20220117 Q45 minutes of lookback meeting |
| 124 | 20220106 Q45 Lookback Steering Group Minutes |
| 125 | 20211220 Q45 Lookback Steering Group Minutes |
| 126 | 20211206 Q45 Lookback Steering Group Minutes |
| 127 | 20211122 Q45 Lookback Steering Group Minutes |
| 128 | 20211115 Q45 Lookback Steering Group Minutes |
| 129 | 20211111 Q45 Lookback Steering Group Minutes |
| 130 | 20170613 Email Q46 Proof read, comment |
| 131 | 20170615 Q46 100 |
| 132 | 20180418 Q45 Letter of Concern |
| 133 | 20181024 Q24 Update on CW |
| 134 | 20190117 Q46 An idea |
| 135 | 20190609 Q46 My Job Plan |
| 136 | 20190612 Q46 GP Concerns regrading Red Flag referral |
| 137 | 20200124 Q47ii Email for response Request AOB Meeting |

| Attachment | Document Name |
|---|---|
| 138 | 20220407 Q47v Notes of meeting CCS meeting 07.04.11 |
| 139 | 20120216 Q47v Notes of meeting CCS meeting 16.02.12 |
| 140 | 20111013 Q47v Notes of meeting CCS meeting 13.10.11 |
| 141 | 20110210 Q47v Notes of meeting CCS meeting 10.02.11 |
| 142 | 20101007 Q47v Notes of meeting CCS meeting 07.10.10 |
| 143 | 20160822 Q47v email confidential AOB |
| 144 | 20160831 Q47v email E Walter Alan Copeland |
| 145 | 20160921- Q47v E meeting Mr O'Brien |
| 146 | 20170224 Q47v email regional urology proposal |
| 147 | 20190906 Q47v email allocation letter update |
| 148 | 20200925 Q47v email Emergency general surgery |
| 149 | 20200925 Q47v email Emergency general surgery A1 |
| 150 | 20181206 Q47v Notes of Thugs Meeting |
| 151 | 20190502 Q47v NOTES Thugs |
| 152 | 20190419 Q47v April 19 ATICs NOTES Business Meeting |
| 153 | 20160616 Q47 vii OPD Project |
| 154 | 20161016 Q47 vii Discharge lounge |
| 155 | 20170118 Q47 vii capital Requisition not raised |
| 156 | 20180110 Q47 vii Urology Registrar foir tonight |
| 157 | 20180608 Q47 vii Urology Waiting list |
| 158 | 20181220 Q47 vii Thorndale |
| 159 | 20190322 Q47 vii Service improvement post |
| 160 | 20190909 Q47 vii Trus Ultrasound |
| 161 | 20200220 Q47 vii Update regarding Fermanagh Urology patients |
| 162 | 20190926 Q47 (vii) Complaint Pers onal Infor |
| 163 | 20161222 Q47vii email Urology missing triage |
| 164 | 20161222 Q47vii email Urology missing triage A1 |
| 165 | 20161223 Q47vii email Backlog report no clinic outcomes as per 15.12.16 |
| 166 | 20161223 Q47vii email Backlog report no clinic outcomes as per 15.12.16 A1 |
| 167 | 20161228 Q47vii email Audit of charts re AOB |
| 168 | 20170106 Q47 vii email TURP audit |
| 169 | 20170110 Q47vii untriaged as of 10 january 2017 |
| 170 | 20170110 Q47vii email Confidential confirmation of further oversight mtg re AOB 10.1 |
| 171 | 20170110 Q47vii email Confidential confirmation of further oversight mtg re AOB 10.1 A1 |
| 172 | 20170110 Q47vii email Confidential confirmation of further oversight mtg re AOB 10.1 A2 |
| 173 | 20170110 Q47vii email Confidential confirmation of further oversight mtg re AOB 10.1 A3 |
| 174 | 20170110 Q47vii email Confidential confirmation of further oversight mtg re AOB 10.1 A4 |
| 175 | 20170113 Q47vii email audit of charts for AOB |
| 176 | 20170116 Q47vii email outstanding charts for AOB |
| 177 | 20170116 Q47vii email outstanding charts for AOB A1 |
| 178 | 20170124 Q47vii email action note 22 Dec AOB action plan MC 24 Jan 17 |
| 179 | 20170124 Q47vii email action note 22 Dec AOB action plan MC 24 Jan 17 A1 |
| 180 | 20170124 Q47vii email strictly private and confid. AOB |
| 181 | 20170208 Q47vii email Return to work action plan Feb 17 |
| 182 | 20170208 Q47vii email Return to work action plan Feb 17 A1 |
| 183 | 20170209 Q47vii email return to action plan Feb 17 |
| 184 | 20170303 Q47vii email urology etriage |
| 185 | 20170313 Q47vii email AOB |
| 186 | 20170313 Q47vii email wrong notes sent through earlier mtg with AOB Weir 9.3.17 |

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| 187 | 20170313 Q47vii email wrong notes sent through earlier mtg with AOB Weir 9.3.17 A1 |
| 188 | 20181123 Q47vii Email AOB Action Plan |
| 189 | 20200626 Q47viii Phlebotomy Hub |
| 190 | 20160614 Qu 12 Prep and action notes – HSCB SHSCT service issues and perf mtg |
| 191 | 20160921 Qu 12 Internal prep notes – HSCT SHSCT service issues and perf mtg |
| 192 | 20191030 Q48 SCSCT Delivery of Core (OP) TRAJ v Actual Oct 19 |
| 193 | 20191030 Q48 SCSCT Delivery of Core (IPDC) TRAJ v Actual Oct 19 |
| 194 | 20180101 Q51 ADEPT Project Stone presentation finance mtg Jan – final |
| 195 | 20180101 Q51 Stone centre quality improvement Team doc |
| 196 | 20121008 Q54 Red Flag Triage |
| 197 | 20121102 Q54 email Urology RF Referrals breaching 72hr triage target |
| 198 | 20121105 Q54 email Urology RF Referrals breaching 72hr triage target |
| 199 | 20130214 Q54 Update Required for Cancer and Clinical team |
| 200 | 20130219 Q54 Urology Referral |
| 201 | 20130409 Q54 urology late triage |
| 202 | 20130417 Q54 Urology Late Triage |
| 203 | 20130705 Q54 Late Urology Triage |
| 204 | 20140219 Q54 Cancer Performance |
| 205 | 20140821 Q54 Cancer AD Urology RF Process |
| 206 | 20150128 Q54 Urology MDM |
| 207 | 20150130 Q54 Missing Urology Referrals |
| 208 | 20150202 Q54 Red Flag Triage |
| 209 | 20150415 Q54 Outstanding Red Flag Urology referral |
| 210 | 20150526 Q54 email Outstanding referrals |
| 211 | 20150701 Q54 Urology Late Triage Escalation |
| 212 | 20151120 Q54 Missing Urology RF Referral Triage |
| 213 | 20160106 Q54 email urgent action required urology referrals not back from triage |
| 214 | 20160107 Q54 email DATIX Personal Information redacted by USI |
| 215 | 20160218 Q54 email urology ref not back from triage |
| 216 | 20160301 Q54 Triage |
| 217 | 20160310 Q54 email Triage |
| 218 | 20170103 Q55 Email Confidential AOB |
| 219 | 20170106 Q56 outstanding notes on PAS as of 6 jan 17 |
| 220 | 20170127 Q56 Email Upgrade Red Flags |
| 221 | 20170124 Q56 Email Action note - 22nd December - AOB Action plan MC 24 January 2017 |
| 222 | 20170124 Q56 Action note - 22nd December - AOB Action plan MC 24 January 2017 |
| 223 | 20170208 updated missing notes as per 16 jan 17 updated |
| 224 | 20170208 Email - updated missing notes as per 16 jan 17 updated |
| 225 | 20170406 Q56 Dr Chada Witness statement |
| 226 | 20181123 Q56 Email AOB Action Plan |
| 227 | 20170608 Q47vii undictated clinics |
| 228 | 20170209 Q58 Returned to work Action Plan / Monitoring Arrangements |
| 229 | 20170508 Q59 MHPS Case Update |
| 230 | 20150616 Q64 Final Report for Urology 2015 |
| 231 | 20220405 Q69 email B5 governance posts |
| 232 | 20211001 Q69 email governance post and live database |
| 233 | 20211001 Q69 email governance post and live database A1 |
| 234 | 20180315 Q69 email governance structure in acute services |
| 235 | 20180624 Q69 email Acute governance structure |

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|---|---|
| 236 | 20180624 Q69 email Acute governance structure org chart A1 |
| 237 | 20180624 Q69 email Acute governance structure proposal discussion A2 |

# Southern Health and Social Care Trust
# Assistant Director of Cancer and Clinical Services
# Band 8C

# Job Description

## JOB SUMMARY

The jobholder will be responsible to the Director of Acute Services for the delivery of high quality care to patients in the Trust's Cancer and Clinical Services Division. He/She will be responsible for the operational management of all specialties and departments in the division. In addition to cancer, this will incorporate clinical services such as critical care, theatres, anaesthetics, radiology, pharmacy, laboratories, psychology, outpatients and infection control in Craigavon Area Hospital, Daisy Hill Hospital and other settings as appropriate. He/She will collaborate closely with senior clinicians and other disciplines to implement the objectives of the Trust's Delivery Plan and ensure effective multidisciplinary working. He/She will provide clear leadership to all staff in the division and will be responsible for effective financial management and the efficient use of all resources. The jobholder will also support the Director of Acute Services with long term planning and service reform initiatives.

As an Assistant Director, the jobholder will be a member of the directorate's senior management team and will therefore contribute to policy development in the directorate and the achievement of its overall objectives.

## KEY RESULT AREAS

### Service Delivery

- lead multidisciplinary teams and oversee the co-ordination of all processes to ensure the delivery of high quality and equitable care to patients in the Trust's cancer and clinical services division.
- ensure the successful implementation of all DHSSPS, HSSA and commissioning priorities and targets in the division with a particular emphasis on those relating to waiting times and the establishment of agreed treatment schedules.
- work closely with senior clinicians and other senior managers in the Trust to secure an appropriate balance between hospital and community based services and achieve an integrated approach in reducing inappropriate hospital admissions and lengths of stay.

- contribute to the development of robust clinical and professional networks within the division and across the Trust.

**Quality and Governance**

- ensure that the needs of patients and their carers are at the core of how all specialties in the division deliver their services and are in accordance with DHSSPS Quality Standards for Health and Social Care and other relevant requirements.
- ensure high standards of governance in the division to include compliance with controls assurance standards, the assessment and management of risk and the implementation of the DHSSPS's Safety First framework.
- ensure the division complies with all professional, regulatory and requisite standards.
- ensure the division meets all targets for the prevention and control of healthcare associated infection and standards of environmental cleanliness.
- ensure all recommendations from the RQIA and other regulatory bodies are implemented within requisite timescales.
- ensure the management of complaints within the division comply with HPSS Complaints and Trust Procedures and are underpinned by transparency and a culture of continuous improvement.
- lead on the implementation of quality initiatives such as Investors in People and Charter Standards in the division.

**Service Planning and Development**

- promote innovation and change to underpin the modernisation of the division's services and oversee the implementation of initiatives such as HQS or similar.
- assist the Director of Acute Services with the development of a strategic plan for the delivery of acute hospital care to the Trust's population in line with regional strategies and priorities.
- work closely with commissioners and relevant stakeholders to secure their commitment and involvement in the development and implementation of planning initiatives and service reforms.
- liaise closely with senior planning staff on service and capital development initiatives and ensure adherence to targets set by the HSSA and the Trust's corporate and delivery plans.
- act as a member of the directorate's senior management team and contribute to its policy development processes.
- represent the division and/or directorate in Trust and/or regional planning teams as appropriate.

**Financial and Resource Management**

- responsible for the management of the division's budget and the meeting of all financial targets by each specialty.
- ensure the effective implementation of all Trust financial policies and procedures in the division which will include ensuring the safe custody of patients' property and accounts and the use of endowments and gifts.
- participate in contract and service level negotiations with commissioners.
- ensure the effective management, use and maintenance of all physical assets in the division.

**People Management**

- provide clear leadership to staff within the division and ensure all specialties have a highly skilled, flexible and motivated workforce.
- work closely with senior human resources staff to take forward the development and implementation of workforce planning and modernisation initiatives.
- ensure that management structures and practices in the division support a culture of effective team working, continuous improvement and innovation.
- ensure the effective implementation of all Trust people management policies in the division and the achievement of all relevant targets such as relating to the management of sickness and absenteeism, turnover etc.
- ensure the effective management of staff health and safety and support in the division.

**Information Management**

- ensure the effective implementation of all Trust information management policies and procedures in the division.
- ensure the division's systems and procedures for the management and storage of information meet internal and external reporting requirements.

**Corporate Responsibilities**

- develop and maintain working relationships with other directorate colleagues to ensure achievement of Trust objectives.
- establish collaborative relationships and networks with external stakeholders in the public, private and voluntary sectors to ensure the Trust effectively discharges its functions.
- 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.

- adhere to 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.
- lead by example in practising the highest standards of conduct in accordance with the Code of Conduct for HPSS Managers.

**General Management Responsibilities**

- participate in the Trust's Staff Development and Performance Review Scheme. Review individually on a regular basis the performance of immediately subordinate staff. Provide guidance on personal development requirements and advise on and initiate, where appropriate, further training.
- ensure that the review of performance identified above is performed for all levels of staff within the Trust in accordance with the Trust Board's policy.
- maintain good staff relationships and morale amongst the staff reporting to him/her.
- where appropriate, review the organisational plan and establishment levels and ensure that each is consistent with achieving objectives and recommend change where appropriate.
- delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making whilst retaining responsibility and accountability for results.
- participate as required in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.
- take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.
- 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 whom he/she has responsibility.

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 Assistant Director of Cancer and Clinical Services works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time by the Director of Acute Services.

**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 into 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.

March 2007

# Southern Health and Social Care Trust
# Assistant Director of Cancer and Clinical Services

## Personnel Specification

Knowledge, skills and experience required:

Applicants must provide evidence by the closing date for application that they are a permanent employee of either Armagh and Dungannon, Craigavon Area Hospital Group Trust, Craigavon and Banbridge Community HSS Trust or Newry and Mourne HSS Trust and have:

- university degree or relevant professional qualification and worked for at least 2 years in a senior management role in a major complex organisation.

OR

- have worked for at least 5 years in a senior management role in a major complex organisation.

AND

- delivered against challenging performance management programmes for a minimum of 2 years in the last 6 years meeting a full range of key targets and making significant improvements.
- worked with a diverse range of stakeholders, internal and external to the organisation, to achieve successful outcomes for a minimum of 2 years in the last 6 years.
- a proven track record of people management, governance and organisational skills for a minimum of 2 years in the last 6 years.
- 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. Particular attention will be given to the following:

- Self Belief
- Self Management
- Seizing the future
- Drive for results
- Leading change through people
- Holding to account
- Effective and strategic influencing

The following additional clarification is provided:

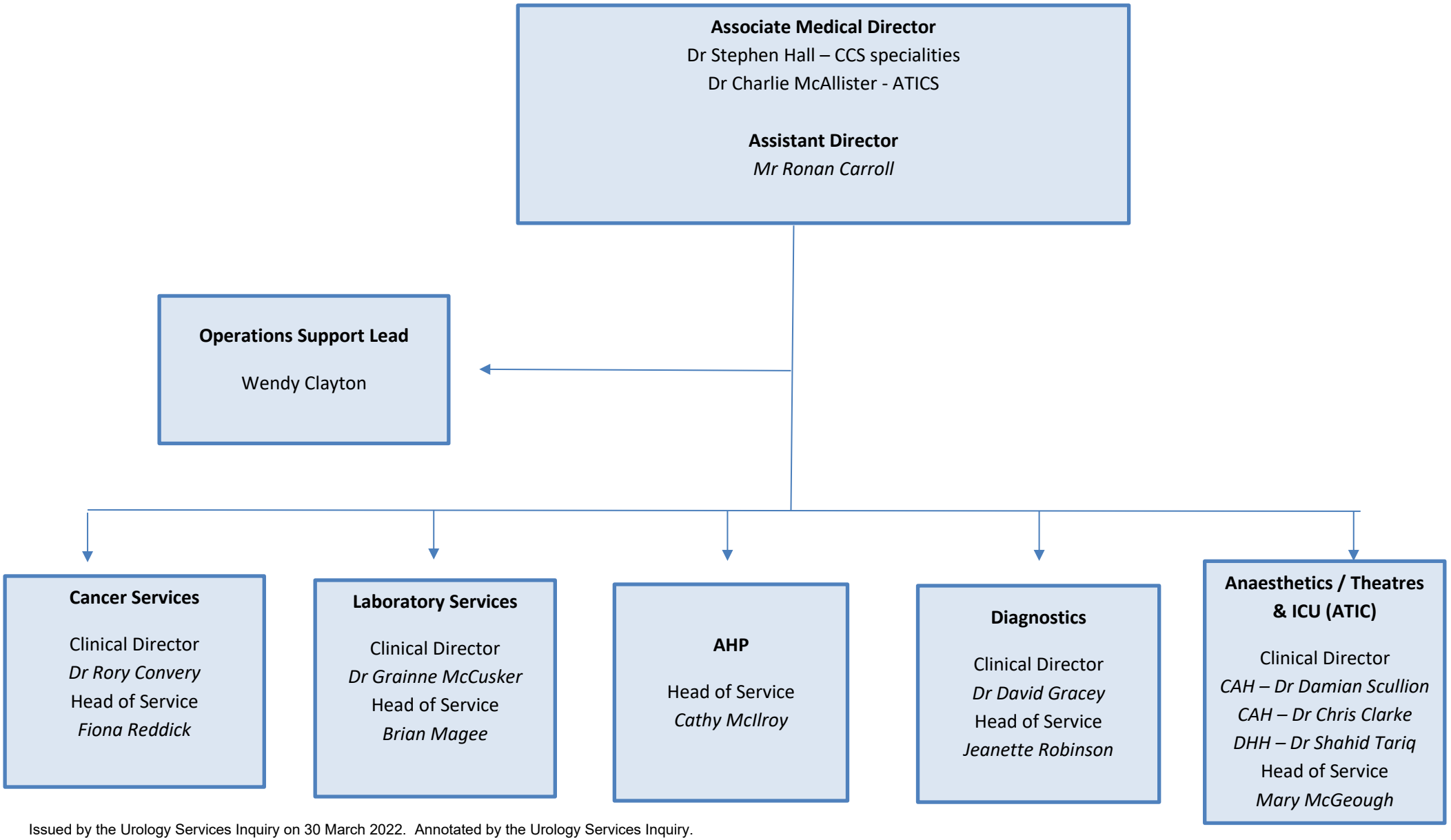
"senior management" is defined as experience gained at Director, Assistant Director or equivalent to mean reporting directly to a Director.

"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;

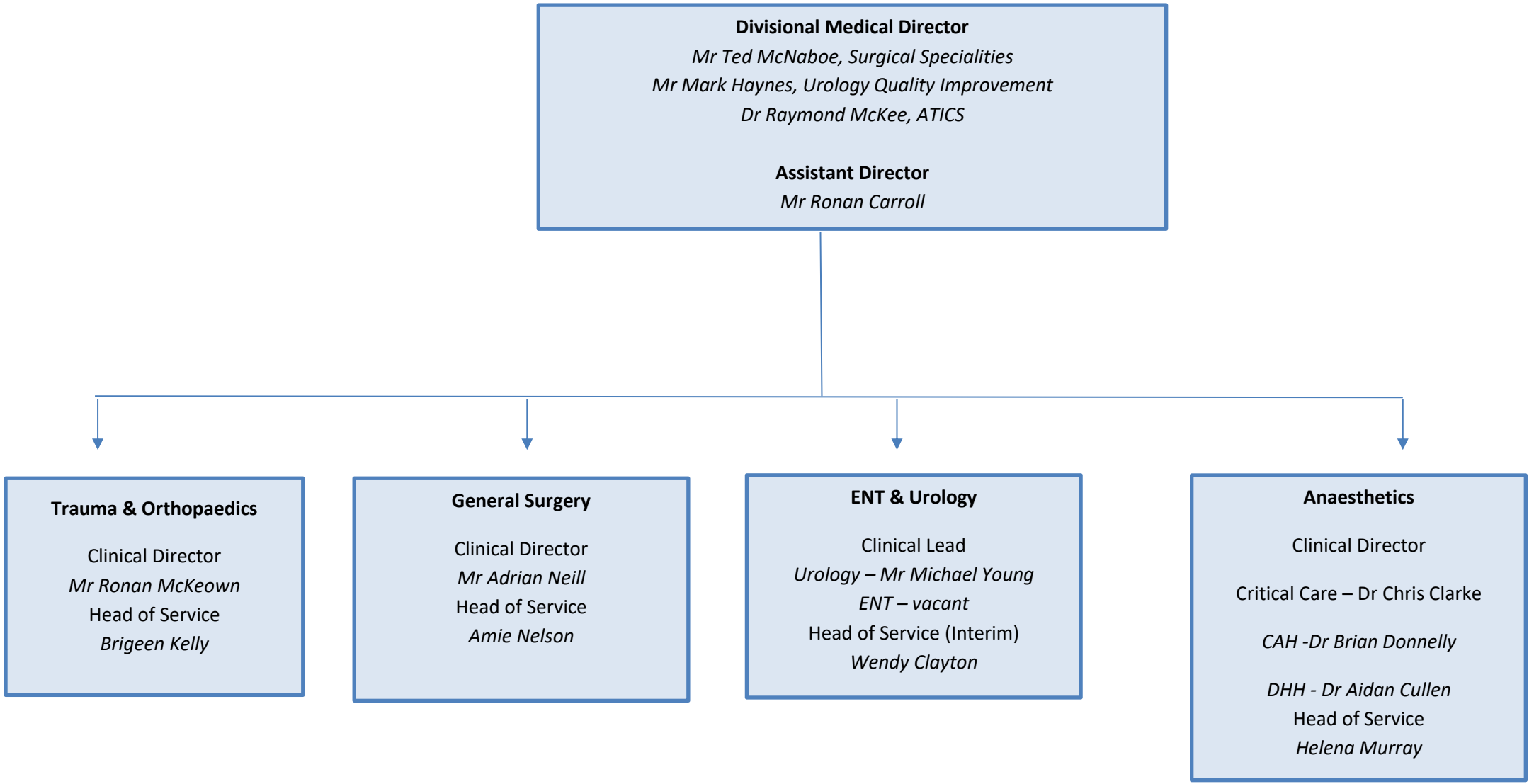
"significant" is defined as contributing directly to key corporate objectives of the organisation.

March 2007

# Management Structure Cancer & Clinical Services (CCS) & Anaesthetics, Theatres and Intensive Care (ATICs) April 2016



# Management Structure Surgery & Elective Care(SEC) & Anaesthetics, Theatres and Intensive Care (ATICs)



**Assistant Director**
Ronan Carroll

**Head of Service**
**ENT, Urology, Outpatients & Ophthalmology**
Martina Corrigan (on secondment)
Wendy Clayton

**Lead Nurse**
Paula McKay

**Lead Nurse**
Josie Matthews

**Lead Nurse**
Tracey McGuigan

**3 South**
**CAH**

***Ward Sister***
Laura White

***Clinical Sisters***
A Lyttle
C Crothers
C O Neill
F Murray
H.Stewart

**Thorndale Unit**
Joanna Percival

Clinical Sister
D Campbell

***CNS***
Jenny McMahon
K O Neil
L McCourt
P Thompson
J Young

**Outpatients CAH**
***Ward Sister***
Joanna Percival

**Clinical Sisters**
***L McCarraher***
***FMGrath***
***C McKenna***

**Outpatients DHH & Banbridge Clinic**
***Ward Sister***
Marilyn Mulligan

**Clinical Sisters**
Julie McNeilly
S Carville

**Outpatients STH & Armagh**
***Ward Manager***
Jacinta McAlinden

**Clinical Sisters**

**Elective Admissions**
**Ward**

***Ward Sister***
Nichola McClenaghan

***Clinical Sisters***
***L Knox***
***B O Neill***

**Southern Health & Social Care Trust**

***Staff Monitoring Listing as at 28th February 2022***

| Surname | Forename | Pers.No. | Contract Type | Work Contract | Multiple Post Holder | Primary Post Staff No | Position |
|---|---|---|---|---|---|---|---|
| McCourt | Leanne Emma | Personal Information redacted by the USI | Permanent | Permanent | X | Personal Information redacted by the USI | |
| Thompson | Patricia | | Permanent | Permanent | | | |
| Young | Jason | | Permanent | Permanent | | | |
| McMahon | Jennifer Eliz | | Permanent | Permanent | | | |
| O'Neill | Kathleen | | Permanent | Permanent | | | |
| Crothers | Clare | | Permanent | Permanent | | | |
| Little | Alyssa | | Permanent | Permanent | | | |
| Murray | Fionntan | | Permanent | Temp Higher Bd | | | |
| O'Neill | Cathy | | Permanent | Permanent | | | |
| Stewart | Hannah | | Permanent | Permanent | | | |
| White | Laura | | Permanent | Permanent | | | |
| Campbell | Dolores Marie | | Permanent | Temp Higher Bd | | | |
| Holloway | Janice | | Permanent | Permanent | X | | |
| McCarragher | Margaret | | Permanent | Permanent | | | |
| McGrath | Fionnuala | | Permanent | Permanent | X | | |
| McKenna | Colleen | | Permanent | Permanent | X | | |
| Percival | Joanna Esther | | Permanent | Permanent | X | | |
| Knox | Leah | | Permanent | Temp Higher Bd | X | | |
| O'Neill | Bronagh | | Permanent | Permanent | | | |
| Wethers | Amy | | Permanent | Permanent | X | | |
| McClenaghan | Nichola | | Permanent | Permanent | | | |
| English | Catherine | | Permanent | Permanent | | | |
| McGinn | Catherine Anne | | Permanent | Permanent | | | |
| Carvill | Sinead | | Permanent | Permanent | | | |
| McNeilly | Julie | | Permanent | Permanent | | | |
| Mulligan | Marilyn Anne | | Permanent | Permanent | | | |
| McAlinden | Jacinta | | Permanent | Permanent | | | |

| Position | Job code | Job Description | Band of Person | Cost Centre Code |
|---|---|---|---|---|
| Clinical Nurse Specialist - Urology | 5A17 | Acute Nurse (7) | 7 | Personal Information redacted by the USI |
| Clinical Nurse Specialist - Urology | 5A97 | Specialist Nurse (7) | 7 | |
| Clinical Nurse Specialist - Urology | 5A97 | Specialist Nurse (7) | 7 | |
| Nurse Specialist Urology | 5A97 | Specialist Nurse (7) | 8A | |
| Nurse Specialist Urology | 5C47 | Acute Wd Sr/CN (7) | 8A | |
| Acute Nurse (6) -DMOS3 | 5A16 | Acute Nurse (6) | 6 | |
| TRF-Acute Nurse (6) | 5A16 | Acute Nurse (6) | 6 | |
| Acute Nurse (6) | 5A16 | Acute Nurse (6) | 6 | |
| Acute Nurse (6) | 5A16 | Acute Nurse (6) | 6 | |
| Acute Nurse (6) | 5A16 | Acute Nurse (6) | 6 | |
| Acute Nurse (7) | 5C47 | Acute Wd Sr/CN (7) | 7 | |
| Acute Nurse (6) | 5A16 | Acute Nurse (6) | 6 | |
| Acute Nurse (6) | 5A16 | Acute Nurse (6) | 6 | |
| Deputy Manager -DMOS2 | 5A16 | Acute Nurse (6) | 6 | |
| Deputy Manager -DMOS2 | 5A16 | Acute Nurse (6) | 6 | |
| Acute Nurse (6) | 5A16 | Acute Nurse (6) | 6 | |
| Department Manager | 5A17 | Acute Nurse (7) | 7 | |
| Clinical Sister | 5A16 | Acute Nurse (6) | 6 | |
| TRF-Acute Nurse (6) | 5A16 | Acute Nurse (6) | 6 | |
| TRF-Acute Nurse (6) | 5A16 | Acute Nurse (6) | 6 | |
| Ward / Department Manager | 5A17 | Acute Nurse (7) | 7 | |
| Macmillan Head and Neck CNS | 5A97 | Specialist Nurse (7) | 7 | |
| Macmillan Head and Neck CNS | 5A97 | Specialist Nurse (7) | 7 | |
| Acute Nurse (6) | 5A16 | Acute Nurse (6) | 6 | |
| Clinical Sister | 5A16 | Acute Nurse (6) | 6 | |
| Acute Nurse (7) | 5A17 | Acute Nurse (7) | 7 | |
| Acute Nurse (7) | 5A17 | Acute Nurse (7) | 7 | |

| Cost Centre Description | WTE | Cost Dist Details | PS group | Lv | Dir | AD |
|---|---|---|---|---|---|---|
| CAH THORNDALE UNIT | 1.00 | | X007 | 06 | DAS | ATICS, Surgery & Elective Care |
| CAH THORNDALE UNIT | 1.00 | | X007 | 07 | DAS | ATICS, Surgery & Elective Care |
| CAH THORNDALE UNIT | 1.00 | | X007 | 04 | DAS | ATICS, Surgery & Elective Care |
| CAH THORNDALE UNIT | 1.00 | | X008 | 03 | DAS | ATICS, Surgery & Elective Care |
| CAH THORNDALE UNIT | 1.00 | | X008 | 03 | DAS | ATICS, Surgery & Elective Care |
| CAH 3 SOUTH SHORT STAY SURG WD | 0.91 | | X006 | 03 | DAS | ATICS, Surgery & Elective Care |
| CAH 3 SOUTH SHORT STAY SURG WD | 0.56 | | X006 | 06 | DAS | ATICS, Surgery & Elective Care |
| CAH 3 SOUTH SHORT STAY SURG WD | 1.00 | | X006 | 01 | DAS | ATICS, Surgery & Elective Care |
| CAH 3 SOUTH SHORT STAY SURG WD | 0.61 | | X006 | 03 | DAS | ATICS, Surgery & Elective Care |
| CAH 3 SOUTH SHORT STAY SURG WD | 1.00 | | X006 | 02 | DAS | ATICS, Surgery & Elective Care |
| CAH 3 SOUTH SHORT STAY SURG WD | 1.00 | | X007 | 02 | DAS | ATICS, Surgery & Elective Care |
| CAH OUTPATIENTS - CAH | 0.91 | | X006 | 01 | DAS | ATICS, Surgery & Elective Care |
| CAH OUTPATIENTS - CAH | 1.00 | | X006 | 07 | DAS | ATICS, Surgery & Elective Care |
| CAH OUTPATIENTS - CAH | 1.00 | | X006 | 03 | DAS | ATICS, Surgery & Elective Care |
| CAH OUTPATIENTS - CAH | 0.57 | | X006 | 07 | DAS | ATICS, Surgery & Elective Care |
| CAH OUTPATIENTS - CAH | 1.00 | | X006 | 01 | DAS | ATICS, Surgery & Elective Care |
| CAH OUTPATIENTS - CAH | 1.00 | | X007 | 07 | DAS | ATICS, Surgery & Elective Care |
| CAH ELECTIVE ADMISSIONS WARD | 1.00 | | X006 | 01 | DAS | ATICS, Surgery & Elective Care |
| CAH ELECTIVE ADMISSIONS WARD | 1.00 | | X006 | 01 | DAS | ATICS, Surgery & Elective Care |
| CAH ELECTIVE ADMISSIONS WARD | 1.00 | | X006 | 03 | DAS | ATICS, Surgery & Elective Care |
| CAH ELECTIVE ADMISSIONS WARD | 0.91 | | X007 | 07 | DAS | ATICS, Surgery & Elective Care |
| CAH-HEAD&NECK SPECIALIST NURSE | 1.00 | | X007 | 04 | DAS | ATICS, Surgery & Elective Care |
| CAH-HEAD&NECK SPECIALIST NURSE | 1.00 | | X007 | 05 | DAS | ATICS, Surgery & Elective Care |
| DHH OUTPATIENTS GENERAL | 1.00 | | X006 | 03 | DAS | ATICS, Surgery & Elective Care |
| DHH OUTPATIENTS GENERAL | 0.88 | | X006 | 07 | DAS | ATICS, Surgery & Elective Care |
| DHH OUTPATIENTS GENERAL | 1.00 | | X007 | 07 | DAS | ATICS, Surgery & Elective Care |
| STH OUTPATIENTS (NURSING) | 0.85 | | X007 | 07 | DAS | ATICS, Surgery & Elective Care |

| SEND REPORT TO | TITLE |
|---|---|
| Wendy Clayton | Acting HOS-Urology, ENT Ophthalmology & Outpatients |
| Wendy Clayton | Acting HOS-Urology, ENT Ophthalmology & Outpatients |
| Wendy Clayton | Acting HOS-Urology, ENT Ophthalmology & Outpatients |
| Wendy Clayton | Acting HOS-Urology, ENT Ophthalmology & Outpatients |
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**Acute Service Directorate - Performance Areas Rolling Risks/Actions Register**

**Date of Last Update: 25/04/2016 - LNL**

**ISSUED TO ASD: 25/4/16**

| No: | Type | Level | Division | RAG | Title of Risk/Target Area | Nature of Risk | Current Performance | Regional Position | Comments | Actions | Lead | Timescale |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Commissioning Plan Target | ASD | All (Op) | Red | Delayed Discharge Coded Information | * Failure to ensure discharge information coded/recorded undermining performance against delayed discharge targets<br>* Trust lowest regional performance (all other Trusts achieving 97 - 100%)<br>* Issue raised at DHSS Accountability meeting | March 96%<br>February 98%<br>January 97%<br>December 95%<br>November 96%<br>October 93%<br>September 63%<br>August 60%<br>July 69%<br>June 66%<br>87 not coded in Jan - 1 ENT, 26 gen surg, 14 gen med, 4 breast surgery, 22 A&E, 1 gyane, 3 haem, 1 HDU, 1 ICU, 1 trauma, 4 urology, | 97 - 100% (2014/15) | * Action plan agreed in June and submitted to DHSS by Chief Executive<br>* Weekly monitoring in place<br>* Performance decreased in July<br>* Urgent refresh of Action Plan undertaken<br>* Gap identified when patients had been discharged from the ward out of hours<br>* Improvement in quanity of coding - up to 79% mid October but concerns around quality as level of complex cases has decreased by 50%<br>* Note - drop in simple discharges performance (see Risk 28 below) ? link to improved performance | * Sinead will do a daily 'mop up' to try and improve actual returns from the ward.<br>* Ward clerks will do a 'mop up' from the night before pre-9am to address gap<br>* SHSCT liaise with other Trusts to share any best practice<br>* All to reinforce actions required with professional Staff<br>* Refresh guidance document on defining simple/complex definitions and applications of S or C codes<br>ATICS/SEC Update: Reports from Sinead continue to be shared to HOS/Lead Nurses for action, number of uncoded delayed discharges have decreased and will continue to be monitored | Anita Carroll<br><br>All Operational A/Ds | Immediate |
| 2 | Commissioning Plan Target | ASD | MUSC | Amber | Re-admissions | *General Re-admission rate (CHKS) below peer.<br>*Peaks in re-admission December/February - analysis indicate General Medicine re-admissions increased | Ref: CHKS/TB report | No comparable CHKS information for region | * Analysis of re-admission peaks indicate G medicine for review<br>* Report Shared with ADM/AD and meeting took place to review data; idnetify paterns/trends; | * Further analysis from CHKS to be undertaken<br>* Follow-up meeting to be arranged | Lesley Leeman<br>Anne McVey | March |
| 3 | Commissioning Plan Standard | ASD | All (Op) | Red | Reviews beyond clinically indicated timescales (excluding visiting specialties from February) | * Delays in review of patient presenting adverse clinical risk | March 13090<br>February 14018<br>January 16987<br>December 17347<br>October 20627<br>September 21915<br>August 22968<br><br>Ref: Monthly OP Review Backlog Report | N/A | * Re-direction of internal resources, in 2015/2016, to provide additional face to face activity and validation of reviews beyond clinically indicated timescales<br>* Actions in place to ensure management of 'urgent' reviews<br>* Monthly monitoring reports in place<br>* Review of previous practice and arrangments at specialty level | * Agreement to recruit validation posts from internal re-direct resouces - ongoing<br>* Additional resources confirmed from HSCB for Q1/Q2 for Cardiology; Diabetology; Endocrinology; General Surgery; Orthopaedics; Pain Management; Rheumatology; Urology | All Operational A/D | Immediate |
| 4 | Commissioning Plan Standard | ASD | ATICS & SEC; CCS & IMWH; MUSC | Amber | Planned procedures beyond clinically indicated Timescales | *Delay in review of patients for planned screening/repreat procedures presenting adverse clincial risk | Endoscopy - There are 1093 patients awaiting a planned procedure with the longest waiter from March 2015. There are a further 742 non-scope patients awaiting a planned procedure. Of these there are 15 patients waiting from 2014 - 4 Urology (longest waiting May 2014) and 11 Cardiology (longest waiting June 2014). | N/A | * Internal target for management of planned endoscopy patients (internal target 12 weeks for urgent new and planned, routine planned are waiting almost 1 year greater than clinically indicated timescale)<br>* Planned list segmented into urgent planned and routine planned to ensure urgent planned patients seen first<br>* On-going discussion at Endoscopy Users Group | * Validation of non-endoscopy long waits required<br>* Agreement to undertake piece of work to identify capacity streams for endoscopy and increase co-ordination of planning and scheduling to optimise<br>* ?? Consideration of additional nurse endoscsopist into training<br>ATICS/SEC continue to monitor planned waiting times, targeting longest waiters | All Operational A/D | Ongoing |
| 5 | Commissioning Plan Target | ASD | All (Op) | Red | Access Time (Outpatients) - General | *Increase in access times associated with capacity gaps and emergent demand | Specialties > 26 weeks:<br>ATICS & SEC: ENT; General Surgery; Orthopaedics; Pain Management; Urology<br>MUSC: Cardiology; Endocrinology; Diabetology; Gastroenterology; Ortho-Geriatric; Neurology; Thoracic Medicine; Rheumatology<br><br>SEC: g surgery/urol/ orthopaedics<br>Ref:Biweekly Access Time Report | N/A | * Recurrent capacity gaps in place and inability to reduce access times due to lack of capacity<br>* Requirement to optimise existing capacity through achievement of SBA volumes and appropriate management of urgent patients<br>* Strict chronological management required and good OP clinic management practice with implementation of recommendations of HSCB review<br>* Information provided to GPs in GP Access Time Report detailing current and projected waiting times<br>* SMT indicate requirement for staff to be supported in dealing with patient enquiries regarding long waits - drafted and shared<br>* Note: Specialties waiting over 52 weeks include Endocrinology; Gastroenterology; Ortho-Geriatrics; Neurology; Orthopaedics; Rheumatology; Urology<br>* Awaiting confirmation from HSCB on the management of paused patients in the IS | * Ongoing focus on length of urgent waits to ensure clinically acceptable - impacting on routine in cases (See risk 6 below)<br>* Additional resources from HSCB in Q1/Q2 confirmed for Cardiology; Diabetology; Endocrinology; ENT; Gastroenterology; General Surgery; Neurology; Orthopaedics; Rheumatology; Thoracic Medicine<br>* All A/Ds and operational leads to ensure additional resources are fully utilised and highlight any risks to performance ASAP as resources could be re-allocated to the 'secondary' list | All Operational AD | Ongoing |
| 6 | Commissioning Plan Target | ASD | All (Op) | Red | Access time differential for routine and urgent patients | Some urgent patients are waiting equal time for appointmentgs as routine patients | Specialties: Urology<br><br>Ref: Monthly Access Times Report | N/A | * Focus on determination of clinically acceptable wait times<br>* Focus on good booking practices to ensure urgent patients are booked first<br>* On-going flexibility of OP clinical templates to ensure urgent patients booked before clinically acceptable timescale<br>* For specific areas see access times tab<br>* Awaiting confirmation from HSCB on the management of paused patients in the IS | * Ongoing focus on length of urgent waits to ensure clinically acceptable - impacting on routine in cases<br>* Urgent waits reviewed at monthly A/D Performance Meetings and routinely operational meetings | All Operational A/D | ongoing |
| 7 | Commissioning Plan Target | ASD | All (Op) | Red | Access Times (In-patient/Day Case) - General | *Increase in access times associated with capacity gaps and emergent demand | Specialities > 52 weeks: Breast Surgery; Cardiology; General Surgery; Orthopaedics; Pain Management; Urology<br><br>Ref: Weekly PTL and Monthly Access Times Report | N/A | * Recurrent capacity gaps in place and inability to reduce access times due to lack of capacity<br>* Requirement to optimise existing capacity through achievement of SBA volumes and manage urgent patients appropriately<br>* Strict chronological management required and good OP clinic management practice<br>* Information provided to GPs in GP Access Time Report detailing current and projected waiting times<br>* SMT indicate requirement for staff to be supported in dealing with patient enquiries regarding long waits - drafted and shared<br>* Awaiting confirmation from HSCB on the management of patients paused in the IS | *Ongoing monitoring of urgent wait times against clinically acceptable levels<br>* HSCB have confirmed additional funding in Q1/Q2 for Cardiology; Dermatology; Pain Management; General Surgery; Gynaecology; Orthopaedics; Urology<br>* All ADs and operational leads to ensure additional resources are fully utilised and highlight any risk to performamce ASAP as resources could be reallocated to the 'secondary' list | All Operational A/D | ongoing |

**Acute Service Directorate - Performance Areas Rolling Risks/Actions Register**

**ISSUED TO ASD: 25/4/16**

**Date of Last Update: 25/04/2016 - LNL**

| No: | Type | Level | Division | RAG | Title of Risk/Target Area | Nature of Risk | Current Performance | Regional Position | Comments | Actions | Lead | Timescale |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 8 | Commissioning Plan Target | ASD | All (Op) | RED | Access Times (Diagnostics) - General | March 2016 position - CT 16 -weeks, CTC 19-weeks, Dexa 19-weeks, MRI-15 weeks, NOUS 15-weeks, Fluroscopy 22-weeks, Endoscsopy 45 weeks (routine)<br>*Increase in access times associated with capacity gaps and emergent demand | Ref: Weekly PTL and Monthly Access Times Report | N/A | * Recurrent capacity gaps in place and inability to reduce access times due to lack of capacity<br>* Requirement to optimise existing capacity and managed urgent patients appropriately<br>* Strict chronological management required and good IEAP management practices<br>* Information provided to GPs monhtly to inform GPs and patients of expected waits<br>* SMT indicate requirement for staff to be supported in dealing with patient enquiries regarding long waits | Awaiting confirmation of funding from HSCB for Q1/Q2<br>When confirmation received secure appropriate IH and IS activity levels to meet allocated volumes | Heather Trouton (Diagnostics)<br>Ronan Carroll / Anne McVey (Endoscopy) | On-going |
| 9 | Commissioning Plan Target | ASD | All (Op) | TBC | Excess Beddays | Inability to meet target | Ref: Trust Board Monthly Performance Report | N/A | * Need to undertake analysis of excess beddays by specialty; elective/non-elective<br>* Need to assess impact of day case rates | * CHKS to provide analysis | | |
| 10 | Commissioning Plan Standard | ASD | MUSC | Amber | Biological Therapies | * Presenting demand in cases of funding for initiation on biological therapies | March - waits >13 weeks | N.A | *Analysis of project requirement for biological therapies undertaken<br>*Escalation to HSCB of requirement beyond funding<br>*Need to ensure arrangements in place for strict compliance with NICE guidance | *strict compliance with NICE guidance<br>*ongoing monitoring of demand with escalation to HSCB (regionall commissioning team) should further demand present | Anne McVey | On-going |
| 11 | SBA | ASD | All (Op) | Red | Failure to deliver SBA Volumes (IP/DC, OP) | * Failure to deliver SBA volumes (in context of current poor access times) | Ref: Month-End SBA Monitoring Summary | N/A | * Specialty areas that will not achieve performance within normal tolerances +/- 5% @ 29/2/16:<br>Out-patients - Manpower/SBA/performance issues - Urology; Orthopaedics; Pain Management; Endocrinology; Diabetology; Dermatology; Thoracic Medicine; Gynaecology;<br>Out-patients - Demand issues - Orthodontics, Colposcopy<br>Inpatients/Daycases - Manpower/performance issues - General Surgery; Breast Surgery; Urology; Orthopaedics; ENT; Gynaecology; Endoscopy<br>* Monthly A/D performance meeting in place to review SBA and routine operational review<br>* Recovery plans in place as appropriate | * Focus on SBA action plans (at Divisional level) to recover SBA to within tolerances +/- 5% by end of September<br>* Recovery plans submitted - General Surgery to be submitted<br>* All SBA proposals concluded with the exception of Urology<br>* Specific focus on endoscopy to seek additional sessional provision<br>* Urgent analysis and review to be undertaken where specialities have lost significant capacity in Month 1 of the 2016/2017 - need to understand why sessional capacity is lost and implement necessary actions to rectify as a matter of urgency | All Operational A/D | On-going |
| 12 | Commissioning Plan Target | ASD | All (Op) | N/A | Failure to achieve target | * Variation in week day and weekend mortality rates presenting clinical risk | Death rate at weekends should not exceed weekday rate by more than 0.1% | N/A | In March there was a 3% death rate on weekdays and 1.8% rate on weekends although cumulativley for 2015/2016 the rate at weekends was more than 0.1% difference to weekdays. | * Analysis to be carried out on March position and monthly monitoring required. | All Operational A/D | On-going |
| 13 | Commissioning Plan Target | DIV | CCS & IMWH | Red | DRTT - Failure to achieve target that 100% of diagnostics (imaging) reported and verified within 28 days for a routine patient and 48 hours for an urgent patient | Patients waiting longer than clinically indicated for reporting of Diagnostic tests | Ref: Monthly Trust Board Performance Report and Bi-Annual Indicators of Performance Report | N/A | * Actions to increase capacity including the appointment of an IS provider to supplement current IS provision<br>* Close monitoring of long waits is required<br>* On-going Regional actions are in discussion for a Regional Radiology Reporting Network<br>* Medica can perform 200 per day 5 days per week<br>* Additional reporting capacity can be provided by 4 ways if required<br>*Need to consider impact of further manpower issues in radiology & any additional actions<br>*Awaiting confirmation of Q1/Q2 funding from HSCB | * Close monitoring of long waits is required.<br>* On-going Regional actions are in discussion for a Regional Radiology Reporting Network.<br>* Internal focus on priority work.<br>* Plain Film reporting IPT submitted to SLCG. | Heather Trouton | On-going |
| 14 | Standard | ASD | CCS & IMWH | Red | Breast Radiology Services (Screen & Sympomatic) | Service at risk due to lack of consultant capacity | * ROUND LENGTH 2015/2016 TARGET 90%<br>February 98.8%; January 99%; December 98%; November 100%; October 99.3%; September 99.5%; August 99%; July 99.7%<br>* SCREEN TO ASSESSMENT - TARGET 90% (Recalled to Assessment within 3-Weeks)<br>February 97%; January 100%; December 71% (2 not booked in time due to Bank Holiday and 10 appointed patients DNA'd); November 81% (awaiting previous films for 2 patients, 5 not read on time and 1 DNA); October 95%; September 94%; August 86% (1 patient not read on time, 2 patients CND due to holidays); July 80%; June 63%<br>* SCREEN TO ASSESSMENT - DATE OF FIRST OFFERED APPOINTMENT - TARGET 100%<br>February 100%; January 100%; December 91%; November 80%; October 93% (1 patient required films); September 96%; August 85% (1 patient no capacity, 2 not read on time, 1 awaiting plain films); July 100%; June 73%<br>* SCREEN TO ROUTINE RECALL - TARGET 90% (Normal Results within 2-Weeks)<br>February 100%; January 100%; December 95%; November 99%; October 99%; September 97%; August 99%; July 99%; June 99% | N/A | * Previously Consultant on sick leave so high risk for screening as leaves 1 consultant for screening - previously 1 remaining consultant had dropped all fluroscopy sessions to do additional screening resulting in access times increasing (Breast Radiology Consultant returned from sick w/c 23.11.15 on phased return)<br>* One of the sustantive reporting radiologists retired 31/3/16 - unable to reruit replacement<br>* Impact on implementation of recurrent symptomatic breast sessions to be determined | * Focus remains on screening with reporting delayed<br>* Need to assess impact of retirement of key reporter - unable to recruit; locum plan in place<br>* ??medium - long term solution | Heather Trouton | Immediate |
| 15 | Operational | DIV | ATICS & SEC | Red | Inability to provide full medical services affecting achievement of SBA, access times, ward services provisions | * Risk regarding the inability to secure appropriate levels of middle grade doctors medical staff<br>* Reduction in level of elective activity that can be undertaken<br>* Impact on rota and need to provide for out of hours cover/ward cover as priority | Affecting General Surgery OP and SBA performance<br><br>Ref: Month-End SBA Monitoring Summary | N/A | * General Surgery funded NIMTDA allocation 4 middle grade; Trust funded 2 middle grade<br>* Impact on contribution to out-patient capacity/on general elective work<br>* Potential impact on rota for both General Surgery and Urology as inability to recruit junior doctors affects capacity<br>* Michael Bloomfield updated at November Elective Monitoring meeting | * Paper to SMT re Contigency<br>? Actions with NIMDTA | Ronan Carroll | On-going |

**Acute Service Directorate - Performance Areas Rolling Risks/Actions Register**

**Date of Last Update: 25/04/2016 - LNL**

**ISSUED TO ASD: 25/4/16**

| No: | Type | Level | Division | RAG | Title of Risk/Target Area | Nature of Risk | Current Performance | Regional Position | Comments | Actions | Lead | Timescale |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 16 | Commissioning Plan Target | DIV | ATICS & SEC | Red | Inability to continue to meet General Surgery elective requirements with General Surgery SBA anticipated to be underperforming from April 2016 | * Risk regarding the on-going provision of General Surgery elective services in the current model - inability to flow patients and fully utilise sessional capacity in current configuration<br>* Significant volume of lost sessions in April | Affecting General Surgery out-patient and IP/DC SBA performance<br><br>Ref: Month-End SBA Monitoring Summary | N/A | * Inability fully utilise sessions in DHH due to reduced demand for conditions suitable for the site<br>* Inability to meet SBA for IP/DC<br>* Change in casemix, practice and demand casemix affecting throughput<br>* Consideration of this issue needs to be undertaken in context of emergency surgical strategy and regional elective care strategy document (still in draft) 23 general surgery sessions lost in April - robust reasons for lost capacity not yet ascertained | * Review of a range of analysis to baseline existing position (theatre utilisation/demand/capacity)<br>* Consideration of flow issues to DHH and plan to be developed in the short-term<br>* A/Ds/Director to meet to consider requirement/process to develop an elective surgical strategy | Ronan Carroll | On-going |
| 17 | Commissioning Plan Target | DIV | IMWH | TBC | Inability to continue to meeting Gynaecology elective surgery SBA | * Risk regarding the on-going provision of gynaecology surgical services in line with current SBA in context of change in casemix | Affecting Gynae IP/DC SBA levels<br><br>Ref: Month-End SBA Monitoring Summary | N/A | * Change in casemix, practice and demand affecting throughput in accordance with traditional SBA<br>* Inability to fully utilise theatre sessions and optimise capacity<br>* Inequitable access times for surgery/access to relevant theatre capacity | * On-going work to translate casemix and SBA for IP/DC into new comparable SBA - procedure based in association with Clinical Directors<br>* Engagement with Commissioner planned for 2016/2017 to present findings | Heather Trouton | September |
| 18 | Commissioning Plan Target | DIV | MUSC | Red | ED performance<br>Failure to meet target that 95% of patients should be treated, admitted or discharged within 4 hours of arrival | * Increased waiting time<br>* Poor patient experience | March 76.7% 4-hour target<br>10 x 12 hour breaches<br><br>Ref: Monthly Trust Board Performance Report | | * IPTs for additional resources for Unscheduled care submitted<br>* Winter pressures/contingency plans in place<br>* Reduced beds in the system from September to December 2015 due to essential works<br>* Additional winter beds opened 16 November 2015<br>* Plans for Ambulatory Unit in development | * Range of ED and whole system initiatives in place to improve flow<br>* Additional pilot of review of 80 years + admission from ED via AC@H team<br>* Additional medical and key professional staff in wards at weekends in January to improve flow in absence of fully implemented 7-day working arrangements<br>* Lookback of Christmas/New Year holiday period to be undertaken<br>* Forward planned for key pressure points in February/March/Easter required | Anne McVey | On-going |
| 19 | Standard | DIR | CCS & IMWH | Red | Pathology reporting backlog | * Clinical risk associated with backlog in pathology reporting<br>* Standard is 7 calender days for urgent and 10 calender for routine | Currently all speciments under 14 days, but this position is fluid<br><br>October - backlog 260<br>September - backlog of 800 specimens | N/A | * Impact associated with vacancy<br>* Inability to recruit - did have 3 applicants for post but all pulled out<br>* Ad hoc contracts in place with BHSCT consultant colleagues providing additional capacity<br>* No IS provision available | * On-going triage of each specimen to manage urgent/piroity cases<br>* Need to consider communication with referrers to advise of current backlog<br>* Continue to utilisation Belfast / Antrim consultants to help with pathology reporting WLI sessions | Brian Magee | On-going |
| 20 | Operational | DIV | ATICS & SEC | TBC | Impact of long routine access times on pre-operative patients - need for rework | * Clincial risk associated with change of conditions/ongoing suitability for surgery<br>* Impact on theatre capacity associated with potential increase in cancelled surgery on the day<br>* Potential double handling with second review consultant patient required impact on on-going review capacity | | N/A | * Requirement to review patients prior to surgery to recheck joints and x-ray due to increasing access times<br>* Key specialty affected Orthopaedics | * Need to assess clinical position in relation to pre-operative review<br>* All A/Ds and operational leads to ensure additional resources fully utilised and highlight any risk to performance ASAP | Ronan Carroll | On-going |
| 21 | Operational | ASD | CCS | TBC | Backlog pre-operative assessment cases | * Impact on elective patient flow<br>* Potential increase in theatre cancellations/lost capacity | | N/A | * Increasing volumes of patients waiting pre-operative assessment<br>* Review of pre-oeprative assessment flow by ATICS<br>* Additional internal funding to clear 1200 backlog of consultant assessment for pre-op (internally re-directed resources) up to the end of March 2015 | * Non-recurrent backlog clearance in progress up to March 2016<br>* Proposal for pilot of pre-op to be developed further to discussion with SLCG (? Cost implication to be determined and agreed with SLCG)<br>* Need to consider impact of clearances of 1200 backlog pre-op cases<br>* All A/Ds and operational leads to ensure additional resources fully utilised and highlight any risk to performance ASAP<br>*Pre-op Team are currently reviewing all processes - complete<br>*Pilot of new process is commencing with Orthopaedics, currently arranging meeting with the Ortho consultants to discuss further.<br>*Non-recurrent funding has been requested for Q1/2<br>*With increased length of weight for patients across specialities, this is resulting in double handling of patients requiring pre-assessment<br>*Assess the impact of the Q1/2 NOP / IPDC non-recurrent additionality | Ronan Carroll | On-going |
| 22 | Operational | DIV | All (Op) | TBC | Inability to provide level of additional capacity committed to from internal redirected resources | Finance risk | | N/A | * With new consultants and additional activity being undertaken for internally re-directed resources and further commitment to HSCB additional funding leading to increase demand for OP accomodation and staffing | * Previously the totality of bids analysed and plan in place for accommodation/nursing provision<br>* Close monitoring required to ensure capacity utilised and any early escalation of risk associated with inability to undertake planned activity<br>* Previously stock take was undertaken and submitted to finance and with estimate of work undertaken to date and that planned to be completed by March | OSLs<br>Martina Corrigan<br>Ronan Carroll | **Completed - Recommended for Closure** |
| 23 | Operational | DIV | ATICS & SEC | TBC | Elective Theatre capacity at CAH | TBC | | N/A | * Insufficient theatre capacity CAH site<br>* Extended days not productive<br>* Rroutine capacity managed via robust scheduled/using of SOW gaps<br>* Failure to be able to utilise threates at DHH sufficiently for casemix | * Update on capcaity plan required ? interim options<br>* Meetings planned to review Theatre issues as part of capital/redevelopment plans | Mary McGeough | On-going |
| 24 | Orthodontic Service | DIV | ATICS & SEC | TBC | Inability to continue to provide support to Orthodontic service | Lack of trained orthodontic nurses | | N/A | * Both trained orthdontic nurses absent<br>* Inability to provide sufficient level of appropriate cover imapcting ability to continue to manage orthodontic patients on site<br>* Capacity secured in School of Denistry for sessional support<br>* Issues escalated to Commissioner | * Capacity secured in School of Denistry for sessional support<br>* Issues escalated to Commissioner | Roanan Carroll | On-going |
| 25 | Standard | ASD | ATICS & SEC | | Ophthalmology - long waits and review backlog | Perception that waits relate to SHSCT | | N/A | * Ongoing work with Commissioner to transfer management of service (still on Trust PAS)<br>* Additional funding HSCB for IS capacity for new OP (BHSCT to manage) | * Actions sit with BHSCT | Ronan Carroll | On-going |
| 26 | Governance | DIR | ATICS & SEC | TBC | Trauma pressures | Trauma demand for in-patient and out-patient beyond the Commissioned level | SBA performance @ 29/2/16:<br>New Out-Patients +18% (+1182)<br>Non-Elective In-Patients +18% (+298) | N/A | * Demand for trauma above Commissioned levels<br>* Interim arrangements in place to divert 10th T&O consultant to trauma facing job plan, however job description with Specialty Advisor prior to advert likely to change focus to standard elective/trauma split job plan with additional capacity for trauma 'lost'<br>* Option to reduce trauma demand advocated by Commissioner - include implementation of Glasgow model | *Phased implementation of Glasgow Model commenced - timescale required<br>* Meeting with Commissioner held to consider future T&O consultant activities and impact of change in job plan to elective facing | Ronan Carroll | On-going |

**Acute Service Directorate - Performance Areas Rolling Risks/Actions Register**

**Date of Last Update: 25/04/2016 - LNL**

**ISSUED TO ASD: 25/4/16**

| No: | Type | Level | Division | RAG | Title of Risk/Target Area | Nature of Risk | Current Performance | Regional Position | Comments | Actions | Lead | Timescale |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 27 | Governance | DIV | MUSC | TBC | Timescale for urgent waits | Cardiology DC - Urgent waits beyond clinical acceptable levels | Urgent waits now reduced to 34-weeks | N/A | * Previously unequaitable waiting times for different cardiology cath lab procedures | * A/D to address individual urgent wait issues with individual operators and seek action/sharing of caseload to reduce risk | Anne McVey | TBC |
| 28 | Financial | DIR | All (Op) | TBC | Underdelivery of IS contracted volumes in 2015/2016:<br>General Surgery Varicose Veins - 80 patients to be seen<br>Ortho In-patients 6 to be seen in 352 and a further 4 to be seen in NWIH<br>Pain In-Patients 35 and Out-Patients 57 | Finanacial Risk | Confirmed underdelivery | N/A | * Whilst providers haD given assurance that there is no risk to delivery of volumes there would be risk following ROTT/RTT and DNA for patients<br>* Patients are now paused in the IS with confirmation awaited from HSCB on management of these patients | * Contract holders to ensure they are managing patients to ensure maximum level seen in IS<br>* Awaiting confirmation from HSCB on management of patients paused within the IS | Contract Owners | March 2016 |

| ID | Opened | Principal objectives | Location (exact) | Title | Des/Pot for Harm | Controls in place | Progress (Action Plan Summary) | Risk level (current) | Register Holding |
|---|---|---|---|---|---|---|---|---|---|
| 3827 | 19/08/2016 | Safe, High Quality and Effective Care | | Due to the move down from level 6 to outpatient department to the current OPD accommodation is not suitable to sustain numbers. | Risk of late diagnosis and treatment. Health and Safety and fire risk to patients and staff. | Reduction in the number of fracture patients that can attend each clinic to be reduced. | 12/11/21 Refurbishment in DHH for fracture clinic will not take place within financial year 2021/2022. Await confirmation of funding for 2022/2023.<br>08/09/2021- accommodation for refurb not available as yet.<br>28/06/2021- remains a risk. Investigating refurbishing Phase 1 OPD in DHH for fracture clinic. Plans developed at a cost of £60k. Waiting to here if funding is to be approved before commencing work.<br>15/02/2021- remains a risk. Due to the Covid 19 pandemic DHH fracture clinics remain in CAH however still risk due to no social distancing. One DHH clinic has moved to an evening clinic from November 2020. Requested fracture accommodation in STH, unfortunately no capacity to date.<br>11/12/2020 - remains a risk. DHH fracture clinics remain in CAH however still risk to no social distancing. One DHH clinic moving to evening clinic from Nov 2020. Requested fracture accommodation in STH, unfortunately no capacity to date.<br>20/10/2020 - remains a risk. DHH fracture clinics remain in CAH however still risk to no social distancing. One DHH clinic moving to evening clinic from Nov 2020. Requested fracture accommodation in STH<br>10/8/2020 - Remain on risk register. DHH fracture clinic transferred to CAH due to covid pandemic. Need new accommodation in DHH to transfer service back large number of patients going through CAH on a Mon and Tuesday, CAH is not suitable for 2 consultant led clinics.<br>18.09.19 Remain on Register until capital allocation<br>24.06.19 - DHH T&O accomodation is priority 1 on the Trust's capital allocation list. To remain on the RR until new accomodation is complete. This will move the fracture clinic from level 2 SAU. 28/3/19 - fracture clinic in DHH continues to be located on level 3 DHH (SAU room), therefore numbers remain reduced. Remains on the capital allocation list<br>6/2/19 - as below no change to risk | HIGH | DIV |
| 4018 | 15/10/2016 | Provide safe, high quality care | | Inpatient / Daycase Planned Backlog | Delay in review of patients planned for screening/repeat procedures presenting adverse clinical risk. | INDC planned backlog in the following surgical specialties: urology, general surgery, ortho and chronic pain. | 19/11/21 ICU beds are currently sitting at 12.WIthin Elective Theatres there are 16 urgent bookable sessions in CAH and 5 urgent bookable sessions in DHH<br>16/09/2021- OSL update- continues to monitor backlog. Due to Covid 19 pressures there are reduced theatre sessions and therefore the focus is on red flag.<br>08/09/2021- Due to the increase in Covid ICU patients, theatres have decreased sessions down to 3 all day urgent bookable in CAH and one AM session per day in DHH. This will result in ongoing backlog in planned and surveillance surgical patients.<br>28/06/2021- OSL continues to monitor planned IPDC backlog. Theatres sessions has increased with DHH restarting 14/06/2021 with 15 theatre sessions. Only RF and urgent at present. Validating top 10 longest waiters each month.<br>15/02/2021- Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to Covid. Currently one 1 urgent bookable list per day Mond to Friday. clinically urgent and priority 2 patients being scheduled. The Trust is currently facing the 3rd surge. No urgent bookable in DHH.<br>11/12/2020 - Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to COVID pandemic. Currently only clinically urgent and priority 2/3 patients being scheduled. The Trust is currently facing the 2nd COVID surge. 1 urgent bookable each day in CAH and 3 days in DHH<br>20/10/2020- Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to COVID pandemic. Currently only clinically urgent and the red flag priority 2 patients being scheduled. The Trust is currently facing the 2nd COVID surge unsure if elective surgery will continue<br>10/8/2020 - Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present. | HIGH | DIV |

| ID | Opened | Principal objectives | Location (exact) | Title | Des/Pot for Harm | Controls in place | Progress (Action Plan Summary) | Risk level (current) | Register Holding |
|---|---|---|---|---|---|---|---|---|---|
| 4019 | 15/10/2016 | Provide safe, high quality care | | Inpatient / Daycase Planned Backlog for Endoscopy | Delay in review of patients for planned screening/repeat procedures presenting adverse clinical risk. | Endoscopy planned backlog. Papers written and submitted to Director re risk.<br>Requested HSCB funding for planned backlog clearance. | 19/11/21 Currently only clinical urgent and red flag priority 2 patients are being scheduled for endoscopy. Planned backlog continues to increase as no planned patients are being booked. Validation of planned endoscopy patients is still ongoing. Endoscopy capacity has decreased due to Covid 19 pressures, the redeployment of theatre based workforce continues to impact on capacity within South Tyrone Hospital (STH). The day clinical centre was redeployed to STH day procedure admission ward during the pandemic which still remains in day procedure. This was a 14 bedded ward historically used to run two endoscopy lists 5 days a week simultaneously. Until they return to CAH it is not possible for STH to return to a 19 planned endoscopy list per week.<br>16/09/2021- Planned endoscopy backlog validation is still in progress<br>28/06/2021- planned endoscopy backlog is currently being validated by the Gastro and General Surgical Team.<br>15/02/2021- Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March due to the COVID pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. as no planned endoscopy patients are being scheduled. Validation of planned endoscopy patients has commenced.<br>20/10/2020- Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March due to the COVID pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. Colon patients being sent Qfit test then prioritised for their colon. Still working on IS contract<br>10/8/2020 - Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. In process of securing contract to bring IS into the Trust for weekend endoscopy additional | HIGH | DIV |
| 4021 | 12/04/2019 | Provide safe, high quality care | | Access Times (Outpatients) - General (not inclusive of visiting specialties) | Increase in access times associated with capacity gaps and emergent demand - Capacity gapin RF, urgent and routine. | ATICs/SEC specialties with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain | 19/11/21 OSL update SEC, New regional guidance has been approved for Outpatient admin validation this will be for ENT, Urology and Trauma and Orthopaedics. From April 19 admin validation has been ongoing, new regional technical guidance has been approved and will commence Jan 2022 and the validation team admin support will increase, recruitment in progress.Capacity reduced due to Covid 19 social distancing guidance which is decreasing the number of booked clinics.<br>IPC guidance is continually reviewed and updated.<br>160921 OSL update- Within outpatients admin validation is ongoing within the following areas: ENT, BFH and orthopaedics. OSL progressing decision with IPC if clinic sizes can be increased.<br>08/09/2021 - Currently only red flag and some urgent patients are being booked however demand is still greater than capacity.<br>Redeployment of DSU and Theatre staff to ICU for surgery reduces theatre capacity on CAH, STH and DHH sites. Six urgent bookable sessions in CAH, fourteen trauma sessions and five urgent bookable sessions in DHH with cancellation of day surgery and endoscopy.<br>28/06/2021- OSL and HOS continue to monitor longest waiters. Currently due to social distancing reduced numbers continue and only red flag and urgent patients being booked. Agreed to contact IPC to see if we can increase numbers at clinics. Admin validation to commence.<br>15/02/2021New Outpatients backlog waiting times continues as a clinical risk. All outpatient cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present. The trust is facing a 3rd surge at present. All outpatients cancelled again and outpatient staff redeployed.<br>0/10/2020 - New Outpatients backlog waiting times continues as a clinical risk. All outpatient cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present. | HIGH | DIV |

| ID | Opened | Principal objectives | Location (exact) | Title | Des/Pot for Harm | Controls in place | Progress (Action Plan Summary) | Risk level (current) | Register Holding |
|---|---|---|---|---|---|---|---|---|---|
| 4022 | 12/04/2019 | Provide safe, high quality care | | Access Times (In-patient/Day Case) - General | Increase in access times associated with capacity gaps and emergent demand. | ATICs/SEC specialties with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain | 19/11/21 OSL and HOS continue to monitor outpatient stragglers >52 weeks. we are currently booking P2 priority patients due to Covid 19 patients.<br>16/09/21 OSL update- OSL and HOS continue to monitor top ten longest waiters for inpatient/day case.<br>08/09/2021 - Due to increase in Covid 19 ICU patients, theatres have decreased sessions down to three all day urgent bookable in CAH and one am session per day in DHH. This will result in ongoing backlog in planned and surveillance surgical patients.<br>28/06/2021- OSL and HOS continue to monitor. Top 10 longest waiters to be validated on a monthly basis. Theatres sessions have increased with DHH restarting 14.06.2021 with 15 theatre sessions. Only priority 2 elective surgery on CAH site.<br>15/02/2021- New outpatient long waiting times continues as a clinical risk. Reduced outpatient capacity due to covid. Still only RF and urgent patients being scheduled. Surge 3 all outpatients have been cancelled and staff redeployed to support the Wards<br>11/12/2020 - New outpatients long waiting times continues as a clinical risk. Reduced outpatient capacity due to covid. Only RF and urgent patients being scheduled. Outpatient accommodation increased slightly from 14/12/2020 but not to full capacity. To continue with reduced numbers due to social distancing<br>20/10/2020 - New outpatients long waiting times continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag new and review patients being booked at present. Reduced capacity due to outpatient rooms being utilised for new covid processes, reduced patients per clinics for social distancing. New referrals have been reduced from March to June 2020 due to covid pandemic.<br>10/8/2020 - New outpatients long waiting times continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag new and review patients | HIGH | DIV |
| 4131 | 03/12/2020 | Safe, High Quality and Effective Care | Trustwide | Reduction in elective capacity due to covid restrictions-Urology ENT, Gen Surgery, Gynae and Orthopaedics | With the Covid-19 pandemic SEC ability to accommodate commissioned levels of activity is not being achieved resulting in increases in waiting times and volumes of patients on the elective and planned waiting list.<br>As a result of increased waiting times and reduced capacity consequently patients may come to harm, increased levels of pain and discomfort and reduced quality of life | Mon-Friday 1x all day Urgent bookable on both sites CAH and DHH<br>Due to limited elective capacity consultants clinically prioritise patients for surgery using the FSSA royal college guidelines, priority to cancer patients.<br>Regional cancer rest meeting working towards equalising waiting times across the province.<br>In house additionally from January 2021 on DHH site<br>Endoscopy- weekend additional sessions in LV | 12/11/2021ICU beds are currently sitting at 12.WIthin Elective Theatres there are 16 urgent bookable sessions in CAH and 5 urgent bookable sessionsin DHH.<br>08/09/2021 - Due to increase in Covid 19 ICU patients, theatres have decreased sessions down to three all day urgent bookable in CAH and one am session per day in DHH. THis will result in ongoing backlog in planned and surveillance surgical patients. Only priority 2 for CAH and DHH sites.<br>28/06/2021- DHH recommenced elective theatres x 15 sessions on the 07/06/2021. CAH elective sessions continue with reduced theatres- currently 2-3 urgent bookable per staff however this is staff dependent. Agency staff have taken leave July/August 21.<br>9/6/2021 the ongoing workforce issues will affect our ability to provide core operating sessions. Primarily for in patient theatres. The action in respect to recruitment is in place. advertisements are going out in June and 9 new registered nurses are due to commence work between June and Sept for CAH in patient theatres. we are currently working with the nurse bank and agency to attract theatres nurses and Dps from agency across mainland UK.<br>15/02/2021- ICU remains open to 16 patients, surge staff from day surgery and theatres/recovery remain in-situ. Currently in surge 3<br>03/12/2020- full de-escalation of CCaNNi critical care surge plan- this is currently medium surge and difficult to predict.<br>Commencement of in house additionally from Jan 2021 for endoscopy and surgical specialties and the January sessions are currently being agreed.<br>Increase urgent bookable theatre sessions | HIGH | DIV |

| ID | Opened | Principal objectives | Location (exact) | Title | Des/Pot for Harm | Controls in place | Progress (Action Plan Summary) | Risk level (current) | Register Holding |
|---|---|---|---|---|---|---|---|---|---|
| 3802 | 27/05/2016 | Safe, High Quality and Effective Care | Anaesthetics, Theatres & Intensive Care Services | Nurse Recruitment for Adult and Paed theatres | Risk of being unable to cover all required theatre sessions with appropriately skilled theatre staff, therefore, there is a risk of sessions not being scheduled or being cancelled if insufficient skilled Theatre staff are not available. | We continue to use the Nursing Team in ATICs across all theatre departments. This includes cross site working, to ensure that we make the best use of our resources to cover the core confirmed sessions. | 19/11/2021- no further update.<br>20/09/2021- Rolling nurse recruitment for Band 6 for paeds theatre is at advert. No paediatric surgery at present due to surge- redeployment of staff to ICU.<br>28/06/2021- Jan/Feb 2021x8 band 5 staff nurses recruited through peri-operative workstream. June 2021 band 5 applications closed, approx 8 band 5 have been recruited. Waiting on checks and start dates.<br>Delivering of care x 1 Band 7 and 10 x Band 6's funding secured. ATICS going out to advertisement (3x CEPs Band 7- 1 funded and 2 at risk).<br>15/02/2021- regional peri operative recruitment drive closing date 05/02/2021, awaiting confirmation of applicants and interviews to be processed. ATICS remain with larger number of vacant adult and paediatric theatre nursing posts.<br>11/12/2020 - request through E&G for a commissioned paediatric nursing course for 21/22. Regional recruitment plans ongoing. HOS ATICS remains on group<br>20/10/2020 - regional recruitment plans ongoing. HOS ATICS sits on the group.<br>10/8/2020 - Since the covid-19 pandemic Paediatric theatre presently being used for outpatient ENT AGPs. No paediatric surgery currently on the DHH site. Only 2 paediatric nurses Band 6 at present, out for recruitment with BSO. Continues as risk.<br>Continuing with recruitment drives for adult theatre nursing staff. Vacancies still remain. For retention Band 5 uplift to Band 6 successfully completed.<br>3/9/19 - only 3 paed nurses at present (1 is 16 hours only).<br>Further nursing gap highlighted to AD and Director - paper attached<br>18/6/19 - Unfortunately continued high level of vacancies in ATICS. Theatre nursing paper has been submitted to the Acute Director. Continue to run main theatres in CAH and DHH at 30% reduction. Risk remains high.<br>28/3/19 - Continued high level of vacancies in theatres and risk to staffing main theatre sessions. Continue to run at 30% less theatre sessions for April 2019. | MOD | DIV |
| 3804 | 27/05/2016 | Safe, High Quality and Effective Care | Outpatients Dept | Pre Op Assessment | Pre-op assessment is currently under resourced to provide the number of assessments required and deal with the increase in demand to the service | Staffing has been structured within pre-op to cover the key areas ensuring the best use of the limited resources. We are currently proactively working to change the existing pre-op processes to ensure that patients are pre-assessed and passed fit before ever being scheduled for surgery. This impacts on the need for additional staffing as we are working to change the processes while having to continue with existing processes. | 20/09/2021- Pre-op staffing currently matches the requirements for urgent bookable. Recruitment required. Will update as necessary.<br>28/06/2021- remains unchanged will discuss way forward with AD.<br>15/02/2021- remains unchanged.<br>11/12/2020 - remains unchanged. Internal audit completed and addressing recommendations<br>2010/2020 - remains unchanged<br>10/8/2020 - Pre-op assessment demand continues outweigh capacity. Out for recruitment BSO band 6. Requested planners to complete a business case to enhance pre-op service.<br>10/8/2020 - Pre-op assessment demand continues outweigh capacity. Out for recruitment BSO band 6. Requested planners to complete a business case to enhance pre-op service.<br>18/9/19 - Lead nurse is interviewing this week for new pre-op nursing staff. Pre-op is one of the projects submitted under demography monies.<br>18/6/19 - Ongoing works pressures continue in pre-op due to demand. Group met to progress pre-op paper however planners will be not support without confirmed funding stream. To remain on RR.<br>28/3/19 - Risks continue as below and additionality continues. Agency band 2 part time to start end of April 19 to support the B5/6 nursing staff.<br>6/2/19 - High sickness rate in pre-assessment at present. Additional hours offered to keep up with demand. Discuss additional admin B2 to be recruited as risk to support the B5/6 | MOD | DIV |

| ID | Opened | Principal objectives | Location (exact) | Title | Des/Pot for Harm | Controls in place | Progress (Action Plan Summary) | Risk level (current) | Register Holding |
|---|---|---|---|---|---|---|---|---|---|
| 3800 | 27/05/2016 | Safe, High Quality and Effective Care | Anaesthetics, Theatres & Intensive Care Services | Anaesthetic cover for maternity services | We currently fail to meet the standards regard to anaesthetic cover for maternity theatres. There is a risk to the Maternity patients from having inadequate cover. The staff is approximately 2.0wte. The nursing levels do not meet the national guidelines. Risk of failing anaesthetic accreditation, currently do not meet the standards. | A paper is being completed with regard to sorting the deficit in both anaesthetic and nursing cover. | 19/11/2021- no change<br>20/09/2021- no change<br>28/06/2021- no change<br>15/02/2021- risk remains the same<br>11/12/2020 - risk remains unchanged, however, in DHH elective c-sections are performed in the main theatres.<br>20/10/2020 - risk remains unchanged, however, in DHH elective c-sections are performed in the main theatres.<br>10/8/2020 - no further update. Risk continues.<br>18.09.19 - HOS & LN's have met and are meeting again in the next month to go through figures for the nursing requirement<br>18/6/19 - meeting was held between gynae and ATICs, business case to be progressed. To be kept on RR<br>28/3/19 - Next ATICS business meeting arranged for 19/4/19, await update from Dr Scullion.<br>6/2/19 - discussed at ATICS business meeting. Dr Scullion investigating the transfer of IMWH maternity theatres | MOD | DIV |
| 3727 | 01/09/2015 | Make the best use of resources | Anaesthetics, Theatres & Intensive Care Services | No equipment store available in Day Surgery Unit CAH | Currently there is a 2 bedded side room unable to be used for patients as it stores the equipment for this unit. This can impact on the availability of beds for the daycase list, particularly when lists are occurring simultaneously. Potential for harm; Potential delay of access to day surgery beds. Limited availability of segregation for patients for IPC reasons and also male/female. | Try to maximise the use of the existing 12 bed spaces. Continues to use the 2-bedded side room for equipment as this reduces the risk to patients and staff of equipment being stored in corridors, this would also be a fire hazard. | 19/11/2021- no change<br>28/06/2021- remains unchanged no funding.<br>15/02/2021- remains unchanged still no capital funding<br>11/12/2020 - remains unchanged<br>20/10/2020 - remains unchanged, no capital funding identified.<br>10/8/2020 - Still no capital funding, risk remains the same.<br>18.09.19 Still no capital funding risk remains the same<br>18/6/19 - still no capital funding identified, risk remains the same.<br>28/3/19 - as below, risk remains as no capital funding identified.<br>6/2/19 - no capital funding, therefore risk remains the same. | MOD | DIV |
| 4095 | 02/06/2020 | Provide safe, high quality care a great place to work | Trustwide | Mishandling of Patient handover resulting in an Information Governance breach | There is a risk that the handover with patients details could be mislaid anywhere on site or in the community.<br>Patient detail not being managed in a confidential manner thereby reveling the patient's private business and exposing the Trust to a breach in public confidence. | All disciplines of staff have been informed of the recent breaches in Information Governance and the consequence of same.<br>All wards and departments have bins with clearly visible signage indicating they are for the disposal of the confidential handover prior to the end of their shift<br>Regular reminders at patient safety briefings to adhere to Trust governance protocols<br>Representative in Acute have met and agreed the content on the handovers.<br>Incident and meeting note shared with OPPC, Peads and MH directorates. | 12/11/20212 An Information Governance audit has taken place and results are pending to ascertain compliance with non identifiable patient from handovers.To await report to ascertain compliance to inform if this risk should remain on register.<br>20/09/2021- AD to confirm is this can be removed from risk register<br>28/06/2021- Additional confidential waste bins at doffing, exits and signs were erected re disposing confidential waste appropriately.<br>24/02/2021- continuously monitored<br>02/06/2020 Staff regularly reminded of necessity to adhere to Trust governance protocols. | LOW | DIV |
| 750 | 28/07/2008 | Safe, High Quality and Effective Care | Anaesthetics, Theatres & Intensive Care Services | STH Theatres and Day Procedure Unit requires UPS/IPS syste, | Theatres and Day Procedure Unit at STH currently does not have any form of backup electrical supply other than the emergency generator; in the event of a power failure all power supplies to socket outlets will drop out for approx. 15 seconds until the generator comes on line. | Battery backup exists on the anaesthetic machine only. | 12/11/2021- no change<br>20/09/2021- UPS/IPS need an injection of £200k. Estates are costing.<br>29/06/2021- less than 50% of the required installation has been completed. I have liaised with estates to advise of the next priorities if a phased approach for installation of further UPS/IPS is being considered when funding becomes available. I have listed the areas below detailing completed works in Green and the work that remains outstanding in red:<br>Theatre 1 pendants Completed<br>Theatre 2 pendants Completed<br>Recovery area main theatre 6 bed spaces and defib plug Not completed<br>DPU recovery 6 bed spaces and defib plug in reception Not completed<br>DPU 1 procedure room pendants Not completed<br>DPU 2 procedure room pendants Not completed<br>DPU Decontamination unit (2 drying cabinets completed and 2 endoscope washers not completed)<br><br>15/02/2021- covid remains a priority for estates no change to risk<br>11/12/2020 - still with estates, priority to covid<br>20/10/2020 - no change and remains with estates. Priority being given to covid<br>10/8/2020 - no change, remains a risk. Helena to e-mail Estates re plan to address IPS/UPS.<br>18.09.19 No change | HIGH | HOS |

| ID | Opened | Principal objectives | Location (exact) | Title | Des/Pot for Harm | Controls in place | Progress (Action Plan Summary) | Risk level (current) | Register Holding |
|---|---|---|---|---|---|---|---|---|---|
| 3801 | 27/05/2016 | Safe, High Quality and Effective Care | Anaesthetics, Theatres & Intensive Care Services | JAG Accreditation | Due to the waiting times for patients having endoscopy procedures, we cannot achieve timeliness of appointments, and therefore, cannot achieve JAG accreditation. This is a regional issue and JAG are aware of same. | JAG is working with HSCB and the Trusts with regard to the revised JAG standards and the potential for 2 levels of accreditation. | 12/11/2021 No ATICS business meeting interface<br>15/09/2021- unchanged.<br>28/06/2021- unchanged.<br>15/02/2021- priority given to covid pandemic. Significantly reduced capacity available on all day surgery sites.<br>11/12/2020 - remains the same, priority being given to covid pandemic<br>20/10/2020 - Due to covid pandemic remains unchanged, currently going into 2nd surge<br>10/8/2020 - Dr P Murphy is the Interim Endoscopy lead. Endoscopy waiting times continue to be an issue in achieving JAG accreditation.<br>18.09.19 Require a led for JAG<br>28/3/19 - next ATICS Business meeting Fri 19/4/19, to discuss taking JAG off the RR.<br>6/2/19 - Consider taking off Directorate RR to be discussed at next ATICS Business meeting. | MOD | HOS |

Southern Health and Social Care Trust

*Quality Care - for you, with you*

# JOB DESCRIPTION

**POST:** Clinical Director – General Surgery

**DIRECTORATE:** Acute Services

**RESPONSIBLE TO:** Divisional Medical Director - Surgery and Elective Care

**ACCOUNTABLE TO:** Medical Director

**COMMITMENT:** 2 PAs

**LOCATION:** Trust wide

**Context:**

The Clinical Director (CD) on behalf of the Divisional Medical Director (DivMD) will be a leader in Divisional Management Team and member of the Directorate Senior Management Team. The CD will report to the DivMD and 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 CD 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 CD will have delegated responsibility on behalf of the DivMD within their areas 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 CD 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.

**Specialties / Areas Responsible For**

- Emergency General Surgery and Breast Surgery Trust wide.
- Elective General Surgery and Breast Surgery Trust wide

**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:

| | |
|---|---|
| • Professional Medical Governance<br>– Staffing and Staff Management<br>– Professional Performance Management<br>– Appraisal and Revalidation<br>• Adverse and Serious Adverse Incident Management<br>• Litigation and Claims Management<br>• Coronial Matters<br>• Complaints<br>• Morbidity and Mortality<br>• Patient Safety (Including Infection Prevention and Control)<br>• Medications management | • Research and Development<br>• Risk Management / Mitigation and Reduction<br>• Learning from Experience<br>• Medical Education in conjunction with DMD/ Dir Med Ed<br>• Medical Workforce development<br>• Quality Improvement<br>• Clinical Audit<br>• Education, Training and Continuing Professional Development<br>• Ensuring Delivery of Effective Evidence-Based Care<br>• Patient and Carer Experience and Involvement<br>• Medical leadership in delivery of MCA and Safeguarding |

**Specific Divisional Responsibilities**

Provide medical leadership and direction regarding strategic development of General Surgery Services within the Southern Trust.

Ensure all clinical staff are aware of Trust policies and procedures in relation to good medical practice, and compliant with relevant standards and guidelines.

**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 Clinical Director will work with the Divisional Medical Director and the Assistant Director and professional leads, 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 CD 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 Consultants and any other relevant medical staff.
- 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** Clinical Director – General Surgery – Trustwide

**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 Mr Ted McNaboe, Interim Divisional Medical Director to allow further discussion of the role of Clinical 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 Pamela Hall 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 week commencing 28th March 2022 (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 2PA's and a fixed management allowance of £7,400 per annum. Successful applicants can opt to have the responsibility allowance superannuable or non-superannuable at the outset of the contract agreement (subject to change) – which will then apply for the duration of the contract.*

**WE ARE AN EQUAL OPPORTUNITIES EMPLOYER**

Southern Health and Social Care Trust

*Quality Care - for you, with you*

# JOB DESCRIPTION

**POST:** Clinical Director – ENT/Urology

**DIRECTORATE:** Acute Services

**RESPONSIBLE TO:** Divisional Medical Director - Surgery and Elective Care
Divisional Medical Director – Urology Improvement

**ACCOUNTABLE TO:** Medical Director

**COMMITMENT:** 1 PA

**LOCATION:** Trust wide

**Context:**

The Clinical Director (CD) on behalf of the Divisional Medical Director (DivMD) will be a leader in Divisional Management Team and member of the Directorate Senior Management Team. The CD will report to the DivMD and 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 CD 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 CD will have delegated responsibility on behalf of the DivMD within their areas 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 CD 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.

**Specialties / Areas Responsible For**

- Ear Nose and Throat Surgery Trust wide.
- Urological Surgical Service Trust wide

**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:

| | |
|---|---|
| • Professional Medical Governance<br>–Staffing and Staff Management<br>–Professional Performance Management<br>–Appraisal and Revalidation<br>• Adverse and Serious Adverse Incident Management<br>• Litigation and Claims Management<br>• Coronial Matters<br>• Complaints<br>• Morbidity and Mortality<br>• Patient Safety (Including Infection Prevention and Control)<br>• Medications management | • Research and Development<br>• Risk Management / Mitigation and Reduction<br>• Learning from Experience<br>• Medical Education in conjunction with DMD/ Dir Med Ed<br>• Medical Workforce development<br>• Quality Improvement<br>• Clinical Audit<br>• Education, Training and Continuing Professional Development<br>• Ensuring Delivery of Effective Evidence-Based Care<br>• Patient and Carer Experience and Involvement<br>• Medical leadership in delivery of MCA and Safeguarding |

**Specific Divisional Responsibilities**

Provide medical leadership and direction regarding strategic development of ENT Surgery and Urological surgical Services within the Southern Trust.

Ensure all clinical staff are aware of Trust policies and procedures in relation to good medical practice, and compliant with relevant standards and guidelines.

**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 Clinical Director will work with the Divisional Medical Directors and the Assistant Director and professional leads, 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 CD 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 Consultants and any other relevant medical staff.
- 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** Clinical Director – ENT/ Urology

**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 Mr Ted McNaboe, Interim Divisional Medical Director to allow further discussion of the role of Clinical 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 Pamela Hall 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 week commencing 28th March 2022 (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 1PA and a fixed management allowance of £7,400 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.*

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Southern Health and Social Care Trust

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# JOB DESCRIPTION

**POST:** Interim Divisional Medical Director – Surgery and Elective Care (Up to 24 Months 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 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:

| | |
|---|---|
| • Professional Medical Governance<br>– Staffing and Staff Management<br>– Professional Performance Management<br>– Appraisal and Revalidation<br>• Adverse and Serious Adverse Incident Management<br>• Litigation and Claims Management<br>• Coronial Matters<br>• Complaints<br>• Morbidity and Mortality<br>• Patient Safety (Including Infection Prevention and Control)<br>• Medications management | • Research and Development<br>• Risk Management / Mitigation and Reduction<br>• Learning from Experience<br>• Medical Education in conjunction with DMD/ Dir Med Ed<br>• Medical Workforce development<br>• Quality Improvement<br>• Clinical Audit<br>• Education, Training and Continuing Professional Development<br>• Ensuring Delivery of Effective Evidence-Based Care<br>• Patient and Carer Experience and Involvement<br>• Medical leadership in delivery of MCA and Safeguarding |

**Specific Divisional Responsibilities**

- On behalf of the Medical Director represent the Trust in regional service development discussions including the development of regionalized surgical services
- Represent the Trust on the Surgical Regional Priority Operational Group

**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

**DIRECTORATE** Surgery and Elective Care

**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 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.*

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Southern Health and Social Care Trust

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**TITLE:** Associate Medical Director

**DIRECTORATE/ DIVISION:** Acute Services – Surgery / Elective Care

**REPORTS OPERATIONALLY TO:** Director of Acute Services

**REPORTS PROFESSIONALLY TO:** Medical Director

**ACCOUNTABLE TO:** Chief Executive

**COMMITMENT:** Maximum of 3 PAs - to be agreed with Director

**LOCATION:** Craigavon Area Hospital / Daisy Hill Hospital

## JOB SUMMARY

The Associate Medical Director (AMD) will as a member of the Directorate Senior Management Team, play an active role in contributing to the strategic direction and the on-going provision of high quality services which are safe and efficient.

Specifically, the AMD will be responsible and accountable for the medical staff within the specialty and their role in the provision of services. As a senior medical leader within the Trust the AMD will work closely with the Director / Assistant Directors of Acute Services to provide medical management within the Directorate and contribute to the overall vision, direction and performance of the organisation with respect to the medical staff and their role in service delivery. The AMD will also be responsible for the safety and capability of the medical workforce within the specialty, providing the Director of Acute Services with defined information for assurance purposes to the Medical Director. The AMD will demonstrate a commitment to lead by example with regard to clinical and social care governance.

The post will be appointed for one year and may be extended at annual performance reviews up to a period of 3 years. After this period, the post will be re-advertised.

## KEY RESPONSIBILITIES

### 1. LEADERSHIP & MANAGEMENT RESPONSIBILITIES

The AMD will work closely with the Director/ Assistant Directors of Acute Services to provide effective leadership within the Directorate**.**

The AMD Surgery & Elective Care will work closely with the AMD's MUSC, ATICs and Cancer & Clinical Services to ensure effective clinical interfaces and patient pathways for out of hospital care, ambulatory care and admission for inpatient care are in place, reviewed and actioned.

The AMD Surgery & Elective Care will work regionally on behalf of the Trust in the development of quality and safety standards for the service and will hold responsibility in the Trust for clinical leadership of these standards.

He / she will also contribute to effective service delivery within the department by managing implementation of the following policies;

**Appraisal**

- Co-ordinate the approved appraisal system, ensuring a process is in place and operating within guidelines.
- Ensure necessary training (within the agreed budget) is available for medical staff (non-training grades) within the Directorate / sub Directorate, manage the approvals process for same and oversee the Division's utilization of the budget for medical training and development.
- Monitor the implementation of appraisal within recommended timescales.
- Undertake appraisal for Clinical Directors.
- Prepare an annual Directorate / sub Directorate Appraisal report for the Director of Acute Services to submit to the Medical Director (in relation to required Annual Trust Board Report).

**Job Planning**

- Provide leadership and support for Job planning within the Division 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 Division / 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 AMD for Education and Training and NIMDTA with regard to junior doctors in training for appropriate advice and support

**Education and Training**

- Liaise with the Associate Medical Director for Education and Training and College Tutors to ensure a plan is in place by specialty for the training of junior doctors in keeping with NIMDTA and GMC requirements (including managing the balance between service delivery and training demands).
- Provide leadership in implementing and achieving compliance with the European Working Time Directive.

## 2. CLINICAL GOVERNANCE RESPONSIBILITIES

The AMD in conjunction with the Assistant Directors and Director of Acute Services will be responsible for having systems and processes in place to review and manage remedial action emerging from incidents, complaints, risk identification and assessment, litigation, audit and clinical indicators. The AMD will have responsibility for the specialty M&M meetings and to ensure emergency medicine contributes to other specialty M&M meetings.

The AMD will be directly responsible to the Director Of Acute Services for patient safety. This includes ensuring processes are in place to identify, review and take remedial action when patient safety issues arise.

The AMD will be responsible for managing potential underperformance of medical staff within the Directorate. With full assistance from HR, the AMD will be responsible for leading the Trust's process for Maintaining High Professional Standards within the Division.

## OTHER CLINICAL GOVERNANCE RESPONSIBILITIES

### Divisional Governance Forum

- Chair the Divisional Specialty Governance Group and participate as agreed in Directorate governance arrangements.
- Work with the Trust / Directorate Governance Co-Ordinator to ensure effective governance of services.

### Standards

- Provide advice to the Director of Acute Services and colleagues on the application of existing and new standards and guidelines e.g. NICE, NSFs, Royal College Guidelines etc.
- Work with relevant managers and colleagues on required implementation plans and lead the implementation of such plans in relation to the medical workforce and clinical practice.
- Act upon the recommendations of any external audits/ reviews (e.g. RQIA, CMO's office, Child Protection etc) working on the development and roll out of an implementation plan in conjunction with the Director/ Assistant Director of Acute Services.
- Assist in the preparation for external inspections.

### Public Health and urgent operational issues

- Provide advice to Director of Acute Services, Medical Director and colleagues (e.g. swine flu, HCAIs).
- Contribute as appropriate to the development and implementation of contingency plans and lead the implementation of these plans in relation to the medical workforce.

## 3. CORPORATE RESPONSIBILITIES

As a senior medical leader within the Trust the AMD will participate and contribute to the corporate performance of the Trust. He / she will share responsibility with other senior managers in the Trust for Trust activities and for the overall performance, clinical and service strategy.

The AMD will also be required to:

- Attend meetings of the Directorate Management team and / or regular meetings with the Director of Acute Services.
- Contribute to the Business Plan of the Directorate to help achieve Trust Delivery Plan priorities.
- Monitor activity against the plan and determine / advise on required actions in conjunction with Director / Assistant Directors of Acute Services
- Lead the implementation of such plans as they apply to the medical workforce and / or clinical practice.

**OTHER CORPORATE RESPONSIBILITIES**

**Service Development & Improvement:**

- Maximise the effectiveness and efficiency of the services within the Division across the Trust's hospital network.
- Regularly review key service data in conjunction with Director / Assistant Director / Heads of Service of Acute Services and advise on delivery options.
- Provide a medical perspective on protocols / pathways related to service improvements.
- Provide input to decisions on the medical capacity required for service developments.
- Provide clinical leadership on service reconfiguration within the Division and Directorate.

**Budgetary management**

- Monitor financial information on medical staffing to ensure staff costs are within budget including the Division's specialty 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.

**Communication**

- Facilitate good communication with medical staff, (through planned meetings with consultant staff and other opportunities).
- Provide effective communication with other clinical and non-clinical managers in support of good multidisciplinary team working.
- Actively promote the development of clinical and professional networks across the Trust's hospital network.
- Actively participate in the AMD Forum which is led by the Medical Director.

**GENERAL REQUIREMENTS**

The post holder will be required to:

- 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.

- 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.

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

- 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.

- 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.

- 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.

- 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. It is not intended to be rigid and inflexible but should be regarded as providing guidelines within which appointee will work.

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

# SOUTHERN HEALTH AND SOCIAL CARE TRUST

## PERSONNEL SPECIFICATION

**JOB TITLE** Associate Medical Director – Surgery / Elective Care Division

**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 required to meet with Dr Richard Wright, Medical Director to allow him to further discuss the role of Associate Medical Directors 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 Laura White on [redacted].

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 short-listed 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/resources/healthcare-leadership-model/

**Please note that interviews for this post will be held as soon after the closing date as possible.**

*The post will be for a period of 1 year (3 sessions per week) and may be extended at annual performance reviews up to a period of 3 years. After this period, the post will be re-advertised.*

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

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

Southern Health and Social Care Trust

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

**JOB DESCRIPTION**

**JOB TITLE:** Clinical Director – Surgery & Elective care (2 posts)

**BASE:** Craigavon Area Hospital / Daisy Hill Hospital

**DIRECTORATE:** Acute Services

**RESPONSIBLE TO:** Director of Acute Services

**OPERATIONALLY RESPONSIBLE TO:** Associate Medical Director – Surgery and Elective care

**ACCOUNTABLE TO:** Chief Executive

**HOURS:** Salaried Part-time position

**JOB SUMMARY**

The appointee will provide clinical leadership and contribute to the strategic development of Surgical Services in the Southern Health and Social Care Trust. The posts will form part of a clinical leadership team comprising a Clinical Director in Trauma and Orthopaedics, a Clinical Director in General Surgery and a Clinical Director in surgical specialties (Orthodontics, ENT and Urology).

Details of the various roles will be agreed following appointment.

There are 2 posts available;
He/She will:

- Participate as a member of the Surgery and Elective Care Divisional Team;
- Be responsible for medical operational issues within Surgery across the Trust.
- Provide professional advice to the Associate Medical Director and Divisional team on professional medical issues of the Division.
- Support the Associate Medical Director in the performance management, job planning and appraisal of designated clinicians.

The appointee will be professionally accountable to the Medical Director for medical professional regulation within the service.

**KEY RESPONSIBILITIES**

**Setting Direction:**

- To support the Trust in the development of a high quality, responsive scheduled and unscheduled care services, ensuring that regional and local targets are achieved.
- To advise the Management Team of Divisional priorities and pressures across the Division.
- Provide leadership and direction to consultants and other medical staff within the specialty.

**Service Delivery:**

- To function as a member of the Divisional management team with responsibility for medical operational and professional issues within Surgery and Elective care.
- Work with the Associate Medical Director to provide clinical leadership in developing responses to specific access targets and in the reform and modernisation of services within the Division.
- Work with the Divisional Team to use the resources of the Division to deliver, in both quality and quantity, the activity and targets agreed for the Division.
- Work with the Surgery and Elective care Divisional team to deliver efficient, effective services within the agreed financial budgets and to provide advice and guidance on the costs and benefits of planned developments.
- Work with the Surgery and Elective Care Divisional Team in supporting the modernisation of related services.
- To support the Trust in planning a response to major incidents and outbreaks.

**Quality, Communication and information management**

- Provide clinical leadership to ensure the implementation of patient safety initiatives.
- Support the Associate Medical Director to ensure a programme of multi-professional clinical audit is implemented within the Division that supports the Southern Trust integrated governance strategy and support the development of benchmarking activities within the Division.
- Support the implementation of the Trust adverse incident reporting and complaints handling mechanisms within the specialty.

**Professional Leadership**

- Support the Associate Medical Director to ensure the highest standards of clinical effectiveness and medical practice in the Division, including the consideration / implementation of local and national recommendations including NICE guidelines, RQIA Reports, Independent Reviews, College Guidelines, SAI recommendations and Regional and National Reports
- To place Patient Safety at the centre of specialty activity

**Medical Education and Research**

- Work with the Associate Medical Director to support the development and delivery of Education and Research within the specialty, ensuring the appropriate Governance arrangements are in place

**Leading the Medical Team**

- Support the Associate Medical Director in the implementation of the consultant contract within the specialty, ensuring the contract supports modernisation, quality improvement and achievement of access targets.
- Support the Associate Medical Director in the effective implementation and monitoring of modernising medical careers (MMC) and EWTD for junior doctors.
- Support the Associate Medical Director in co-ordinating the appraisal of all grades of doctors, including locum tenens, in line with regional guidance.
- Where required, take part in the recruitment process for new doctors or ensure that other colleagues do so effectively.
- Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.
- Work with the Associate Medical Director to ensure a system of induction is in place for all doctors within the specialty.
- Work with the Associate Medical Director to develop and lead a team of Specialty/Site Leads to assist the Trust in the redesign, modernisation and improvement of service delivery.
- Support the Associate Medical Director in the appraisal of all grades of designated doctors, including locum tenens, in line with regional guidance.
- Ensure that doctors within the specialty comply with arrangements for the assessment of fitness for clinical work.
- Work with the Associate Medical Director and Assistant Director of Surgery and Elective Care to ensure the equitable and fair management of annual, discretionary and study leave process which meets the needs of the service and the development needs of the medical workforce within the Trust.

**Collaborative Working**

- Actively promote the development of clinical and professional networks between the Trust hospital sites.
- Liaise with clinical colleagues to ensure that activities across the Trust are appropriately co-ordinated and integrated.
- Support the development of effective multi-professional team working and communication across both acute hospital sites

**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 into 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.

**Responsibility Allowance**

- Responsibility Allowance: **£7,676 per annum** (This is a pensionable allowance)
- Dedicated time within job plans between 0.25 PA and up to a maximum of **1 PA per week.** This time allocation will be timetabled into the job plan as additional HPSS responsibilities and will be proportionate to the demands of the role, size of the division etc.
- Training and support to ensure doctors are equipped with the necessary skills to develop within their leadership role and increase breadth and depth of their leadership capacity.

*This job description is subject to review in light of changing circumstances. It is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the Clinical Director will work.*

Southern Health and Social Care Trust

*Quality Care - for you, with you*

# PERSONNEL SPECIFICATION

**JOB TITLE:** Clinical Director – Surgery and Elective Care (2 posts)

**DIRECTORATE:** Acute Services

**October 2018**

**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.*

***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 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.

You should also note that shortlisted applicants will be assessed against the criteria stated in this specification as it links to the NHS Leadership Framework. Candidates who are short-listed for interview are therefore advised to familiarise themselves with this framework to ensure that at interview they can adequately demonstrate they have the required skills to be effective in this demanding leadership role. For ease of reference a copy of the Summary document on the NHS Leadership Framework is available with this advertisement. Further information may be obtained from www.nhsleadershipqualities.nhs.uk

*The successful candidate will be appointed for a period of up to 1 year in the first instance subject to satisfactory performance.*

***WE ARE AN EQUAL OPPORTUNITIES EMPLOYER***

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

Southern Health and Social Care Trust

# Public Inquiry Quality Assurance Group

## *Clinical and Social Care Governance*

### *28th March 2022*

Issued by the Urology Services Inquiry on 30 March 2022. Annotated by the Urology Services Inquiry.

# What is Clinical Governance?

Clinical governance is the **system through which NHS organisations are accountable for continuously improving the quality of their services** and safeguarding high standards of care by creating an environment in which clinical excellence will flourish (Department of Health (UK), 2021)

Southern Health and Social Care Trust

# The Measurement and Monitoring of Safety


Southern Health and Social Care Trust

# What Has Gone Before

## 2 Reviews into CSCG structures

- (i) 2011 A System of Trust
- (ii) 2019 Governance Review by Leadership Centre

## Proposal presented to SMT 1st September 2020

- (i) To realign CSCG structures
- (ii) To increase resourcing in the CSCG function

## Proposal presented to SMT 2nd November 2021

- (i) To establish a CSCG working group to strengthen assurance mechanisms
- (ii) To move to a Corporate Business Partner Model for CSCG

Southern Health and Social Care Trust

# Recommendations From Clinical and Social Care Governance Review 2019

| THEME/ REC NO | RECOMMENDATION |
|---|---|
| 1 | The Trust Board should review the cycle of Trust Board Reports and the Board of Directors' public meeting |
| 2 | The Director of Finance, Procurement and Estates is also invited to attend the meetings in the interests of integrated governance and also as the Chief Executive has delegated responsibility for Health and Safety Management to this Executive Director. |
| 3 | The Chair of the Governance Committee should be involved in the development of the agenda and the cycle of reports. It is also recommended that the cycle of reports is reviewed and submitted to the Committee for approval commencing April 2020 |
| 4 | The clinical and social care key performance indicators should be further developed and submitted for approval through the Senior Management Team. |
| 5 | The SMT Terms of Reference should be reviewed including the provision for tabling urgent papers |
| 6 | The remit and responsibilities of the SMT Governance Board should be reviewed and a separate Terms of Reference developed to include the purpose, membership and reporting lines to Trust Board via the Governance Committee of Trust Board. (See also Assurance & Accountability Framework proposals at Section 4 1.9). The role of the SMT Governance Board should also be clearly defined in the Integrated Governance Strategy |
| 7 | The Trust Governance Structures should be reviewed and Trust Board Sub Committee/Oversight/Steering Groups constituted to which the various integrated governance steering groups, forum and committees will report and provide the organisation with a first level of assurance (see Appendix 2). |
| 8 | The Terms of Reference and annual work plans/action plans (where applicable) for Board Committees and Sub Committees should be held centrally. |

HSC Southern Health and Social Care Trust

# Recommendations From Clinical and Social Care Governance Review 2019

| THEME/ REC NO | RECOMMENDATION |
|---|---|
| 9 | Any short – medium term Director's Oversight Groups should be added to the Governance Structure (Integrated Assurance Framework) for the duration of their remit as 'Task and Finish Groups' e.g. IHRD Directors Oversight Group. |
| 10 | To ensure that all committees provide clarity in their terms of reference, delegated powers and reporting requirements the Trust should consider developing a standard template to define the terms of reference for all Board Sub Committees, Steering Groups and Advisory/Specialist Groups. |
| 11 | The Trust should consider introducing the role of Board Secretary/Head of Office to support the Trust Board and the Integrated Governance Framework. |
| 12 | The Integrated Governance Framework should be reviewed as a matter of urgency to ensure it provides clear descriptions of the roles and responsibilities of key stakeholders. It is also recommended that the Framework provides electronic links to key corporate Trust Strategies and Policies and extant guidance where applicable. |
| 13 | Arrangements for Adult Safeguarding should be reviewed to identify any potential risks/gaps in control or assurance in this area. |
| 14 | The Trust should consider the implications of implementing the Regional 'Being Open' framework which includes compliance with IHRD Recommendation 69 (i) ~ Trusts should appoint and train Executive Directors with specific responsibility for 'Issues of Candour'. |
| 15 | The Trust should undertake an audit/review of the Management of Medical Devices and Equipment to provide assurance that systems are in place across the organisation. |
| 16 | The Trust should develop an organisational risk audit and assessment tool with associated audit programme based on the Controls Assurance standards. |

HSC Southern Health and Social Care Trust

# Recommendations From Clinical and Social Care Governance Review 2019

| THEME/REC NO | RECOMMENDATION |
|---|---|
| 17 | The Draft Risk Management Strategy should be submitted for approval as a matter of urgency. |
| 18 | The Trust Board should consider the application of the Risk Appetite Matrix in respect of the organisation's Corporate Objectives and associated Board Assurance Framework and Corporate Risk Register. |
| 19 | A risk management training programme should be developed and delivered to underpin the publication of the approved Risk Management Strategy and the training should include risk appetite, risk assessment/evaluation and management of risk registers |
| 20 | The management of the Board Assurance Framework and Corporate Risk Register should be delegated to the Executive Medical Director in line with the Risk Management Strategy. |
| 21 | A standardised Directorate risk register template should be considered when Datix risk register module is implemented. |
| 22 | A Trust flow chart should be developed to underpin the Regional Adverse Incident Reporting Policy/Procedure (when disseminated) which accurately reflects local/ Trust roles and responsibilities especially at Executive Director level. |
| 23 | Corporate oversight of the management of adverse incidents should be strengthened to include a quality assurance component which will be dependent upon the resources and skills available within the Clinical and Social Care department |
| 24 | The Trust should constitute an SAI Review Group and/or SAI Rapid Review Group [or similar] which should provide independent scrutiny and challenge to the SAI process including review of level of investigation, independence of review panel and approval of terms of reference when SAIs are initiated. In addition, the Review Group should oversee completed reports before submission to the HSCB. The Review Group should be chaired by the MD or his/her Deputy and will report to a Trust Board Sub Committee. The Review Group should meet on a four weekly basis initially. |
| 25 | |
| 26 | The Trust should develop an SAI RCA/Systems Analysis toolkit based on the training provided by external provider. |
| 27 | The Trust should consider developing the role of a Service User Liaison Officer [or similar] for engagement with families throughout the SAI process |
| 28 | The Trust Health and Safety Committee should review their Terms of Reference and submit to the relevant Board Sub Committee for approval. |
| 29 | The Trust should review and revise the existing H & S audit tool for use as outlined above in Recommendation 16. |
| 30 | |

# Recommendations From Clinical and Social Care Governance Review 2019

| THEME/ REC NO | RECOMMENDATION |
|---|---|
| 31 | The remit of the Corporate Complaints Officer should be reviewed in line with the extant Trust Complaints Management Policy |
| 32 | The current process of screening of complaints should be reviewed and parameters for alerts to be clearly defined to include alerts to professional Executive Directors |
| 33 | It is recommended that the Trust constitutes a Director's Oversight Complaints Review Group as a task and finish group to focus on reviewing Policy and Procedure and improving the management of complaints and experience of the service user. Membership should include a Non-Executive Director and/or a Service User(s). |
| 34 | The management of Legal Services should be reviewed in line with IHRD Recommendations 36, 51 and 52 |
| 35 | The Trust should explore the options for an electronic policy and procedure management system that is accessible, easy to navigate, contains a search facility and includes the capacity for email notification of new/changed policy and automates a review/revise reminder |
| 36 | The Corporate oversight of the management of Standards and Guidelines should be reinstated and the former Accountability (Compliance) reporting arrangements are also reinstated. |
| 37 | The Trust should further develop the Standards and Guidelines model developed within Acute Services and provide a central management system within the Corporate Clinical and Social Care Team under the leadership of the Medical Director. |
| 38 | The Trust should review the Sub Committee Structure to include an oversight committee for the management of Standards and Guidelines either a full time committee or a Task and Finish Sub Committee (see also Recommendation 7). |
| 39 | The 2018 Clinical Audit Strategy and Action Plan should be reviewed and updated. |


Southern Health and Social Care Trust

# Recommendations From Clinical and Social Care Governance Review 2019

| THEME/REC NO | RECOMMENDATION |
|---|---|
| 40 | The Clinical Audit Committee should be reinstated and the reporting arrangements considered in the review of the Trust Board Committee Structure Section 4.2.6 and Appendix 1 |
| 41 | The resource implications for the delivery of the RMMR should be considered in line with the proposals for the Medical Leadership model. (Section 4.21 Medical Leadership and Section 4. 23.1 Corporate Clinical and Social Care Governance Department). |
| 42 | The RMMR process should be adequately resourced and supported to ensure optimum outputs and clinical engagement. This includes the resources required within the Corporate Clinical and Social Care Clinical Audit team to ensure the development of administrative systems for the central suppository of minutes and attendance logs (see also Recommendation 44 and 45 below) |
| 43 | The Trust should review the Terms of Reference, including membership, and strengthen the purpose of the Lessons Learned Forum. |
| 44 | 1) It is recommended that the Trust consider the information management systems and administrative support required to support the implementation of the Governance Review recommendations.<br>2) To ensure that the Trust maximises the potential for the use of patient safety software it is vital that a dedicated Datix systems administrator is appointed who can ensure the quality of data provided as this has been identified as a gap at present (see also Clinical and Social Care Governance Structures below). |
| 45 | It is recommended that the Corporate Clinical and Social Care Governance team is re-structured and two additional Senior Manager posts are considered to provide leadership to related functional areas.<br>It is further recommended that there is an urgent review of the Corporate Clinical & Social Care Governance structure and business case development for consideration by the SMT. |
| 46 | The Trust should ensure that the directorate governance reporting arrangements are included in a review of Trust Board Sub Committee Structure and the review of the SMT Terms of Reference as above |
| 47 | It is recommended that the agenda, membership and timeliness of the weekly Governance Meeting is reviewed and terms of reference developed. The meetings should be kept as short briefing meetings and held face to face with members. There should be a short summary template report developed which can then be used as an internal communication to NEDs. |
| 48 | In light of the weekly governance meeting, it is recommended that a review of the terms of reference including purpose, membership and frequency is undertaken. |

HSC Southern Health and Social Care Trust

# Areas of Development to Date

## Standards and Guidelines

- Appointment of Senior Manager for Corporate S&G oversight
- Framework for management of S&G cross Trust under development

## Serious Adverse Incidents

- Appointment of Senior Manager for Corporate SAI oversight
- Creation of Family Liaison Service
- Appointment of Corporate SAI medical chairpersons
- Executive Director oversight of SAI process in development

## Complaints

- Appointment of Corporate Service User feedback manger
- Project to support the management of complaints and feedback underway

## Clinical Audit

- Dedicated Senior Clinical Audit manager appointed
- Refresh of Clinical Audit strategy and policy underway
- Identification of resource required to support clinical audit function operationally and corporately underway

HSC Southern Health and Social Care Trust

# Weekly CSCG Debrief

## Background

- The Trust is committed to delivering high quality, safe and effective services. To achieve this there must be a fast and responsive mechanism to:
- de-brief on newly emerging issues e.g. SAIs, Never Events, Complaints, Adult safeguarding, Medicines management, Litigation etc;
- brief staff on newly issued Standards & Guidelines, Safety alerts etc; and
- report the above to Trust SMT, as part of the integrated governance arrangements of the Trust's assurance and accountability framework.
- The Weekly Governance meeting, Chaired by the Medical Director, is a multi-disciplinary, cross Directorate vehicle through which this is achieved.

## Purpose / Role of the Group

- To review Directorate patient safety concerns which emerged in the week prior to the meeting of the group
- To identify learning from the events surrounding these concerns
- To identify opportunities for improvement based on a thorough understanding of the issue which caused the concern
- To provide a Weekly Governance paper to SMT detailing the issues/concerns of the previous week.

## Membership

- Medical Director (Chair)
- Executive Director of Nursing; Deputy Medical Director Governance, Safety and Quality (Alternate Chair); Deputy Medical Director of Education and Workforce; Assistant Director Clinical and Social Care Governance and Infection Prevention & Control; Assistant Director Clinical and Social Care Governance; Corporate Clinical and Social Care Governance Coordinator; Operational Directorate Governance Coordinators;Governance Officer, Clinical and Social Care Governance; Complaints Manager;Datix Risk Manager; Head of Patient Safety Data and Improvement; Senior Manager of Standards, Risk & Learning; Litigation Manager; Medicines Governance Pharmacist; Head of Service – Adult Safeguarding; Head of Information Governance; Liaison Officers; Assistant Director Quality Improvement / Head of Continuous Improvement; CSCG Admin staff member

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# Integration of CSCG

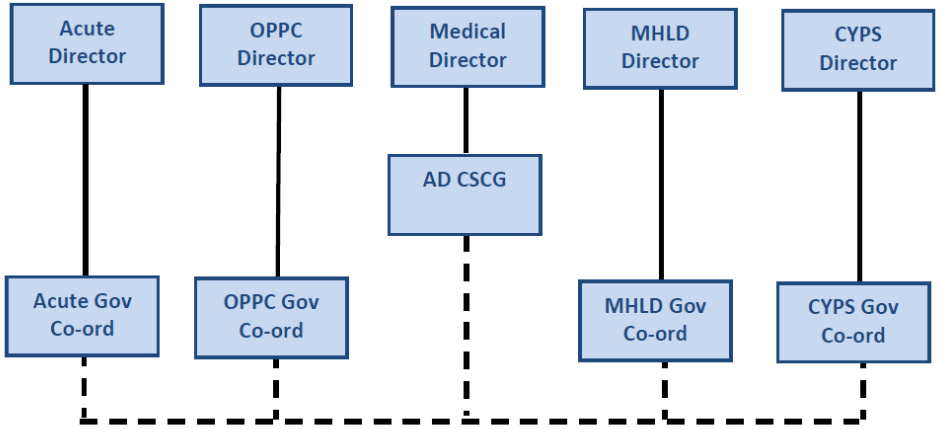



*Figure 1 – Current Clinical and Social Care Governance Structure within the Trust*

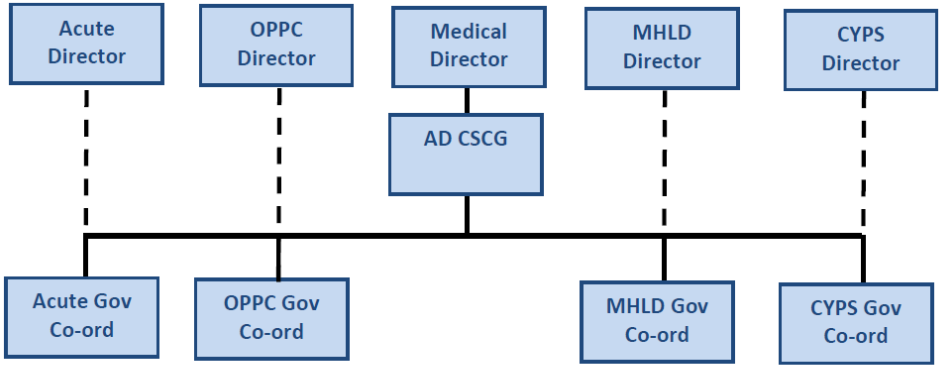



*Figure 2 – Proposed Clinical and Social Care Governance Structure*

*Corporate Clinical Social Care Governance Functions And Structures Proposal September 2020*

Southern Health and Social Care Trust

# CSCG Business Partner Model

*Corporate Business Partner Model to be phased in by 31st March 2022:*

(i) Dec 21 – Feb 2022 – Identification of CSCG resource in operational Directorates

(ii) March 2022 - Agreement of funding transfers into Medical Directorate effective 1st April 2022 and engagement with Financial Management to effect budget changes for April 2022

(iii) Line management responsibility for Governance coordinators to transfer to Medical Directorate effective 1st April 2022

(iv) Governance coordinators to engage with their operational CSCG teams prior to March 2022

HSC Southern Health and Social Care Trust

QUALITY & SAFETY

# Quality and Safety Group Model

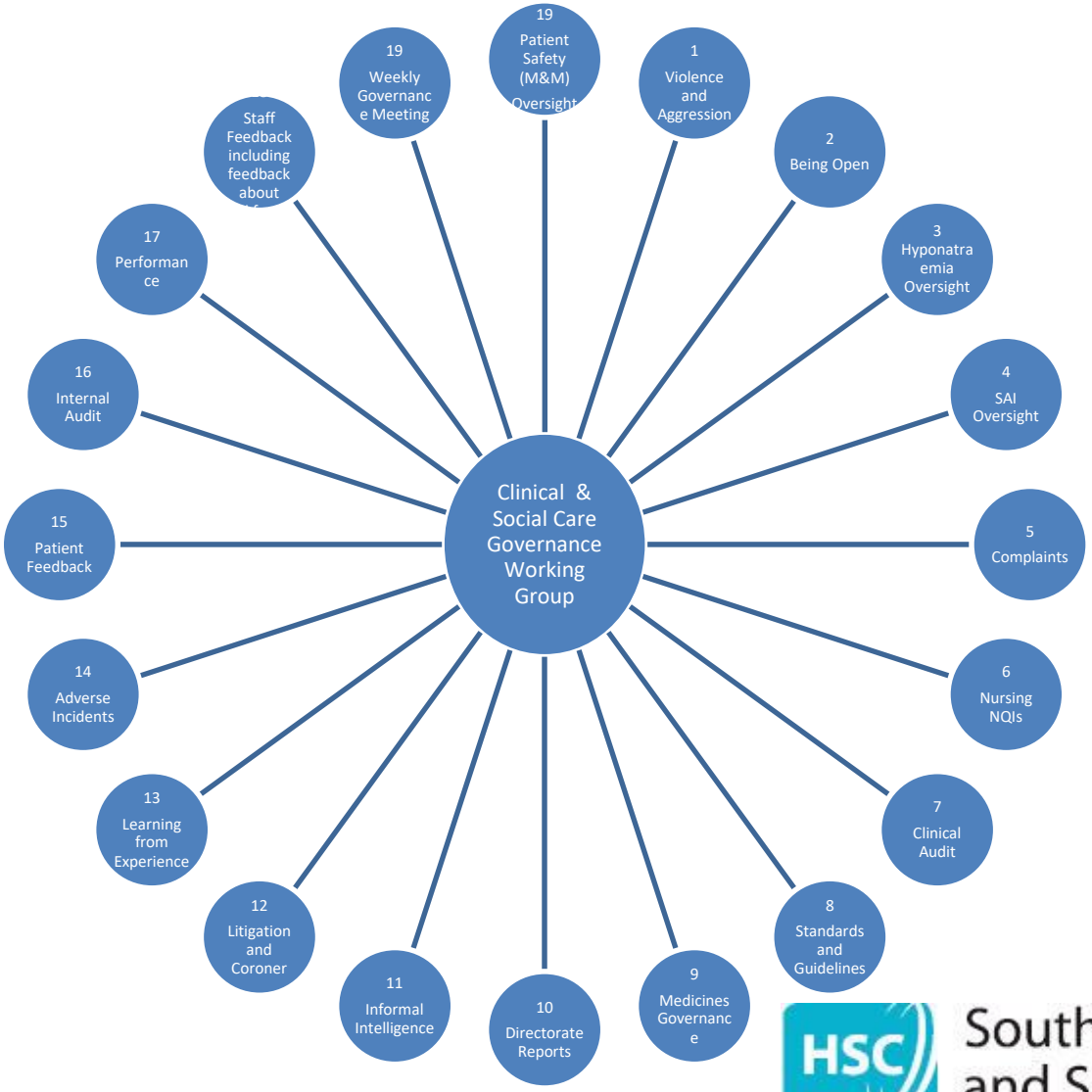
Implementation of a Quality and Safety Working Group fed by multiple workstreams, the Chairs of which are responsible for driving improvements in their service/professional area

- Patient Safety (M&M) Oversight
- Violence and Aggression
- Being Open
- Hyponatraemia Oversight
- SAI Oversight
- Complaints
- Nursing NQIs
- Clinical Audit
- Standards and Guidelines
- Medicines Governance
- Directorate Reports
- Informal Intelligence
- Litigation and Coroner
- Learning from Experience
- Adverse Incidents
- Patient Feedback
- Internal Audit
- Performance
- Staff Feedback including feedback about Workforce
- Weekly Governance Meeting

HSC Southern Health and Social Care Trust

QUALITY & SAFETY

# Quality and Safety Group Model




HSC Southern Health and Social Care Trust

QUALITY & SAFETY

# Quality and Safety Group Model – Purpose and Aims

## Purpose / Role of the Group

- To contribute to the development of a culture which does not have a narrow focus on past incidents but has a more rigorous interrogation of what safety means that encompasses both system and 'softer' cultural factors, such as patient feedback and safety culture
- To provide intelligence, rather than data, to the Governance Committee which enables it to ask questions of the organisation, challenge us to provide alternative data and use the information to drive improvement
- To assist with the triangulation of data by drawing links and associations between data from different sources
- To ensure that issues of concern are highlighted to the Governance Committee
- To answer the question 'is healthcare getting safer across your organisation and what measures do you have to show this?'

HSC Southern Health and Social Care Trust

QUALITY & SAFETY

# Quality and Safety Group Model - Triangulation

## Triangulation – Use and Outputs

- Linking with collective leadership directorate members to determine whether data in performance reports is accurate and capturing any concerns / areas of risk
- Consider findings from internal data sources , internal and external reviews and visits alongside papers presented at the meetings to corroborate findings
- Reviewing qualitative information such as comments from service user and carer feedback and staff surveys alongside data from multiple sources
- Identify potential risk areas through consideration of a range of different data simultaneously
- identifying common themes from all sources of data presented

## Triangulation – Value

- Ensuring indicators or metrics of quality performance are valid and reliable
- Ensuring concerns about findings can be escalated
- Ensuring there are detailed, credible and evidence-based findings underpinning action plans which can be delivered
- Ensuring there is confidence in how Trust leaders work together and challenge evidence and action plans and resolve concerns
- Diverse membership will assist in avoiding bias and undue influence
- Create a network of 'peers' that would be likely to reach a similar judgment based on the same information, in the same context
- Provide assurance reporting to Trust Governance Committee on the Quality and Safety of the care provided by the Trust

HSC Southern Health and Social Care Trust

QUALITY & SAFETY

# Quality and Safety Group Model – Membership and Frequency

## Proposed Membership

- Medical Director (chair) – Director of Nursing and AHPs and Director of Social Work (Deputy Chairs)
- Directorate Collective Leadership Members (To include professional leaders, governance leads, Service user representatives and operational managers)
- Quality Improvement Leads
- Operational Directors or nominated Assistant Directors
- Deputy Medical Director Safety and Quality
- Assistant Director Clinical and Social Care Governance
- Assistant Director Systems Assurance
- Assistant Director Quality Improvement
- Corporate Governance Coordinator
- Senior Manager Standards, Risk & Learning
- Head of Patient Safety Data & Improvement
- Head of Clinical Audit

## Frequency

- Meetings Monthly Initially

## Operational Delivery

- Rolling Focus Agenda – Review of information at each Meeting

HSC Southern Health and Social Care Trust

QUALITY & SAFETY

# Risk Management and Appetite

Development of a framework for risk appetite that allows the board to use a common language in the deliberation of complex clinical and social care governance risks

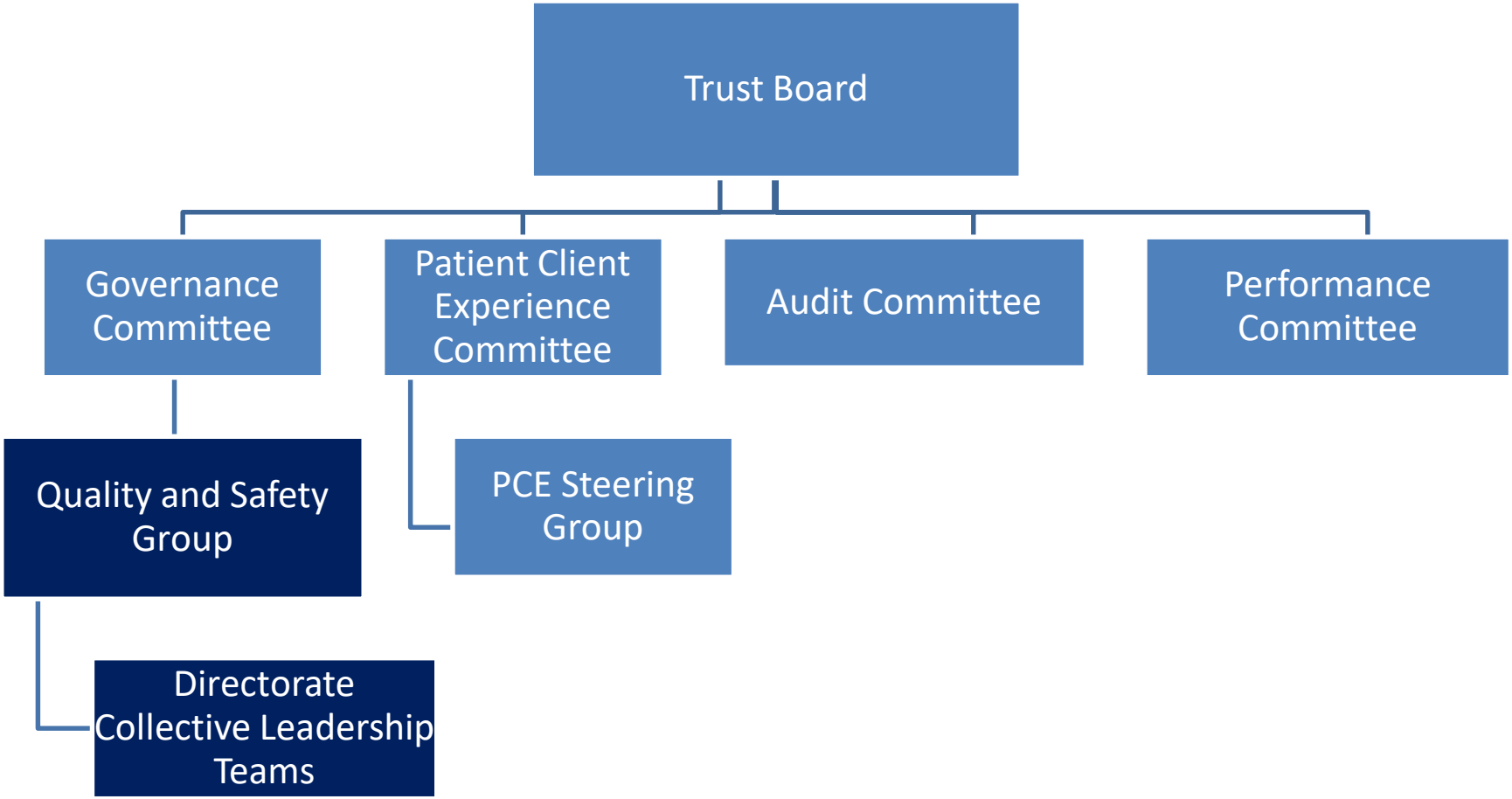
Framework should include risk appetite descriptions that allows all to use a common language in deliberation of risk sharing

Ensure that in the application of the Risk appetite framework that appropriate escalation of risk is brought to the attention of SMT, Trust Governance Committee and where deemed necessary Trust Board

HSC Southern Health and Social Care Trust

QUALITY & SAFETY

# Quality and Safety Reporting Arrangements




HSC Southern Health and Social Care Trust

# Divisional Medical Director Roles

## *Linking CSCG Responsibilities*

| | |
|---|---|
| • Professional Medical Governance<br>–Staffing and Staff Management<br>–Professional Performance Management<br>–Appraisal and Revalidation<br>• Adverse and Serious Adverse Incident Management<br>• Litigation and Claims Management<br>• Coronial Matters<br>• Complaints<br>• Morbidity and Mortality<br>• Patient Safety (Including Infection Prevention and Control)<br>• Medications management | • Research and Development<br>• Risk Management / Mitigation and Reduction<br>• Learning from Experience<br>• Medical Education in conjunction with DMD/ Dir Med Ed<br>• Medical Workforce development<br>• Quality Improvement<br>• Clinical Audit<br>• Education, Training and Continuing Professional Development<br>• Ensuring Delivery of Effective Evidence-Based Care<br>• Patient and Carer Experience and Involvement<br>• Medical leadership in delivery of MCA and Safeguarding |

HSC Southern Health and Social Care Trust

# Next Steps

Move to corporately integrate and oversee Clinical and Social Care Governance activity via a business partner model

Further develop operational clinical leads to undertake local assurance around CSCG and implementation of quality improvement activity

Development of Collective Leadership Models at Directorate level (To include professional leaders, governance leads, Service user representatives and operational managers)

Development of a strengthened Clinical Audit function including corporate level supports

Strengthening of SAI function with introduction of executive oversight group

Launch of Quality and Safety Oversight group

HSC Southern Health and Social Care Trust

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

# INTEGRATED ELECTIVE ACCESS PROTOCOL
## 30th April 2008

| DOCUMENT CONTROL<br>INTEGRATED ELECTIVE ACCESS PROTOCOL | | | |
|---|---|---|---|
| **Authors** | Michelle Irvine – Programme Director, Elective Workstream<br>Maria Wright – Associate Director, Outpatients<br>Rosemary Hulatt – Associate Director, Diagnostics | | |
| **Issue Date**<br>**1st Draft** | Wednesday 20th February 2008 | | |
| **Comments by** | Close of Play - Friday 7th March 2008 | | |
| **2nd Draft** | 27th March 08 | | |
| **Final Protocol**<br>**Date Approved** | 30th April 08 | | |
| **Issue Date** | Friday 9th May 2008 | | |
| **Screened By** | Service Delivery Unit, DHSSPSNI | | |
| **Approved By** | | **Signature** | |
| **Distribution** | Trust Chief Executives; Directors of Planning and Performance;<br>Directors of Acute Care; DHSSPS | | |
| **Review Date** | April 2009 | | |

# CONTENTS

## ABBREVIATIONS

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

# SECTION 1

# CONTEXT

## 1.1 INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## 1.2 UNDERPINNING PRINCIPLES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## 1.3 OWNERSHIP

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

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

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

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

## 1.4 REGIONAL TARGETS

1.4.1 The targets in respect of elective treatments are:

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

## 1.5 DELIVERY OF TARGETS

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

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

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

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

**1.6 CAPACITY**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## 1.7 BOOKING PRINCIPLES

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

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

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

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

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

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

1.7.7 The definition of a booked appointment is:

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

1.7.8 Booking Process

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

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

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

1.7.11 Principles for booking Cancer Pathway patients

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

1.7.12 Principles for booking Urgent Pathway patients

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

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

1.7.13 Principles for booking Routine Pathway patients

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

1.7.14 Principles for Booking Review Patients

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

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

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

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

## SECTION 2

# GUIDANCE FOR MANAGEMENT OF ICATS SERVICES

## 2.1 INTRODUCTION

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

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

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

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

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

## 2.2 KEY PRINCIPLES

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

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

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

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

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

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

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

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

2.2.8 Staff should be supported by appropriate training programmes.

## 2.3 CALCULATION OF THE WAITING TIME

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

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

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

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

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

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

## 2.4 NEW REFERRALS

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

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

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

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

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

## 2.5 BOOKING

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

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

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

## 2.6 REASONABLE OFFERS

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

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

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

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

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

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

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

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

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

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

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

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

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

## 2.8 MAXIMUM WAITING TIME GUARANTEE

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

## 2.9 COMPLIANCE WITH TRUST LEAVE PROTOCOL

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

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

## 2.10 CLINIC OUTCOME MANAGEMENT

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

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

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

## 2.11 REVIEW APPOINTMENTS

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

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

## 2.12 TEMPLATE CHANGES

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

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

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

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

## 2.13 VALIDATION

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

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

# SECTION 3

# GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

## 3.1 INTRODUCTION

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

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

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

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

## 3.2 CALCULATION OF THE WAITING TIME

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

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

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

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

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

## 3.3 KEY PRINCIPLES

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

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

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

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

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

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

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

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

**3.4 NEW REFERRALS**

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

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

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

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

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

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

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

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

## 3.5 URGENT AND ROUTINE APPOINTMENTS

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

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

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

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

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

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

## 3.6 BOOKING

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

## 3.7 REASONABLE OFFERS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## 3.9 MAXIMUM WAITING TIME GUARANTEE

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

## 3.10 COMPLIANCE WITH LEAVE PROTOCOL

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

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

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

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

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

## 3.11 CLINIC OUTCOME MANAGEMENT

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

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

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

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

## 3.12 REVIEW APPOINTMENTS

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

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

## 3.13 CLINIC TEMPLATE CHANGES

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

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

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

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

## 3.14 VALIDATION

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

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

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

## 3.15 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

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

## SECTION 4

# PROTOCOL GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

## 4.1 INTRODUCTION

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

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

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

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

## 4.2 CALCULATION OF THE WAITING TIME

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

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

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

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

**4.3 KEY PRINCIPLES**

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

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

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

4.3.4 Staff should be supported by appropriate training programmes.

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

## 4.4 NEW DIAGNOSTIC REQUESTS

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

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

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

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

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

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

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

## 4.5 URGENT AND ROUTINE APPOINTMENTS

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

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

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

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

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

## 4.6 CHRONOLOGICAL MANAGEMENT

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

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

## 4.7 BOOKING METHODS

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

## 4.8 REASONABLE OFFERS

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

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

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

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

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

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

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

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

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

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

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

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

## 4.10 TRANSFERS BETWEEN HOSPITALS

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

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

## 4.11 COMPLIANCE WITH TRUST LEAVE PROTOCOL

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

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

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

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

## 4.12 SESSION OUTCOME MANAGEMENT

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

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

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

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

### 4.13.1 DIAGNOSTIC TEST OUTCOME

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

### 4.14 FOLLOW UP APPOINTMENTS

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

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

### 4.15 TEMPLATE CHANGES

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

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

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

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

## 4.16 VALIDATION

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

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

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

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

## 4.17 PLANNED PATIENTS AND DIAGNOSTICS TESTS CLASSIFIED AS DAY CASES

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

## 4.18 PLANNED PATIENTS

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

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

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

## 4.19 HOSPITAL INITIATED CANCELLATIONS

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

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

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

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

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

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

## 4.20 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

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

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

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

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

## SECTION 5

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

## 5.1 INTRODUCTION

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

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

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

## 5.2 KEY PRINCIPLES

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

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

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

## 5.3 CALCULATION OF THE WAITING TIME

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

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

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

## 5.4 NEW REFERRALS

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

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

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

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

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

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

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

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

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

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

## 5.5 URGENT AND ROUTINE APPOINTMENTS

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

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

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

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

## 5.6 CHRONOLOGICAL MANAGEMENT

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

## 5.7 CAPACITY PLANNING AND ESCALATION

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

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

## 5.8 REASONABLE OFFERS

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

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

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

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

## 5.9 AHP SERVICE INITIATED CANCELLATIONS

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

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

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

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

## 5.10 MAXIMUM WAITING TIME GUARANTEE

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

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

## 5.11 COMPLIANCE WITH LEAVE PROTOCOL

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

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

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

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

## 5.12 CLINIC OUTCOME MANAGEMENT

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

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

## 5.13 REVIEW APPOINTMENTS

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

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

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

## 5.14 CLINIC TEMPLATE MANAGEMENT

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

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

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

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

## 5.15 ROBUSTNESS OF DATA / VALIDATION

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

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

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

# SECTION 6 PROTOCOL GUIDANCE FOR MANAGEMENT OF ELECTIVE ADMISSIONS

## 6.1 INTRODUCTION

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

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

## 6.2 COMPUTER SYSTEMS

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

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

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

## 6.3 CALCULATION OF THE WAITING TIME

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

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

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

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

## 6.4 STRUCTURE OF WAITING LISTS

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

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

## 6.5 INPATIENT AND DAY CASE ACTIVE WAITING LISTS

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

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

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

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

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

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

**6.6 COMPLIANCE WITH TRUST HR LEAVE PROTOCOL**

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

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

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

## 6.7 TO COME IN (TCI) OFFERS OF TREATMENT

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

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

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

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

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

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

## 6.8 SUSPENDED PATIENTS

6.8.1 A period of suspension is defined as:

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

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

- A maximum period not exceeding 3 months.

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

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

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

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

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

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

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

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

## 6.9 PLANNED PATIENTS

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

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

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

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

## 6.10 CANCELLATIONS AND DNA'S

### 6.10.1 Patient Initiated Cancellations

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

**6.10.2 Patients who DNA**

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

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

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

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

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

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

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

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

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

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

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

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

## 6.11 PERSONAL TREATMENT PLAN

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

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

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

## 6.12 CHRONOLOGICAL MANAGEMENT

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

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

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

## 6.13 PRE-OPERATIVE ASSESSMENT

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

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

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

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

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

## 6.14 PATIENTS WHO DNA THEIR PRE OPERATIVE ASSESSMENT

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

## 6.15 VALIDATION OF WAITING LISTS

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

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

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

## 6.16 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

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

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

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

## 6.17 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

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

Health and Social Care Board

*Via Email Only*

To: Chief Executives of each Health & Social Care Trust

*From the Chief Executive*

**Health & Social Care Board**
**12-22 Linenhall Street**
**BELFAST**
**BT2 8BS**

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Email: Personal Information redacted by the USI

+ Accompanying Paper to all AD's

Date: 8 December 2021

Dear Colleague

**REVISED INTEGRATED ELECTIVE ACCESS PROTOCOL (IEAP)**

You will be aware of that work had been undertaken to revise the 2008 IEAP which concluded in June 2020.

The Department has considered the revised document and notes the changes that have been made to reflect pathway developments and new ways of working. The changes will have a minor, yet positive impact on patients/service users as reflected in the equality screening.

It has been agreed that the Waiting List Management Unit will support performance managing the implementation of the protocol.

I would appreciate if you could circulate within your respective Trusts for implementation and to note the protocol will be uploaded to the Departmental website.

Yours sincerely

Personal Information redacted by the USI

**SHARON GALLAGHER**
**Chief Executive**

**Encs**

**cc:** Jim Wilkinson
Lisa McWilliams

# INTEGRATED ELECTIVE ACCESS PROTOCOL

June 2020

# Integrated Elective Access Protocol

**Protocol Summary -**

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

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

**Integrated Elective Access Protocol**

**Version**

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

**Integrated Elective Access Protocol Review Group**

The Integrated Elective Access Protocol Review Group consisted of;

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

## Integrated Elective Access Protocol

### Document control

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

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

### Monitoring compliance with protocol

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

# Contents

## Abbreviations

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