2.8. Phase of care: Perioperative care (where relevant)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

| 2.9. Phase of care: Discharge plan of care (where relevant)<br>Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice at the time the care was provided<br>Please also include any other information that you think is important or relevant. |
|---|
| |
| Please rate the care received by the patient during this phase:<br>5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐<br><br>Section not applicable ☐ |

| 2.10. Other area of care (please specify)<br>Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.<br>Please also include any other information that you think is important or relevant. |
|---|
| |
| Please rate the care received by the patient during this phase as:<br>5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐<br><br>Section not applicable ☐ |

| 2.11. Overall care<br>Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.<br>Areas identified where learning could occur, including areas of good practice, should be included in addition to any potential areas of further investigation.<br>Please also include any other information that you think is important or relevant. |
|---|
| |
| Please rate the care received by the patient during this phase as:<br>5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐<br><br>Section not applicable ☐ |

| 2.12. If care was below an acceptable standard, did it lead to harm?<br>If yes, please provide details and state an action plan |
|---|
| |

| 2.13. If the patient died is it considered more likely than not to have resulted from problems in care delivery or service provision?<br>If yes, please provide details and state an action plan (consider whether a serious incident investigation is required). |
|---|
| |

| 2.14. If a family member, carer, or staff raised concerns, please outline any feedback provided and state who was responsible for providing this feedback. Please state further action required.<br>If no feedback was provided, please consider how the outcome of this review should be fed back to the relevant people, considering the duty of candour principle. |
|---|
| |

| 2.15. Were the patient records adequate for the purpose of the review? | Yes ☐<br>No ☐ |
|---|---|
| Please outline any difficulties in accessing appropriate information: | |
| | |

Time taken to complete Section 2 of this form (minutes): .....

Date of completion: .....

Name of person completing Section 2: .....

Job title of person completing Section 2: .....

## Assessment of problems in healthcare for Urology patients

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm. Please circle correct response.

**Problem types**

| | |
|---|---|
| **1. Problem in assessment, investigation or diagnosis** | **Yes No** |
| **Did the problem lead to harm?** | **No Uncertain Yes** |
| **In which phase(s) did the problem occur?** | **Triage**<br>**Initial assessment or review**<br>**Review of Diagnostics**<br>**Ongoing Outpatient Care**<br>**Admission and Initial Management**<br>**Ongoing Inpatient Care**<br>**Care during a procedure (excluding IV cannulation)**<br>**Perioperative care**<br>**Discharge plan of care**<br>**Other area of care** |
| **2. Problem with medication / IV fluids / electrolytes / oxygen** | **Yes No** |
| **Did the problem lead to harm?** | **No Uncertain Yes** |
| **In which phase(s) did the problem occur?** | **Triage**<br>**Initial assessment or review**<br>**Review of Diagnostics**<br>**Ongoing Outpatient Care**<br>**Admission and Initial Management**<br>**Ongoing Inpatient Care**<br>**Care during a procedure (excluding IV cannulation)**<br>**Perioperative care**<br>**Discharge plan of care**<br>**Other area of care** |

| | |
|---|---|
| **3. Problem related to treatment and management plan** | **Yes No** |
| **Did the problem lead to harm?** | **No Uncertain Yes** |
| **In which phase(s) did the problem occur?** | **Triage**<br>**Initial assessment or review**<br>**Review of Diagnostics**<br>**Ongoing Outpatient Care**<br>**Admission and Initial Management**<br>**Ongoing Inpatient Care**<br>**Care during a procedure (excluding IV cannulation)**<br>**Perioperative care**<br>**Discharge plan of care**<br>**Other area of care** |
| **4. Problem related to operation / invasive procedure** *(other than infection control)* | **Yes No** |
| **Did the problem lead to harm?** | **No Uncertain Yes** |
| **In which phase(s) did the problem occur?** | **Triage**<br>**Initial assessment or review**<br>**Review of Diagnostics**<br>**Ongoing Outpatient Care**<br>**Admission and Initial Management**<br>**Ongoing Inpatient Care**<br>**Care during a procedure (excluding IV cannulation)**<br>**Perioperative care**<br>**Discharge plan of care**<br>**Other area of care** |
| **5. Problem with infection management** | **Yes No** |
| **Did the problem lead to harm?** | **No Uncertain Yes** |
| **In which phase(s) did the problem occur?** | **Triage**<br>**Initial assessment or review**<br>**Review of Diagnostics**<br>**Ongoing Outpatient Care**<br>**Admission and Initial Management**<br>**Ongoing Inpatient Care**<br>**Care during a procedure (excluding IV cannulation)** |

| | |
|---|---|
| | **Perioperative care**<br>**Discharge plan of care**<br>**Other area of care** |
| **6. Problem in clinical monitoring** (including failure to plan, to undertake, or to recognise and respond to changes)<br><br>**Did the problem lead to harm?**<br><br>**In which phase(s) did the problem occur?** | **Yes** **No**<br><br>**No** **Uncertain** **Yes**<br><br>**Triage**<br>**Initial assessment or review**<br>**Review of Diagnostics**<br>**Ongoing Outpatient Care**<br>**Admission and Initial Management**<br>**Ongoing Inpatient Care**<br>**Care during a procedure (excluding IV cannulation)**<br>**Perioperative care**<br>**Discharge plan of care**<br>**Other area of care** |
| **7. Problem in resuscitation following a cardiac or respiratory arrest** (including cardiopulmonary resuscitation (CPR))<br><br>**Did the problem lead to harm?**<br><br>**In which phase(s) did the problem occur?** | **Yes** **No**<br><br>**No** **Uncertain** **Yes**<br><br>**Triage**<br>**Initial assessment or review**<br>**Review of Diagnostics**<br>**Ongoing Outpatient Care**<br>**Admission and Initial Management**<br>**Ongoing Inpatient Care**<br>**Care during a procedure (excluding IV cannulation)**<br>**Perioperative care**<br>**Discharge plan of care**<br>**Other area of care** |
| **8. Problem of any other type not fitting the categories above** (including patient records and documentation, informed consent, communication with patients and carers and organisational issues)<br><br>**Did the problem lead to harm?**<br><br>**In which phase(s) did the problem occur?** | **Yes** **No**<br><br>**No** **Uncertain** **Yes**<br><br>**Triage**<br>**Initial assessment or review**<br>**Review of Diagnostics**<br>**Ongoing Outpatient Care** |

| | |
|---|---|
| | **Admission and Initial Management**<br>**Ongoing Inpatient Care**<br>**Care during a procedure (excluding IV cannulation)**<br>**Perioperative care**<br>**Discharge plan of care**<br>**Other area of care** |

# General Medical Council

# Aidan O'BRIEN

GMC reference no: 1394911

Results of search on: 24 Jun 2022 at 14:49 BST
The details shown are valid at the date and time of the search only.

Registered with a licence to practise

This doctor has conditions

GP This doctor is not on the GP Register

SR This doctor is on the Specialist Register

Urology from 07 Aug 2013

**This doctor is subject to revalidation**

This doctor is not currently connected to a Designated Body.

| | |
|---|---|
| Primary medical qualification | MB BCh 1978 Queens University of Belfast |
| Provisional registration date | 28 Dec 1978 |
| Full registration date | 27 Feb 1980 |
| Gender | Male |

## Further information

This doctor may work at any grade in the NHS including consultant. Doctors working in general practice in the UK health service are required to be on the General Practitioner Register. Please refer to the relevant NHS performers lists regulations.

Annual retention fee due date: 27 Feb 2023

## Doctor's history

Fitness to practise history (since 20 October 2005)

| From | To | Status | Details |
|---|---|---|---|
| 14 Jun 2022 | Present | This doctor has interim conditions - view | |

Conditions on the doctor's registration

**From 14 Jun 2022**

1 He must personally ensure that the GMC is notified of the following information within seven calendar days of the date these conditions become effective: a of the details of his current post, including: i his job title ii his job location iii his responsible officer (or their nominated deputy) b the contact details for his employer and any contracting body, including his direct line manager c of any organisation where he has practising privileges and/or admitting rights d of any training programmes he is in e of the contact details of any locum agency or out-of-hours service he is registered with.

2 He must personally ensure the GMC is notified: a of any post he accepts, before starting it b that all relevant people have been notified of his conditions, in accordance with condition 5 c if any formal disciplinary proceedings against him are started by his employer and/or contracting body, within seven calendar days of being formally notified of such proceedings d if any of his posts, practising privileges or admitting rights have been suspended or terminated by his employer before the agreed date within seven calendar days of being notified of the termination e if he applies for a post outside the UK.

3 He must allow the GMC to exchange information with his employer and/or any contracting body for which he provides medical services.

4 He must only work in non-clinical roles and in medico-legal work.

5 He must personally ensure that the following persons are notified of the conditions listed at 1 to 4: a his responsible officer (or their nominated deputy) b the responsible officer of the following organisations i his place(s) of work and any prospective place of work (at the time of application) ii all his contracting bodies and any prospective contracting body (prior to entering a contract) iii any organisation where he has, or has applied for, practising privileges and/or admitting rights (at the time of application) iv any locum agency or out-of-hours service he is registered with v if any organisation listed at (i to iv) does not have a responsible officer, he must notify the person with responsibility for overall clinical governance within the organisation. If he is unable to identify this person, he must contact the GMC for advice before working for that organisation. c his immediate line manager and senior clinician (where there is one) at his place of work, at least 24 hours before starting work (for current and new posts, including locum posts).

Registration and licensing history (since 20 October 2005)

| From | To | Status |
|---|---|---|
| 06 May 2022 | Present | Registered with a licence to practise |
| 16 Nov 2009 | 15 Dec 2020 | Registered with a licence to practise |
| 20 Oct 2005 | 16 Nov 2009 | Registered |

**Please note:**

All doctors who were registered before 20 October 2005 have their registration 'From' date set to 20 October 2005.

This is the date when the register went online.

If you need to know whether the doctor was registered before 20 October 2005 please contact us.

Southern Health and Social Care Trust

*Quality Care - for you, with you*

# Chief Executive

# JOB DESCRIPTION

| | |
|---|---|
| **JOB TITLE** | Chief Executive – Level 2 Senior Executive |
| **REPORTS TO** | Board of the Southern HSC Trust |
| **ACCOUNTABLE TO** | Permanent Secretary – Department of Health |
| **BASE** | Trust Headquarters,<br>Craigavon Area Hospital |

## JOB SUMMARY

The Chief Executive is the most senior executive member of the Trust Board and provides the vision, strategic direction and leadership to enable the Trust to achieve its strategic goals and objectives and deliver long term and sustained growth. The Chief Executive is responsible for ensuring the Trust delivers on its vision, values and priorities, continually aligning these to the Trust's strategic plans.

As the Accountable Officer for the Trust, the Chief Executive is accountable to the Trust Board, DoH and HSCB and ultimately the Minister for the performance and governance of the Trust in the delivery of high quality care, responsive to the needs of the population in line with prevailing performance standards and targets.

The Chief Executive has overall responsibility for the management and performance of the Trust, including meeting Ministerial priorities as defined by the DoH and HSCB, fulfilling statutory requirements, delivering against clinical and non-clinical performance targets, securing continuous improvement and for providing safe, high quality and effective services within a clear financial framework.

The Chief Executive will lead service transformation across the Trust and work in collaboration with the wider system to rebuild health and social care, given the profound and long lasting impact of Covid-19 on the population of Northern Ireland.

He/she will place an authentic and continuous focus on our people, ensuring that everyone recognises that they must continue to look after each other and foster a culture of inclusion and belonging, as well as taking action to grow the workforce, train and develop our people, and work together differently to deliver health and social care in challenging times.

## KEY RESULT AREAS

### DELIVERY

1. Lead the development of the corporate business plan for the provision of services in partnership with key stakeholders internally and externally.

2. Deliver against Ministerial priorities as established in Departmental strategies and policies and translated into targets. In particular, the Chief Executive will be expected to deliver against all targets which are identified as critical and mandatory by the DoH and HSCB.

3. Ensure that the needs of patients, clients and their carers are at the core of the way that the Trust delivers services and that people, physical, capital and financial resources are effectively deployed to meet those needs, in line with targets, achieving the best outcomes possible.

4. Ensure that systems to provide high standards of care are based on good practice, research evidence, national standards and in accordance with guidelines, and to audit compliance to those standards and the statutory duty of care.

5. Achieve and sustain a high level of public confidence in the appropriateness, priority, safety and effectiveness of services provided by the Trust.

**LEADERSHIP**

6. Provide clear, positive and highly visible leadership, motivation and development to all staff throughout the Trust to ensure their engagement with and commitment to achieving strategic change and delivering on the corporate plan.

7. Foster a team culture consistent with the Trust's values and the priority given to equality and inclusion.

8. Demonstrate appropriate and consistent role modelling of the Trust's values, as the senior leader of the organisation.

9. Provide clear leadership for the Trust in the development of strategic plans, ensuring these are aligned with regional requirements and are effectively implemented through annual business plans.

10. Development of a common understanding of the vision and strategic aims of the Trust.

11. Work with the Trust Board, staff and partners in the local health economy to ensure aligned delivery against strategic plans.

12. Build and develop strong positive relationships with a range of partners and stakeholders to improve the Trust's reputation and increase confidence.

13. Work with other key strategic partners, both within and outside of the health and social care economy, to ensure key issues associated with health inequalities are addressed.

12. Lead by example in practicing the highest standards of conduct in accordance with the HSC Code of Conduct.

13. Continuously strive to develop self and improve capability in the leadership of the Trust and its staff.

**PATIENT/CLIENT CARE & EXPERIENCE**

14. Ensure that the needs of patients, clients and their carers are at the core of the way that the Trust delivers services and in doing so, ensure that the Trust is a learning organisation and that a culture of collective leadership, which is fully consistent with the Trust's Safety, Quality, Experience (SQE) approach, is embraced by every member of staff.

15. Ensure that patient, service user and carer involvement and co-production is embedded and supported throughout the Trust.

**OUR PEOPLE**

16. Foster a culture of inclusion and belonging for our people, as well as ensuring actions to grow the workforce, train and develop our people, are maximised.

17. Ensure the development of systems to promote the health and well-being of our people.

18. Ensure that people management practices support continuous improvement in the capability of our people and quality of services provided including encouragement of and widening participation in learning opportunities.

19. Develop and maintain systems to support performance appraisal for all our people to ensure they are encouraged and developed to their fullest potential and that under performance is dealt with quickly and supportive remedial action taken.

20. Develop, through the Director of Human Resources & Organisational Development, management information on staff utilisation and development, which improve management and a rigorous continuous improvement culture.

21. Ensure that the Trust has a diverse and representative workforce, and that the right skills are in the right place to deliver its objectives.

**CORPORATE MANAGEMENT**

22. With the Chair, be responsible for the organisational structure of the Trust, its probity and effectiveness.

23. Manage the Trust through the senior management team, ensuring and maintaining effective operational management processes.

24. Ensure that the work of the Trust is clearly and effectively communicated to employees throughout the organisation and that all members of the Trust Board are aware of issues and opinions of key staff groups.

25. Continually evaluate and review all services in order to deliver user centred treatment and care. Lead change across the organisation and develop an innovative and open culture where our people are able to make decisions, ideas flow and solutions are welcomed.

26. Ensure that systems and processes are in place to enable the Trust Board and relevant external bodies to evaluate the effectiveness of the Trust's use of human, capital and financial resources and that people perform to the best of their ability and address under-performance quickly and effectively.

27. Implement strong strategies, positive working relationships and communication to promote the Trust, our people and our services using a wide range of media.

**GOVERNANCE**

28. Work with the Chair to ensure that the Board works effectively in fulfilling its role to deliver effective governance in accordance with public sector values and the relevant code of practice.

29. Work with the senior management team to ensure that assessment on the fulfilment of statutory functions and associated reports to Trust Board and externally, are completed as necessary ensuring that any action to manage risks internally in the Trust is taken promptly.

30. Ensure that robust arrangements are in place to meet the statutory clinical and integrated governance requirements.

31. Ensure that arrangements are in place to assure all quality standards.

32. Ensure that effective systems are embedded to take learning from complaints, concerns, adverse incidents, morbidity and mortality, litigation and coronial outcomes, quality indicators and areas of good practice internal to the Trust,

regional and national etc and translate these into action and opportunities for improvement.

33. Monitor and report on performance against delivery targets, risk assessment and mitigation and ensure corrective action is taken when there is unacceptable deviation from the Trust's agreed corporate plan.

**EXTERNAL RELATIONSHIPS**

34. Establish collaborative relationships with external partners in the public, private and voluntary sectors to develop initiatives which will improve services and inter-agency communication.

35. Develop linkages with other Trusts, the HSCB, Public Health Agency (PHA) and the DoH to promote best practice and innovation in the provision of services.

36. Work with the DoH, the HSCB, the PHA and other Trusts in developing a strategy for dealing with the media which reflects Ministerial views and which secures the confidence of public representatives.

37. Ensure effective on-going political engagement with public representatives including members of the UK Parliament, members of the Northern Ireland Assembly and elected representatives of the District Councils within the Trust's geography.

**FINANCES**

38. Work through the senior management team to ensure that budgets are managed appropriately and give the best outcomes for resources available.

39. Ensure that robust financial systems and controls are in place to achieve "break-even" on budgets and that immediate action is taken to control over-spends.

40. Develop, through the Finance and HR Directors, effective and relevant management information on financial spend and inter-linkages such as overtime, absence and agency costs, which inform management and control of budgets.

**GENERAL REQUIREMENTS**

41. 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.

42. Co-operate fully with the implementation of the Trust's Health and Safety arrangements.

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

44. All employees of the Trust are required to be conversant with the Trust's policy and procedures on records management. Chief Executives are responsible for all records held, created or used as part of their business including patient/client, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000, the Environment Information Regulations 2004 and the Data Protection Act 2018.

45. 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.

46. Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

47. As Accountable Officer comply with the Code of Business Conduct.

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the postholder works.

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

# PERSONNEL SPECIFICATION

**JOB TITLE** Chief Executive

***QUALIFICATIONS / EXPERIENCE***

1) Successful and proven track record of senior leadership and management[1] for a period of at least 3 years in a major complex organisation[2] with a strong service user / customer focus.

2) Effective delivery of improving corporate performance in a service user/customer focused context.

3) Effective contribution to the development of strategic thinking as part of a corporate team.

4) Track record of building high performing, inclusive teams and developing diverse talent.

5) Effective financial management in a major complex organisation[2], securing value for money.

6) Effective external stakeholder management demonstrating careful analysis and authoritative judgment and building organisational reputation.

7) A Degree OR equivalent Professional Qualification OR evidence of continuing management development[3].

8) Hold a full current driving licence valid for use in the UK and have access to a car on appointment[4]. In respect of this point the successful applicant may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere.

***LEADERSHIP STYLE***

1) People focused leader, able to empathise effectively with colleagues at all levels

2) An effective performance manager, outcome focused, setting high standards but team oriented, with a supportive, coaching style

3) Instils energy, purpose and urgency in teams to deliver impactful outcomes.

4) Naturally collaborative, particularly across external boundaries.

*[1]'senior leadership and management' is defined as experience gained at Chief Executive or Director level, or equivalent in a major complex organisation*

*[2]'major complex organisation" is defined as one with at least 200 staff or an annual budget of at least £25 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders'*

*[3]management development is the structured process by which managers enhance their skills, competencies and/or knowledge, via formal or informal learning methods, to the benefit of both individual and the organisation.*

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

**WE ARE AN EQUAL OPPORTUNITIES EMPLOYER**

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

HSC Health and Social Care

Southern Health and Social Care Trust
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# Job Description

**JOB TITLE** Medical Director

**LOCATION** Trust Headquarters, Craigavon Area Hospital

**ACCOUNTABLE TO** Chief Executive

## JOB SUMMARY

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

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

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

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

## KEY RESULT AREAS

### PROFESSIONAL LEADERSHIP

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

2. Develop and maintain effective relationships with GMC that supports the registration and regulation of the medical workforce.

3. Work closely with colleagues to enhance communication and working relationships between clinical leaders and senior managers and ensure that opportunities to improve services are harnessed.

4. As Responsible Officer, ensure the following are in place:

   - an appraisal policy that meets the requirements of revalidation
   - effective clinical governance systems that can provide doctors with the supporting information they need for appraisal and revalidation
   - a system which ensures all doctors are given the opportunity to take part in an annual appraisal and which tracks participation
   - regular briefing for Trust Board on progress
   - a process for recognising and responding to concerns about doctors in line with '*Maintaining High Processional Standards in the Modern HPSS'*.

5. Provide professional leadership and guidance to support Associate Medical Directors, Clinical Directors and Lead Clinicians throughout the Trust in relation to governance of the medical workforce, including clinical practice and service change.

6. Provide medical leadership to attract, educate, develop and retain a quality workforce from both local and international pools.

7. Ensure sound working relationships with the Director of Public Health, other Medical Directors and the Public Health Agency

**CLINICAL GOVERNANCE**

1. As a member of the Senior Management Team and Trust Board, assume corporate responsibility for ensuring an effective system of integrated governance within the Trust which delivers safe, high quality care, a safe working environment for staff and appropriate and efficient use of public funds.

2. Provide professional advice to the Senior Management Team as to the appropriate indicators of safety, quality and performance, to inform and commission the measurement of such indicators as part of Senior Management Team Governance, to regularly review this information, and to provide assurance or expert input into necessary next steps to address any issues arising from same.

3. Work with other professional Directors to lead multidisciplinary teams to ensure there is a system for audit of clinical practice that assesses and reviews the quality of services provided and ensures that any learning is incorporated into professional practice and systems.

4. While the operational responsibility and accountability for patient safety rests with operational Directors, assume responsibility for:

   a) Participation in regional co-ordination of patient safety initiatives, bringing intelligence and direction on these approaches into the organisation and providing strategic and professional advice on implementation.

   b) Co-ordinating the implementation of agreed Patient Safety priority projects and monitoring systems, as endorsed by Senior Management Team, within the wider Clinical and Social Care Governance arrangements of the Trust.

   c) Reviewing and monitoring the impact of Patient Safety Initiatives and providing regular Patient Safety reports to Senior Management Team, Governance Committee and Trust Board.

5. Ensure the development and maintenance of professional standards and education liaising with professional and education bodies as necessary

6. Provide advice on medical workforce policy including staffing levels, changes in working patterns and skill mix which will ensure the delivery of effective and efficient clinical services to patients and clients

7. Ensure that all doctors and dentists in the Trust work within agreed procedures, and, as appropriate the GMC's guidance "Good Medical Practice" and the GDC's "Standards for Dental Professionals"

8. Set up systems for meeting and liaising with Associate Medical Directors and Clinical Directors in the Trust to ensure appropriate arrangements are in place for securing patient and client safety.

9. Ensure effective systems of clinical risk management and adverse event reporting are in place demonstrating trend analysis and processes to share learning.

10. Support the development and implementation of the Trust's Audit Strategy.

11. Ensure compliance with relevant assurance standards.

12. Provide arrangements for the clinical scrutiny of claims and litigation.

13. Ensure that there are effective systems in place to support the Trust's research governance arrangements.

14. Act as the designated lead Director for strategic management of patient safety initiatives, and the link Director with the Patient Safety Forum and other regional fora.

**QUALITY**

1. Promote high standards of medical and dental practice and provide advice and support to ensure the development of a quality culture with a focus on continuous improvement.

2. Ensure robust systems and processes for monitoring and improving outcomes for people who use our services are in place to provide assurance that clinical care is safe and effective.

3. Ensure effective systems are in place to comply with regional requirements for morbidity and mortality review and ensure compliance with Coroner's court processes.

4. Support innovation and change to underpin the modernisation of services

5. Be responsible for the delivery of undergraduate and postgraduate medical education and training to the standards and requirements set out in the service level agreements with Queen's University Belfast (QUB) and NIMDTA.

6. Act as the Trust Data Guardian, providing an advocacy role for data protection on behalf of patients, their families and carers.

7. Ensure systems and processes are in place to support responses to complaints, provide trend analysis and systems to share learning.

8. Work in partnership with the members of the Trust Senior Management Team to ensure the integration of learning from complaints, incidents and claims into the service delivery model within the Trust, via the Lessons Learned Committee.

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

**MEDICAL EDUCATION & TRAINING**

1. Ensure the quality of medical education and training within the Trust, working closely with education and training bodies and ensure the Trust has a highly skilled career grade medical workforce. This will include accountability for the quality of undergraduate training including delivery of QUB Accountability Framework and utilisation of SUMDE budget, and the provision of Annual Report to Trust Board.

2. Lead on the post graduate training of junior doctors in training within the Trust, including managing the relationship between NIMDTA and the Trust, and ensuring the Trust and NIMDTA work in partnership to maintain a high standard of education and related patient safety.

3. Lead on the work related to the "Sub Deanery" for Queens University (QUB) Medical School within the Trust, including managing the relationship between QUB and the Trust, and ensuring the Trust and QUB work in partnership to maintain a high standard of education and supervision of the Medical students placed. This work includes an Annual report and financial report on the funding provided to the Trust by QUB in respect of the work of the sub-deanery.

4. Management of the Associate Medical Director (AMD) for postgraduate Medical Education, induction and training for Junior Doctors, QA / evaluation of training and supporting operational Directors to address issues arising from Deanery and PMETB evaluation and inspections.

5. Ensure that all doctors and dentists in the Trust work within agreed procedures, and, as appropriate the GMC's guidance 'Duties of a Doctor', 'Good Medical Practice' and related documents, and succeeding and replacement documents or the GDC's lifelong learning requirements.

6. Ensure the implementation of an effective process of professional self-regulation for doctors employed by the Trust.

**RESEARCH & DEVELOPMENT**

1. The postholder will be responsible for the strategic and operational management of Research and Development within the Trust, including the line management of the Associate Medical Director for Research and Development and associated support staff. This role includes responsibility for CAS for Research and provision of Research and Development Annual Report to Trust Board.

2. Responsible for the Trust's Research Committee to agree a programme of research and development and ensure the extant legal and regularity permissions are obtained.

**SERVICE DELIVERY**

1. Strategic management and co-ordination of effective Emergency Planning within the Trust and the provision of annual reports to Trust Board.

2. Ensure a Major Incident Policy is in place for the Trust, and suitable support is in place for the testing, recording and subsequent modification of the policy and attached plans are reviewed constantly and reported on at agreed intervals.

3. Management of ECRs and Drug Requests for Southern Trust patients, and responsible for medical evaluation, decision-making and liaison with Commissioner in relation to same.

4. Responsible to Trust Board for the discharge of medical statutory functions.

5. Lead Director for the Trust's litigation arrangements.

**FINANCIAL AND RESOURCE MANAGEMENT**

1. Be accountable for the management of the Directorate's budget (pay and non pay) and the meeting of all financial targets by each division and service.

2. Advise and assist the Trust Board and Chief Executive in determining its expenditure on clinical services.

3. Participate in contract and service level negotiations with Commissioners.

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

**LEADERSHIP & PEOPLE MANAGEMENT**

1. Ensure effective engagement with doctors and dentists and their representatives including co-chairing the Trust's Local Negotiating Committee (LNC)

2. Ensure the aims and targets of the New Deal for junior doctors are implemented and compliance with EWTD for junior doctors and career grade doctors is achieved and maintained.

3. Support managers both in establishing and reviewing performance targets with individual consultants, recognising workloads and other pressures on medical staff and ensuring adequate mechanisms are in place for the support of medical staff

4. Responsible, in association with the Director of Human Resources & Organisational Development, for the management of disciplinary matters and complaints relating to medical staff

5. Provide exemplary and visible leadership and promote a strong positive model of valuing staff, effective communication and engagement so as to enable staff to perform to the best of their abilities to deliver high quality care and support and be involved in the transformation agenda.

6. Ensure that management structures and practices in the Directorate are fit for purpose and support a culture of effective team working, collective leadership, continuous improvement and innovation, always striving to remain focused on person-centred care for citizens of the Trust.

7. Ensure the effective implementation of all Trust people management policies in the Directorate and the achievement of all relevant targets such as relating to corporate mandatory training, personal development plans, the management of sickness and absenteeism, turnover etc.

8. Ensure the effective management of staff health and safety and support in the Directorate.

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

10. Maintain staff relationships and morale amongst the staff reporting to him/her.

11. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

12. Participate, as required, in the selection and appointment of staff in accordance with procedures laid down by the Trust.

13. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

**CORPORATE & COLLECTIVE LEADERSHIP**

1. Demonstrate exemplary standards of corporate leadership and share a collective responsibility for all Trust corporate decisions, initiatives and the effective implementation and communication of same.

2. Actively promote a culture of collective leadership within the Trust, and across organisational boundaries, in line with the four key components of the *HSC Collective Leadership Strategy.*

3. Share a collective responsibility for the Trust's financial performance and the achievement of all quality, safety and other legislative requirements.

4. Share a collective responsibility for the Trust's overall corporate governance processes to include the implementation of an integrated governance framework that assures safe and effective care for patients and clients and complies with public sector values and codes of conduct, operations and accountability.

5. Lead by example, to ensure the Trust demonstrates respect through its culture and actions, for all aspects of diversity in the population it serves and the staff who provides the services.

6. Share a collective responsibility for the Trust's corporate planning, policy and decision making processes as a member of the Directorate's senior management team and ensure the Trust's objectives and decisions are effectively communicated.

7. Continually strive to develop self and improve capability in the leadership of the Trust and its staff.

8. Lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HSC Staff.

9. Participate in the Director on-call rota.

**GENERAL REQUIREMENTS**

The post holder will be required to:

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

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

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

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

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

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

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

8. Represent the Trust's commitment to providing the highest possible standard of the patient/client experience and services delivered by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

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

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

May 2018

# PERSONNEL SPECIFICATION

**JOB TITLE** Medical Director

| ESSENTIAL CRITERIA | |
|---|---|
| The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the selection / interview stage. You must therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. | |
| **Factor** | **Criteria** |
| **Eligibility** | Be an employee of an organisation within Health & Social Care within Northern Ireland[1] |
| **Qualifications/ Experience** | 1. Registration with the GMC, have a licence to practice and be on the GMC Specialist Register.<br><br>2. A minimum of three years' experience in a senior medical management[2] role in a major complex organisation[3] AND clear significant[4] personal evidence of:-<br><br>• managing major service improvement and transformation;<br>• high level leadership and people management skills;<br>• effective medical professional governance and risk management;<br>• building strategic relationships with external agencies / partners |
| **Other** | 3. Hold a full current driving licence valid for use in the UK and have access to a car on appointment[5]. In respect of this point the successful applicant may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere. |

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

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

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

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

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

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

**Notes to applicants:**

1. *We will not accept CVs, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms*;

2. *You must clearly demonstrate on your application form how you meet each of the required criteria – failure to do so will result in you not being shortlisted.*

3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer will be withdrawn*

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

**WE ARE AN EQUAL OPPORTUNITIES EMPLOYER**

**Successful applicants may be required to attend for a Health Assessment**

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

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

# Job Description

**JOB TITLE** Director of Mental Health & Disability

**LOCATION** Trust Headquarters, Craigavon Area Hospital

**ACCOUNTABLE TO** Chief Executive

**JOB SUMMARY**

The post-holder will be a key member of the Trust's Senior Management Team and will be accountable to the Chief Executive for leading the delivery of safe, effective and high quality services within the portfolio of the Trust's Mental Health and Disability Directorate. S/he will play a key strategic role in leading and managing the transformation of mental health, disability and dementia services in line with the principles and strategic direction for health and social care contained in *Health and Wellbeing 2026: Delivering Together.*

As a Director, the post-holder will be an effective and influential ambassador for the Trust. S/he will engage with external stakeholders to enhance local partnerships and new and innovative collaborative approaches to enable and support people living in the Trust's area to achieve their full health and wellbeing potential.

The post-holder will provide exemplary and visible leadership. S/he will be a member of the Trust's Senior Management Team and therefore will have both an individual and a corporate leadership responsibility to contribute fully to the development, delivery and achievement of the Trust's corporate objectives.

**KEY RESULT AREAS**

**SERVICE DELIVERY**

1. Act as an ambassador representing the Trust on regional work streams, which will include influencing policy direction, contributing to and / or leading on strategic development, implementation, review and evaluation of transformation plans for mental health and disability services.

2. Lead the development and implementation of the Mental Health & Disability Directorate's strategic plan in line with Health and Wellbeing 2026 - Delivering Together, Bamford Review and other key strategic reforms.

3. Work collaboratively with regional colleagues to strengthen the achievement of scale and spread of evidenced based local service improvement models. Seize opportunities for Trust participation in the testing of prototypes / pilots that will enable innovation to inform further system wide learning.

4. Lead a range of services in a co-ordinated way, working in partnership with statutory agencies, voluntary and independent sectors ensuring that a comprehensive and equitable range of high quality, responsive and efficient health and social care services are delivered.

5. Work closely with other statutory and voluntary agencies in order to maximize the opportunities for mixed economies of care to build capacity and innovative solutions to improve the ethos of self-help, self-management and self-sustaining healthier communities.

6. Ensure a close interface between Trust Directorates ensuring early intervention to promote an upstream approach to prevention, rehabilitation, optimum health and well-being for efficient patient flow and patient experience.

7. Work collaboratively with the Director of Children and Young People to ensure service delivery is seamless from adolescent services to adult services.

8. Actively seek and strengthen existing and new models of co-production and co-design at all levels within Disability, Mental Health and Dementia Services which will fully support Regional Care Pathways.

9. Influence and work collaboratively with commissioners and relevant stakeholders to secure their commitment and involvement in the implementation of strategic planning initiatives and targets.

10. Lead and be accountable for the development and implementation of all Directorate initiatives to support carers in line with the DOH strategy “Valuing Carers”.

**QUALITY, GOVERNANCE & PERFORMANCE**

1. Ensure that the needs of patients, clients and their carers are at the core of how the Directorate delivers its services and are in accordance with DOH Quality Standards for Health and Social Care and other relevant requirements. This will include driving up the quality of care, improving outcomes and enhancing the patient/client experience in line with the principles for change contained in Health and Wellbeing 2026: Delivering Together.

2. Lead and be accountable for ensuring excellent standards of governance in the Directorate to include compliance with all relevant professional requirements and standards, adult safeguarding policies and procedures, the assessment and

management of risk and the implementation of all relevant learning and best practice.

3. Manage and maintain a robust framework of performance management which will enable Assistant Directors to lead multidisciplinary teams to deliver high quality and person centred approaches to care.

4. Ensure ongoing, critical evaluation of the Directorate's performance, taking corrective action as required, to maximize performance against specific Objectives & Goals for Improvements (OGIs) and agreed trajectories for improvement.

5. Lead the defining and monitoring of performance standards in contracts/service level agreements with independent service providers and oversee arrangements through the cross directorate Independent Sector Governance Committee.

6. Ensure the management of complaints and SAIs within the Directorate comply with DOH, HSCB and Trust complaints procedures / SAI procedures and are underpinned by candour, transparency and a culture of continuous improvement.

**SERVICE TRANSFORMATION AND ORGANISATIONAL DEVELOPMENT**

1. Deliver on a challenging agenda in line with the principles contained in Health and Wellbeing 2026: Delivering Together, for Mental Health and Disability Services with a focus on 'recovery not illness*'.*

2. "Horizon scan and plan" and lead on the Directorate's response to strategic and cross cutting issues so as to ensure the Trust is best placed to meet future challenges and meet need.

3. Identify and drive the necessary changes to culture and practice within the Directorate to support the strategic and transformational agenda and ensure the focus for transformation is understood, accepted and delivered.

4. Lead the development and implementation of workforce modernisation initiatives including 'Power to the People' regional policy directions.

5. Build and lead successful partnerships and collaboration with other sectors, providers and local communities to deliver sustainable and new approaches to health and wellbeing and the delivery of care.

**LEADERSHIP AND PEOPLE MANAGEMENT**

1. Provide exemplary and visible leadership and promote a strong positive model of valuing staff, effective communication and engagement so as to enable staff to perform to the best of their abilities to deliver high quality care and support and be involved in the transformation agenda.

2. Promote and maintain highly positive working relationships with trade union colleagues and ensure effective engagement with them in planning for and implementing service reforms and changes.

3. Ensure that management structures and practices in the Directorate are fit for purpose and support a culture of effective team working, collective leadership, continuous improvement and innovation, always striving to remain focused on person-centred care for citizens of the Trust.

4. Ensure the effective implementation of all Trust people management policies in the Directorate and the achievement of all relevant targets such as relating to corporate mandatory training, personal development plans, the management of sickness and absenteeism, turnover etc.

5. Ensure the Directorate has a robust workforce strategy to enable all service changes and plans.

6. Ensure the effective management of staff health and safety and support in the Directorate.

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

8. Maintain staff relationships and morale amongst the staff reporting to him/her.

9. Delegate appropriate responsibility and authority to the level of staff within his/her control consistent with effective decision making, while retaining overall responsibility and accountability for results.

10. Participate, as required, in the selection and appointment of staff in accordance with procedures laid down by the Trust.

11. Take such action as may be necessary in disciplinary matters in accordance with procedures laid down by the Trust.

**FINANCIAL AND RESOURCE MANAGEMENT**

1. Be accountable for the management of the Directorate's budget (pay and non pay) and the meeting of all financial targets by each division and service.

2. Ensure the effective implementation of all Trust financial policies and procedures in the Directorate which will include ensuring the safe custody of residents' property and accounts and the use of endowments and gifts.

3. Lead Directorate procurement of services from the independent sector.

4. Lead and be accountable for the effective management, use and maintenance of all physical assets in the Directorate.

5. Lead the development of capital investment strategies within the Directorate, ensuring these reflect and contribute meeting targets set by the HSCB and the Trust's Corporate Plan.

**CORPORATE AND COLLECTIVE LEADERSHIP**

1. Demonstrate exemplary standards of corporate leadership and share a collective responsibility for all Trust corporate decisions, initiatives and the effective implementation and communication of same.

2. Actively promote a culture of collective leadership within the Trust, and across organisational boundaries, in line with the four key components of the *HSC Collective Leadership Strategy.*

3. Share a collective responsibility for the Trust's financial performance and the achievement of all quality, safety and other legislative requirements.

4. Share a collective responsibility for the Trust's overall corporate governance processes to include the implementation of an integrated governance framework that assures safe and effective care for patients and clients and complies with public sector values and codes of conduct, operations and accountability.

5. Lead by example, to ensure the Trust demonstrates respect through its culture and actions, for all aspects of diversity in the population it serves and the staff who provides the services.

6. Share a collective responsibility for the Trust's corporate planning, policy and decision making processes as a member of the Directorate's senior management team and ensure the Trust's objectives and decisions are effectively communicated.

7. Continually strive to develop self and improve capability in the leadership of the Trust and its staff.

8. Lead by example in practicing the highest standards of conduct in accordance with the Code of Conduct for HSC Staff.

9. Participate in the Director on-call rota.

**EMERGENCY PLANNING AND BUSINESS CONTINUITY**

1. Lead on the development, testing and review of relevant emergency response and business continuity plans to ensure a state of emergency preparedness for the provision of a proportionate, effective response to emergency situations and business continuity issues.

## GENERAL REQUIREMENTS

The post holder will be required to:

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

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

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

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

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

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

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

8. Represent the Trust's commitment to providing the highest possible standard of the patient/client experience and services delivered by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

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

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

May 2018

# PERSONNEL SPECIFICATION

**JOB TITLE** Director of Mental Health & Disability

| ESSENTIAL CRITERIA | |
|---|---|
| The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the selection / interview stage. You must therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. | |
| **Factor** | **Criteria** |
| **Eligibility** | 1. Be an employee of an organisation within Health & Social Care within Northern Ireland.[1] |
| **Qualifications/ Experience** | 2. Hold a university degree or recognised professional qualification or equivalent qualification in a relevant[2] subject.<br><br>3. A minimum of three years' experience in a senior management[3] role in a major complex organisation[4] AND clear significant[5] personal evidence of:-<br>• managing major service improvement and transformation;<br>• implementing financial control<br>• high level leadership and people management skills;<br>• effective governance and risk management;<br>• building strategic relationships with external agencies/ partners |

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

[2] ***'relevant subject'*** *will be interpreted to mean any business, administrative, corporate function or health related qualification*

[3] ***'senior management'*** *is defined as experience gained at Director, Assistant Director or equivalent in a major complex organisation*

[4] ***'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*

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

| | |
|---|---|
| **Other** | 4. Hold a full current driving licence valid for use in the UK and have access to a car on appointment[6]. In respect of this point the successful applicant may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere. |
| **Selection / Interview stage** | |
| Candidates shortlisted and invited for further stages of selection will be assessed using the nine dimensions of leadership behaviour as specified in the ***NHS Leadership Academy Healthcare Leadership Model.*** Shortlisted candidates will need to demonstrate that they have the required knowledge, skills, competencies and values to be effective in this role. | |

**Notes to applicants:**

1. *We will not accept CVs, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms*;

2. *You must clearly demonstrate on your application form how you meet each of the required criteria – failure to do so will result in you not being shortlisted.*

3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer will be withdrawn*

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

**WE ARE AN EQUAL OPPORTUNITIES EMPLOYER**

**Successful applicants may be required to attend for a Health Assessment**

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

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

Southern Health and Social Care Trust

*Quality Care - for you, with you*

# Deputy Medical Director

## Medical Appraisal and Revalidation

## (24 Months Initially)

*Date of Advertisement: 19th August 2021*

*Closing Date: 3rd September 2021*


## Invitation from the Medical Director

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

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

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

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

then I look forward to receiving your completed application form.

**DR MARIA O'KANE**
**MEDICAL DIRECTOR**

Southern Health and Social Care Trust

*Quality Care - for you, with you*

**JOB DESCRIPTION**

**JOB TITLE:** Deputy Medical Director Medical Appraisal and Revalidation (Up to 6 PAs)

**BASE:** Base to be determined, however, post will have a Trustwide remit

**DIRECTORATE:** Medical Directorate

**RESPONSIBLE TO:** Medical Director

**ACCOUNTABLE TO:** Medical Director

## JOB SUMMARY

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

## KEY RESPONSIBILITIES

### Setting Direction

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

**Medical Appraisal and Revalidation**

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

relating to the development and implementation of appraisal.

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

**Medical Performance Support**

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

**Private Practice and Paying Patients**

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

**Collaborative Working**

- Work closely with Divisional Medical Directors, Associate Medical Directors and Medical Human Resources and Finance to provide information on medical appraisal and revalidation issues
- Work closely with Divisional Medical Directors, Associate Medical Directors, Clinical Directors, and Clinical and Social Care Governance teams to support quality improvement activities relating to medical appraisal and revalidation issues
- Liaise with clinical colleagues to ensure that activities the post holder is responsible for across the Trust are appropriately co-ordinated and integrated.
- Work closely with the Medical Human Resources team to deliver on all aspects of this role.

**Service Development & Improvement**

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

## GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.
4. Adhere at all times to all Trust policies/codes of conduct, including for example:
    - Smoke Free policy
    - IT Security Policy and Code of Conduct
    - standards of attendance, appearance and behaviour
5. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
6. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
7. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004, the Data Protection Act 2018 and General Data Protection Regulations. Employees are required to be conversant

with the Trusts policy and procedures on records management and to seek advice if in doubt.

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

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

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

**SOUTHERN HEALTH & SOCIAL CARE TRUST**

# PERSONNEL SPECIFICATION

**JOB TITLE:** Deputy Medical Director Appraisal and Revalidation

**DIRECTORATE:** Medical Directorate

**HOURS:** Up to 6PA's

**Notes to applicants:**

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

## ESSENTIAL CRITERIA

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

| Factor | Criteria |
|---|---|
| ***QUALIFICATIONS / EXPERIENCE*** | 1. Hold full registration with the General Medical Council (GMC London) with a license to practice[1].<br>2. Have a minimum of 2 years' experience in a senior medical management / clinical leadership role[2] in a major complex organisation[3].<br>3. Demonstrate personal responsibility for achieving measurable improvements in outcomes for Health and Social Care Services for a minimum of 2 years.<br>4. Have worked with a diverse range of stakeholders to achieve successful outcomes for a minimum of 2 years.<br>5. Evidence of practical experience of medical professional governance.<br>6. Evidence of practical experience supporting Medical Appraisal and Revalidation processes |

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

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

[3] '[2]'*major complex organisation' is defined as one with at least 200 staff or an annual budget of at least £50 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders*

| *The following are essential criteria which will be measured during the interview stage.* | |
|---|---|
| **KNOWLEDGE, TRAINING & SKILLS** | 7. Have an ability to provide effective leadership at a strategic level to enable the ongoing development and improvement of services.<br><br>8. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.<br><br>9. Demonstrate highly effective communication skills to meet the needs of the post in full. |
| **Other** | 1. Hold a full current driving licence valid for use in the UK and have access to a car on appointment[4].<br>In respect of this point the successful applicant may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere. |

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

**WE ARE AN EQUAL OPPORTUNITIES EMPLOYER**

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

Southern Health and Social Care Trust

*Quality Care - for you, with you*

# Deputy Medical Director

## Governance, Safety and Quality Improvement

*Closing Date: Thursday 24th October 2019 @12.30pm*

Working together | Excellence | Openness & Honesty | Compassion

# Invitation from the Medical Director

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

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

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

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

then I look forward to receiving your completed application form.

**DR MARIA O'KANE**
**MEDICAL DIRECTOR**

Southern Health and Social Care Trust

*Quality Care - for you, with you*

# JOB DESCRIPTION

**JOB TITLE:** Deputy Medical Director Governance, Safety and Quality Improvement (Up to 7 PAs, with additional management allowance £15,000 per annum)

**BASE:** Base to be determined, however post will have a Trustwide remit

**DIRECTORATE:** Medical Directorate

**RESPONSIBLE TO:** Medical Director

**ACCOUNTABLE TO:** Medical Director

## JOB SUMMARY

The Deputy Medical Director (Governance, Safety and Quality Improvement) will focus with the Medical Director on providing strong leadership, systems and process to lead on clinical standards and governance across the organisation, providing expert advice, lead on strategy implementation, support the development of clinical governance, safety and improvement plans, and participate in education and training programmes as required. Opportunities to continue to deliver direct clinical care for the Southern Trust will be encouraged.

## KEY RESPONSIBILITIES

### Setting Direction

- Provide professional leadership to medical staff, communicating the organisation's perspective to clinicians and building commitment among

clinicians to achieve the Trust's objectives and overall aim of safe, high quality and responsive services in line with HSC values.

- Provide advice to the medical director and clinical colleagues on clinical standards, guidelines and priorities.
- Support the development of robust multidisciplinary systems to ensure clinical and social care governance processes are adhered to and services are equitable across all Trust services.
- Promote a culture of patient safety and facilitate the delivery of agreed safety, learning and improvement goals.

**Clinical Governance**

- Deputise for the Medical Director, where required, and take a lead role in developing links between the Medical Director's office and the wider organisation in respect of clinical standards and governance.
- To support Divisional Medical Directors, Associate Medical Directors, alongside the Executive Director of Nursing and AHP and Operational Directors to ensure the delivery of safe, responsive and effective clinical services.
- Support, where appropriate, investigations, including analysis of clinical and other incidents, review research and national guidelines to improve practice and provide judgment where medical practice may differ.
- Provide leadership on the management of reviews and investigations of a clinical nature, such as those arising from complaints or adverse events where service users are involved.
- Supported by Morbidity and Mortality chairs, oversee and provide assurance on Trust Morbidity and Mortality processes and highlight areas where further investigation / analysis may be required
- Refer concerns to the Executive Medical Director and, if required, involve the appropriate responsible director (e.g. Executive Director of Nursing or Operational Director).
- Support Trust implementation of the recommendations contained in the Inquiry into Hyponatraemia related Deaths

**Quality Improvement**

- Along with the Executive Medical Director, the Deputy Medical Director will maintain oversight, as the NCEPOD Ambassador of the Trust's contribution to national audits and local clinical audit the way in which data from these audits forms part of the approach to patient safety, learning and improvement.
- Provide oversight and assurance on Trust process for the implementation of Standards and Guidelines to ensure they form part of the approach to patient safety, learning and improvement. Provide oversight and assurance on Trust processes for Clinical Guidelines to ensure they form part of the approach to patient safety
- Provide clinical leadership for medical staff who are undertaking quality improvement activities including alignment to clinical effectiveness priorities, identifying training needs and mentoring programmes.
- Secure effective engagement with clinicians at all levels and encourage cross professional collaboration to deliver service improvement
- Support and advise on the development of a lessons learned framework for the Trust to ensure learning from mortality and morbidity reviews, audit, complaints, litigation and adverse incidents is embedded in organisational systems and processes
- Supported by the Clinical Director, Research and Development lead on the management and oversight of Trust Research and Development activities both internal and external party arrangements.

**Collaborative Working**

- Work closely with Divisional Medical Directors, Associate Medical Directors, Clinical Directors, and Clinical and Social Care Governance teams to support quality improvement activities relating to the clinical effectiveness and governance.
- Liaise with clinical colleagues to ensure that activities the post holder is responsible for across the Trust are appropriately co-ordinated and integrated.
- Work closely with the corporate and operational directorate clinical and social care governance teams team to deliver on all aspects of this role.

**Service Development & Improvement**

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

## GENERAL REQUIREMENTS

The post holder will be required to:

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

under the Freedom of Information act 2000 the Environmental Information Regulations 2004, the Data Protection Act 2018 and General Data Protection Regulations. Employees are required to be conversant with the Trust's 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 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. Seek to engage and involve service users and members of the public in keeping with the Trust's Personal and Public Involvement Strategy and as appropriate to the job role.

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

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

# PERSONNEL SPECIFICATION

**JOB TITLE** Deputy Medical Director Governance, Safety and Quality Improvement

| ESSENTIAL CRITERIA | |
|---|---|
| The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the selection / interview stage. You must therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. | |
| **Factor** | **Criteria** |
| **Qualifications/ Experience** | ***QUALIFICATIONS / EXPERIENCE***<br><br>1. Hold full registration with the GMC with a license to practice[1].<br><br>2. Have a minimum of 2 years' experience in a senior medical management / clinical leadership role[2] in a major complex organisation[3].<br><br>3. Demonstrate personal responsibility for achieving measurable improvements in outcomes for Health and Social Care Services for a minimum of 2 years.<br><br>4. Have worked with a diverse range of stakeholders to achieve successful outcomes for a minimum of 2 years.<br><br>5. Evidence of practical experience developing and supporting clinical and social care governance assurance processes involving multidisciplinary team-working. |

[1] *The Trust reserves the right to review and consider, as appropriate, the information available about you on the GMC register as part of this selection process. This information will be treated in confidence and will not debar you from appointment unless the selection panel considers that it renders you unsuitable for appointment.*

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

[3] *'[2]'major complex organisation' is defined as one with at least 200 staff or an annual budget of at least £50 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders*

| | |
|---|---|
| | ***The following are essential criteria which will be measured during the interview stage.***<br><br>**KNOWLEDGE, TRAINING & SKILLS**<br><br>6. Have an ability to provide effective leadership at a strategic level to enable the ongoing development and improvement of services.<br><br>7. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.<br><br>8. Demonstrate highly effective communication skills to meet the needs of the post in full. |
| **Other** | 1. Hold a full current driving licence valid for use in the UK and have access to a car on appointment[4]. In respect of this point the successful applicant may be required to travel throughout Northern Ireland, the United Kingdom, the Republic of Ireland, and elsewhere. |
| **Selection / Interview stage** | |
| Candidates shortlisted and invited for further stages of selection will be assessed using the nine dimensions of leadership behaviour as specified in the ***NHS Leadership Academy Healthcare Leadership Model*** and the ***HSC's Values.*** Shortlisted candidates will need to demonstrate that they have the required knowledge, skills, competencies and values to be effective in this role. | |

**Notes to applicants:**

1. *We will not accept CVs, letters, additional pages or any other supplementary material in place of, or in addition to completed application forms*;

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

2. *You must clearly demonstrate on your application form how you meet each of the required criteria – failure to do so will result in you not being shortlisted.*

3. *Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer will be withdrawn*

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

**WE ARE AN EQUAL OPPORTUNITIES EMPLOYER**

**Successful applicants may be required to attend for a Health Assessment**

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

SOUTHERN HEALTH AND SOCIAL CARE TRUST

JOB DESCRIPTION

TITLE OF POST: Assistant Director – Medical Directorate

DIRECTORATE: Medical Directorate

REPORTS TO: Medical Director

JOB SUMMARY:

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

JOB ROLE:

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

- Medical leadership
    - Medical revalidation
    - Medical appraisal
    - Medical Job planning
    - Medical leadership development
    - Delivering on the Medical Directors/AMDs identified priorities
- Medical education
    - Undergraduate training
    - Postgraduate training
- Patient safety and clinical & quality indicators
    - Mortality & Morbidity
    - Clinical audit
    - Clinical guidelines
- Research & Development
- Infection prevention and control
- Business continuity and emergency planning
- Financial management within the Medical Directorate
- Staff management within the Medical Directorate

This post also has lead responsibility within Acute Services for:

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

JOB DETAIL AND KEY RESULT AREAS:

Medical leadership
Medical Education

1. Provide managerial support to the designated Responsible Officer for the Trust in the revalidation of the Trust Medical workforce.
2. Development, implementation and on-going management of an effective scheme of medical appraisal which will meet the requirements of revalidation as defined by the General Medical Council.
3. Participation and development of collaborative working channels with regional colleagues, the DHSSPS and the General Medical Council on the development of frameworks to support the implementation of revalidation, including development of MSF, Patient and Client Feedback and on-line appraisal systems.
4. Lead role in the development of corporate responses to consultations linked to professional governance.
5. Lead role in the interpretation of professional regulatory advice in relation to appraisal, revalidation, Good Medical Practice, continuing professional development – and lead responsibility for the development and/or amendment of polices/guidelines to reflect changes.
6. Provide leadership and support for medical job planning within the Trust
7. Work with Medical HR on the development of reports and updates, on behalf of the Medical Director on professional workforce issues to Senior Management Team, Governance Committee and Trust Board.
8. Research and development of audit methodologies that provide assurance to the Responsible Officer on the quality of medical appraisal.
9. Attendance at regional and national conferences to ensure best practice within the field of clinical leadership is applied within the Southern Trust.

10. Where required, lead the development and refinement of in-house bespoke information systems to monitor appraisal processes, professional registration, continuing professional development, study leave and mandatory training of medical staff.
11. Operational responsibility for the undergraduate medical education functions in the Trust.
12. Delivery of the QUB Accountability Framework – including liaison with regional committees, implementation of quality assurance and governance arrangements for undergraduate education.
13. Explore and develop links with other undergraduate suppliers including RCSI where appropriate.
14. Development of appraisal/performance management/response to feedback mechanisms to ensure quality educational experience.
15. Operational responsibility for the Trust postgraduate medical education functions.
16. Ensure that processes exist for effective communication with all junior medical staff, irrespective of working patterns.
17. Work collaboratively with Operational and Medical HR to ensure the aims and targets of the New Deal for junior doctors are implemented and compliance with EWTD for junior doctors and career grade doctors is achieved and maintained.
18. Work collaboratively with Medical HR in the preparation of business cases for Junior doctor EWTD/New Deal compliance and manage the process of obtaining internal and external approvals in line with local and regional policy and standards.
19. Management of the relationship with NIMDTA in relation to Deanery Visits and the associated remedial actions.
20. Lead responsibility for the analysis of General Medical Council – Trainer and Trainee Surveys and development of supporting action plans.
21. Work collaboratively with NIMDTA and Medical HR to support the revalidation of junior medical staff.
22. Responsibility for the development of e-learning and on-site induction programme for junior medical staff.
23. Operational responsibility for the continuing medical education of Consultant and SAS doctors.
24. Develop a comprehensive programme of supervision for new start Consultants and SAS doctors.
25. Oversee the development of a leadership development programme for Consultants and SAS doctors.

26. Oversee the implementation of the Trust's Specialty doctor Framework.

## Patient Safety and Clinical & Quality Indicators

1. Work with the Clinical Audit and Governance teams in the development of in-house clinical indicators, including research of best practice, development of methodologies, development, pilot and implementation.
2. Keep up to date with guidelines, best practice in relation to clinical indicators and patient safety and implement learning where appropriate.
3. Responsibility for the management of the implementation of external clinical guidelines and standards apportioned to the Medical Director, including their interpretation, development of implementation plans and on-going monitoring.
4. Implement and co-ordinate the Trust's M&M programme.
5. Liaise with regional bodies to develop further M&M reporting systems.
6. Support the Trust's whistleblowing Framework across medical staff groups in association with HR.

## Research and Development

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

Infection Prevention and Control

1. Managerial responsibility for the Trust Infection Prevention and Control Team.
2. Managerial support for the Infection Prevention and Control Governance structure.
3. Communication and collaborative working with internal and external agencies and stakeholders to ensure the achievement of performance and strategic objectives in relation to Healthcare Associated Infections.
4. Ensure regional policy and guidelines in relation to HCAI are effectively communicated, responded to and implemented.
5. Deputise for Medical Director at relevant internal and external committees/meetings in relation to HCAI.
6. Ensure effective mechanisms for performance management of HCAI infections against internal and external targets.
7. Responsibility for the achievement of Infection Control – Controls Assurance Standard.
8. Co-ordinate the Trust's response to achieving relevant PHA infection control targets.
9. Co-ordinate the work streams of the Antibiotic Stewardship champions.
10. Chair the Microbiology/infection Control Team meetings where appropriate.
11. Establish a leadership structure within the microbiology team, liaising with other Trusts and develop networking arrangements.

Business Continuity & Emergency Panning

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

Financial management

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

Staff management

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

Acute Services

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

GENERAL REQUIREMENTS

The post holder will be required to:

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

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

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

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

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

6. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the 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.

7. Take responsibility for his/her own on-going 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.

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

This Job Description will be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time. It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

PERSONNEL SPECIFICATION

JOB TITLE: Assistant Director – Medical Directorate

QUALIFICATIONS / EXPERIENCE:

1. University degree or relevant professional qualification and worked for at least 2 years in a senior management role in a major complex organisation.
OR
At least 5 years experience in a senior management role in a major complex organisation.

AND

2. Have a minimum of 2 years' experience in delivering against challenging performance management programmes meeting a full range of key targets and making significant improvements

3. Have a minimum of 2 years' experience working with a diverse range of both internal and external stakeholders to achieve successful outcomes.

4. Hold a full current driving license valid for use in the UK and have access to a car or access to a form of transport to meet the mobility needs of the post.

KNOWLEDGE, TRAINING & SKILLS:

5. Have an ability to provide effective leadership at a Strategic level to enable the ongoing development and improvement of services.

6. Demonstrate evidence of high level skills in;

a) effective planning and organisation
b) Governance and Risk Management
c) People Management

7. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.

8. Demonstrate highly effective communication skills to meet the needs of the post in full.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Southern Health and Social Care Trust

*Quality Care - for you, with you*

# Acting Assistant Director for Clinical and Social Care Governance

Southern Health and Social Care Trust

*Quality Care - for you, with you*

# JOB DESCRIPTION

| | |
|---|---|
| **JOB TITLE** | Assistant Director for Clinical and Social Care Governance (Acting) |
| **BAND** | 8C |
| **DIRECTORATE** | Medical Directorate |
| **INITIAL LOCATION** | Craigavon Area Hospital |
| **REPORTS TO** | Medical Director |
| **ACCOUNTABLE TO** | Medical Director |

**JOB SUMMARY**

The Acting Assistant Director for Clinical and Social Care Governance will assist the Medical Director, Chief Executive, Trust Board and Senior Management Team in driving forward effective Clinical and Social Care Governance (C&SCG) arrangements in the Trust.

S/he will take a lead role in ongoing development and management of the Trust's clinical and social care governance element of its Assurance Framework and the management of the clinical and social care aspects of the Corporate Risk Register by ensuring that risks to the attainment of Trust objectives, particularly the delivery of safe, high quality care, have been identified and that action plans are in place to eliminate or mitigate the identified risks.

S/he will also take a lead role in providing assurance to the Trust Board and Senior Management Team that the Trust's C&SCG and risk management systems, processes and governance arrangements are appropriate and working effectively, the provision of intelligence for assurance by Operational and Executive Directors that clinical and social care services are safe and of good quality and that standards are being met. This will include overseeing and managing the clinical and social care governance and risk management action plan commissioned by the Senior Management Team and ensuring the delivery of the organisational strategy on C&SCG.

## KEY DUTIES / RESPONSIBILITIES

1. To develop and implement effective systems to assure the Trust Board and Senior Management Team that robust Clinical and Social Care Governance (CSCG) arrangements are in place and are working effectively across the Trust.

2. Will work with the Medical Director / Chair of the Trust's multidisciplinary Clinical and Social Care Governance Lessons Leaned Forum, ensuring the provision of high level intelligence, advice and recommendations to the Chief Executive and Senior Management team on CSCG matters.

3. Provide advice on CSCG policies and procedures and good practice including the formulation and introduction of new policies and practices in light of e.g. legislative developments, external inspections/ reports, and investigations.

4. Have lead responsibility for monitoring, evaluating and reporting to SMT Governance the Trust's compliance with response deadlines and the effective and timely development and implementation of action plans in respect of external inspections/reports and investigations in relation to clinical and social care standards, safety and quality of care.

5. Ensure the provision of high quality specialist advice to the Trust Board, Senior Management Team, Directors and senior managers across the Southern Trust on CSCG issues.

6. Interpret key consultative documents regarding proposals for legislative reform and/or extended provisions and provide informed responses on behalf of the Southern Trust. Prepare position paper(s) forecasting the implications of same and develop associated action plans to ensure existing policy complies with best practice standards.

7. Develop, implement and lead structures, systems and processes to assess the robustness of clinical and social care governance systems and processes throughout the Trust and across all professional disciplines to ensure that the Trust Board and Senior Management Team have an accurate assessment of the safety and quality of health and social care services provided or commissioned by the Trust.

8. Lead and develop the Trust's risk management systems and processes to ensure that the organisation's risks are properly identified and managed, and that the Trust has

timely and accurate risk registers in place at all levels – team, division, Directorate and Corporate.

9. To lead the development, implementation and monitoring of effective systems to assure Trust Board and the Senior Management Team that robust systems are in place and working effectively across the Trust in relation to Standards and Guidelines

## STRATEGY

10. To take a lead role in the development, promotion, and implementation of the Trust's CSCG strategy, ensuring that it is patient/client focused, understood by staff, embedded in practice, and regularly reviewed and amended in the light of risks, clinical/social changes, legislative and regulatory requirements.

11. To take forward the strategic review and implementation of the Risk Strategy to ensure appropriate systems and arrangements are in place to effectively capture and mitigate the organisation's risks at all levels within the Trust.

12. To work with the Trust's operational, executive and corporate Governance Leads and support leads on the ongoing development of systems and procedures to monitor the implementation and effectiveness of changing professional, clinical and operational practice in improving the safety and quality of care, which takes due regard of evidence-based practice, lessons learned from reviews, complaints, incidents, accidents and public inquiries, and to provide recommendations and advice to SMT Governance on the Governance Action Plan and priority areas for action.

13. To ensure that a 'Learning From Experience" strategy and process is in place that identifies learning from clinical and social care incidents, lead the implementation and embedding of learning through co-ordination of agreed actions and integrated support from clinical and social care governance staff and workforce development and training leads, ensuring systems are in place for effective feedback to staff where issues of concern have been raised and actions identified to address same.

14. To assist in the development of the Trust Board Assurance Framework by co-ordinating the ongoing development of health and social care safety and quality indicators.

15. To assist in the development of the Trust Annual Quality Report and the processes for implementation and monitoring of the Trust Quality Improvement Framework

## LEADERSHIP

16. Working with the Medical Director, Chief Executive, Trust Directors and others to create an organisational climate which encourages staff to understand and enact their roles and responsibilities in relation to clinical and social care governance, proactively review practice in line with these roles, report untoward incidents, implement local resolution or appropriate escalation to manage the identified risks from same, and draw conclusions and identify areas for action without fear of recrimination or censure.

17. Provide leadership to ensure a systematic approach to the reporting of clinical and social care incidents and near misses and a culture of appropriate and timely reporting, analysis and learning across the organisation.

18. To work on behalf of the Senior Management Team and with Trust's multidisciplinary Clinical and Social Care Governance Team to develop for approval the Trust's Clinical and Social Care Governance Action Plan, identifying and providing evidence to support the prioritisation of actions, and leading the integration of these priorities and actions into the Trust's Board Assurance Framework.

19. To lead the delivery of the Clinical and Social Care Governance Action Plan on a yearly work cycle with the focus on providing assurance to the Senior Management Team and the Trust Board, that systems, policies and procedures are in place and work effectively and that the organisation's services are safe and of high quality.

20. To ensure there are mechanisms in place to share information and update staff in governance and risk management issues.

## RESEARCH & DEVELOPMENT

21. To develop systems and processes to ensure that evidence based practice is embedded within the Trust that takes into account the latest developments in research.

22. Within the Trust's overall clinical and social care governance structures and arrangements, to work with the Executive Directors for Nursing and AHPs, Social Work and Medical Director to embed structures and systems to ensure the Trust is complying with new regulations on practice and the latest workforce standards and developments emerging from Department, Commissioner and Professional bodies. Where the Trust is not compliant with these regulations and standards, to ensure that

governance systems are effective in properly alerting this to SMT Governance and Trust Board for action.

23. To lead and manage the Effectiveness and Evaluation Unit within the Trust, ensuring that the Trust's Audit Programme is in line with corporate objectives, service needs and the Clinical & Social Care Governance Action Plan.

24. Co-ordinate and monitor the planned programmes of multi-professional audit across the Trust and ensure these are implemented and integrated within the overall governance priorities of the Trust.

25. To ensure the effective implementation and evaluation of audits commissioned by the Senior Management Team Governance Committee.

26. To lead the development and population of a Trust wide Audit database.

27. To provide quarterly reports of clinical and social care incidents indicating trends, making recommendations for risk management, co-ordinating and quality assuring the risk management action plans, and leading and supporting the delivery of these plans.

**COMMUNICATIONS**

28. To ensure systems and processes are effective in resolving difficult situations and contentious issues that may arise as a consequence of changing practice and developments within the Trust in relation to governance issues.

29. To ensure that effective policies and procedure are in place to investigate untoward clinical and social care incidents as appropriate and ensure that remedial action is taken as necessary to reduce the Trust's exposure to future risks.

30. To ensure links between clinical / social care effectiveness, clinical / social care audit, risk management, education and research and development.

**PATIENT SAFETY AND CLINICAL QUALITY INDICATORS**

31. Lead and Support the development and implementation of the Trust Patient Safety Strategy

32. Have oversight and responsibility for the Quality Improvement Data and Audit Team

33. Have oversight and responsibility for Quality Improvement Data and Audit and the systems to support Patient Safety

34. Have oversight and responsibility for the Quality Assurance of Clinical and Social Care Governance and Patient Safety systems

35. Work with the Clinical Audit and Governance teams in the development of **in-house clinical indicators**, including research of best practice, development of methodologies, development, pilot and implementation.

36. Keep up to date with guidelines, best practice in relation to clinical indicators and patient safety and implement learning where appropriate.

37. Responsibility for the management of the implementation of **external clinical guidelines** and standards apportioned to the Medical Director, including their interpretation, development of implementation plans and on-going monitoring.

38. Implement and co-ordinate the Trust's Patient Safety / M&M programme.

39. Liaise with regional bodies to develop further Patient Safety/ M&M reporting systems.

40. Oversight and responsibility for Learning from the Experience of Clinical and Social Care Governance events

41. Oversight and responsibility for Quality Assurance processes dealing with Adverse Incidents including SAIs, Complaints , Datix etc

42. Oversight and responsibility for Quality Assurance of the development and implementation of the IHRD Recommendations, including audits and Being Open Recommendations

43. Oversight and responsibility for the quality assurance of the implementation of NICE and other Clinical Standards and Guidelines.

44. **HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES**

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

1. Establish and promote a supportive, fair and open culture that encourages and enables all parts of the team to have clearly aligned goals and objectives, to meet the required

performance standards and to achieve continuous improvement in the services they deliver.

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

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

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

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

## GENERAL REQUIREMENTS

The post holder will be required to:

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

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

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

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

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

6. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with

limited exceptions, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004, the General Data Protection Regulations (GDPR) and the Data Protection Act 2018. Employees are required to be conversant with the [org name] policy and procedures on records management and to seek advice if in doubt.

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

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

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

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

*January 2020*

Southern Health and Social Care Trust

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# PERSONNEL SPECIFICATION

**JOB TITLE AND BAND**
Temporary Replacement for Interim Assistant Director of Clinical & Social Care Governance,
Band 8C

**DIRECTORATE** Medical Directorate

**HOURS** 37.5 per week

**Notes to applicants:**

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

| **ESSENTIAL CRITERIA** | |
|---|---|
| **SECTION 1:** The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below. | |
| **Factor** | **Criteria** |
| **Experience / Qualifications/ Registration** | 1. Hold a University Degree or recognised Professional Qualification or equivalent qualification in a relevant[1] subject AND have a minimum of 2 years' experience in a Senior[2] Role in a major complex organisation[3] |

[1] *'Relevant' will be interpreted to mean any business, administrative, corporate function or health related qualification.*

[2] *'Senior' will be interpreted to mean Band 7 or equivalent or above.*

[3] *'Major complex organisation' is defined as one with at least 200 or more staff and/ 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.*

| | |
|---|---|
| | **OR** have a minimum of 5 years' experience in a senior[ii] Role in a major complex organisation.[iii]<br><br>2. Have a minimum of 2 years' experience in delivering against challenging performance management programmes meeting a full range of key Corporate goals, demonstrated through personal involvement in;<br>o The associated strategy development,<br>o Implementation and;<br>o Sustainability of the objectives.<br><br>3. Have a minimum of 2 years' experience of managing major change programmes addressing significant[4] organisational change, demonstrated through personal involvement in;<br>o Risk management,<br>o Planning and implementation of the change,<br>o Evaluating the impact of the change in transforming services for the better.<br><br>4. Have a minimum of 2 years' experience working with a diverse range of internal and external stakeholders;<br>o To deliver and improve services,<br>o Demonstrating effectiveness in developing and maintaining networks through lasting working relationships,<br>o Which contribute to service improvement, and;<br>o Where the contribution of others is encouraged.<br><br>5. Have a minimum of 2 years' experience in managing services where;<br>o Successful outcomes can be evidenced,<br>o Leadership is demonstrated in the areas of strategic planning, inspiring and motivating individuals and teams to strengthen performance,<br>o The best use of resources is made, in line with service values and goals.<br><br>6. Have a minimum of 2 years' experience in ensuring robust governance arrangements are in place which ensure high performance service outcomes in terms of quality, safety and standards, demonstrated through;<br>o Rigorous performance management measures, and;<br>o Holding others to account for achieving performance standards. |

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

| | |
|---|---|
| | |
| **Other** | 7. Hold a full current driving licence[v] valid for use in the UK and have access to a car on appointment |
| **SECTION 2**: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage: | |
| **Skills / Abilities** | 8. Demonstrate a commitment to the provision of high quality and safe services with an ability to drive a culture of continuous improvement.<br><br>9. Demonstrate evidence of highly effective planning and organisational skills.<br><br>10. Have an ability to effectively manage a delegated budget to maximize utilization of available resources.<br><br>11. Have an ability to provide effective leadership to enable transformation of services.<br><br>12. Demonstrate effective communication skills to meet the needs of the post in full. |

| **DESIRABLE CRITERIA** | |
|---|---|
| **SECTION 3:** These will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. **You should therefore make it clear on your application form how you meet these criteria. Failure to do so may result in you not being shortlisted**. | |
| **Factor** | **Criteria** |
| **Experience** | Experience in a Corporate, Clinical and Social Care Governance role within a health and / or social care setting. |

**PLEASE NOTE:**

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role. It is intended that shortlisted applicants will be assessed against the criteria stated in this

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

specification, linked to all seven domains of the NHS Leadership Framework found at the following link[5];
http://www.leadershipacademy.nhs.uk/discover/leadership-framework/supporting-tools/documents-to-download/

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

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

**Successful applicants may be required to attend for a Health Assessment**

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

**WE ARE AN EQUAL OPPORTUNITIES EMPLOYER**

[5] *The Trust would highlight that this is NOT the 2013 Leadership Model and candidates should ensure they use the link stated in the pack*

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| ue | What does this mean? | What does this look like in practice? - Behaviours |
|---|---|---|
| W<br>king Together | ether for me for people we<br>upport. We work across Health and Social<br>ith other external organisations and<br>ecognising that leadership is the<br>ty of all. | • I work with others and value everyone's contribution<br>• I treat people with respect and dignity<br>• I work as part of a team looking for opportunities to support and help people in both my own and other teams<br>• I actively engage people on issues that affect them<br>• I look for feedback and examples of good practice, aiming to improve where possible |
| ompassion | itive, caring, respectful and understanding<br>se we care for and support and our<br>We listen carefully to others to better<br>and take action to help them and ourselves. | • I am sensitive to the different needs and feelings of others and treat people with kindness<br>• I learn from others by listening carefully to them<br>• I look after my own health and well-being so that I can care for and support others |
| Excellence | o being the best we can be in our work,<br>prove and develop services to achieve<br>nges. We deliver safe, high-quality,<br>te care and support. | • I put the people I care for and support at the centre of all I do to make a difference<br>• I take responsibility for my decisions and actions<br>• I commit to best practice and sharing learning, while continually learning and developing<br>• I try to improve by asking 'could we do this better?' |
| ness & Honest | nd honest with each other and act with<br>ndour. | • I am open and honest in order to develop trusting relationships<br>• I ask someone for help when needed<br>• I speak up if I have concerns<br>• I challenge inappropriate or unacceptable behaviour and practice |

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

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# ROLE DESCRIPTION

| | |
|---|---|
| **JOB TITLE** | Interim Assistant Director Infection Prevention and Control |
| **BAND** | Band 8c |
| **DIRECTORATE** | Medical Directorate |
| **INITIAL LOCATION** | Craigavon Area Hospital |
| **REPORTS TO** | Medical Director |
| **ACCOUNTABLE TO** | Chief Executive |

## JOB SUMMARY

The post holder will provide expert clinical advice and leadership for the infection control service on behalf of the Medical Director to ensure service users are protected from the risk of acquiring infection and sustaining an environment in which excellence in care can flourish. To deliver this the post holder will work closely with Trust Directors, Executive Director of Nursing, Senior Medical staff, Heads of Departments and Link Practitioners for Infection Prevention and Control.

The post holder will provide challenge to inappropriate healthcare hygiene practice, and will be responsible for the development and implementation of strategy, policies and plans for the infection prevention and control service for the Trust. The post holder will actively promote strategies to raise awareness of infection control and decontamination issues within the Trust.

## KEY DUTIES / RESPONSIBILITIES

1. Act as the Trust expert and clinical lead for infection prevention and control, providing expert advice to clinicians, managers and other staff to manage infectious outbreaks and other untoward incidents
2. Review, develop and implement a strategy and policies for Infection Prevention and Control across the organisation
3. Responsible for providing infection control and prevention input in the procurement of specialist equipment
4. Provide expert advice on equipment decontamination issues and work closely with managers to support comprehensive Decontamination audits
5. Ensure delivery of an annual programme of infection control audits, advising on the use of suitable audit tools for local audits and regularly undertaking major audits

using appropriate research tools, analysing and evaluating the outcomes and ensuring change in practice as required

6. Lead on the monitoring of the incidence of health-related infection, management of outbreaks, investigation of hazardous practice, complaints and Serious Adverse Incidents relating to infection control
7. Lead on the interpretation of national policy relating to infection prevention and control, which will be adapted to local level and monitor the implementation of these policies
8. Work in partnership with the Department of Health, Public Health Agency, Health and Social Care Board and other partner organisations for the prevention and control of infection and management of communicable infections
9. Work in partnership with the Department of Health, Public Health Agency, Health and Social Care Board other agencies and organisations to identify gaps in service and interventions in relation to infection prevention and control, and in identifying trends in infection diseases
10. Produce infection prevention and control reports outlining progress with the Key Performance indicators identified in the annual plan

**Setting Direction and Leadership**

11. On behalf of the Medical Director provide IPC specialist advice to Trust Senior Management Team, COVID Bronze Group and COVID Bronze operational group
12. Provide leadership, guidance and oversight on the activities of the IPC team
13. Liaise with Secondary and Primary care colleagues, including General Practitioners to advise on COVID 19 care pathways with the goal of a coordinated pathway for service users
14. Liaise with Silver command group and escalate issues from a local level as appropriate

**Personal Protective Equipment (PPE)**

15. Interpret national and regional guidance on application of PPE for Trust staff
16. Provide guidance to Trust staff on appropriate PPE relevant to each clinical setting
17. Provide advice to the Director of Finance who has responsibility for PPE procurement on PPE in line with requirements in national and regional guidance
18. Represent the Trust/medical director on regional workgroups on regional management of current and future PPE strategies and usage

**Secondary Care Support**

19. Oversee the provision of IPC advice and training to Trust teams who provide services within secondary care
20. Oversee the provision of advice to clinical teams who are designing new patient pathways and services in the context of COVID
21. Oversee the provision of IPC advice to secondary care staff

**Social Care Support**

22. Oversee the provision of IPC advice and training to Trust teams who provide services within the community
23. Where appropriate as directed by DOH, support the Public Health Agency in the provision of IPC advice to independent sector providers
24. Oversee the monitoring and intelligence relating to Southern Area care homes to inform a proactive IPC response to potential and actual community COVID outbreaks

**Screening, Testing and Contact Tracing**

25. Interpret national and regional guidance on provision of screening and testing arrangements
26. Oversee local Trust implementation of regional screening, testing and contact tracing programmes
27. Represent the Trust/medical director on regional workgroups on regional screening, testing and contact tracing

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# Assistant Director of Mental Health Inpatient Services Band 8C

Working together Excellence Openness & Honesty Compassion

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# JOB DESCRIPTION

| | |
|---|---|
| **JOB TITLE** | Assistant Director of Mental Health Inpatient Services |
| **BAND** | 8C |
| **DIRECTORATE** | Mental Health & Disability Services |
| **INITIAL LOCATION** | Bluestone Unit |
| **REPORTS TO** | Director of Mental Health and Disability Services |
| **ACCOUNTABLE TO** | Director of Mental Health and Disability Services |

**JOB SUMMARY**

Reporting to the Director of Mental Health & Disability, and as a member of the Directorate's Collective Leadership Team, the post holder will be responsible and accountable for the strategic, operational, performance and business management of **all in-patient services in the Mental Health and Disability Directorate**. These currently are based on the St Luke's site in Armagh in Gillis Ward for in-patient memory services and in Craigavon Area Hospital's Bluestone campus for In-patient Mental Health and Disability Services.

- As the primary priority, s/he will ensure patient **safety** and excellent service **quality** across the services, implementing and embedding the HSC values and collective leadership behaviours.
- Provide significant input in the shaping and development of the Directorate scorecard.
- Collaborate closely with colleagues Assistant Directors for Mental Health Community Services and Community Disability Services, senior clinicians/lead professionals to implement the objectives of the agreed divisional balanced scorecard and ensure effective multidisciplinary decision-making and service delivery.

- Provide strong operational leadership to all aspects of Acute / In-patient services across the Mental Health and Disability Directorate and ensure effective management and support for operational staff.
- Provide and develop a positive working environment and open culture, which foster high morale and commitment amongst all staff and promotes their wellbeing, professional and personal development.
- Ensure that Mental Health and Disability In-patient services are developed in line with the population needs, service demand and agreed regional priorities.

Be accountable for the delivery of clinical care across all Mental Health and Disability in-patient services, and take responsibility along with the Divisional Medical Director for effective clinical governance arrangements. Fully support the Director of Mental Health and Disability Services with long term strategic planning and service reform initiatives**.**

**KEY DUTIES / RESPONSIBILITIES**

**KEY RESULT AREAS**

**Service Delivery**

1. Lead multidisciplinary teams and oversee the co-ordination of all processes to ensure the delivery of high quality and equitable care to service users in the mental health division.

2. Ensure the successful implementation of all DoH, HSCB and commissioning priorities and targets in the division.

3. Work closely with senior clinicians/lead professionals and other senior managers in the Trust to secure an appropriate balance between hospital and community based services to achieve an **integrated** approach to maximize alternatives to hospital admission

4. Lead multidisciplinary teams to deliver high quality Mental Health and Disability In-patient services and achieve all relevant targets, with particular emphasis on the Mental Health 5 year plan, You In Mind Regional Care Pathway and other regional reform and modernization programmes.

5. Ensure the effective engagement of user and carers' groups, voluntary groups and other sectors to enable their input to the design, delivery and review of service improvements.

**Quality and Governance**

6. Ensure that the needs of patients and their carers are at the core of how all services in the division are delivered, that they are safe and meet DOH Quality Standards for Health and Social Care and other relevant requirements.

7. Ensure the Trust's Mental Health and Disability In-patient services comply with all professional, regulatory and requisite standards and the discharge of statutory functions.

8. Ensure **Quality Improvement** is inclusive, data-driven and part of the culture of the division, maximized by the Assistant Director's leadership and example

9. Ensure high standards of **governance** in Mental Health and Disability In-patient services, to include compliance with standards, the assessment and management of risk and the implementation of the DOH Safety First framework.

10. Ensure the Mental Health and Disability In-patient service facilities have high standards of ambience and environmental cleanliness.

11. Ensure the Mental Health and Disability In-patient services adhere to guidance, standards and recommendations from RQIA, other professional regulatory bodies such as the GMC, NISCC, the NMC and the Royal College of Psychiatrists Centre for Quality and to pursue with vigour the Royal College Centre for Quality Improvement Quality Standards for In-Patient care.

12. Ensure performance management processes are robust and are implemented.

13. Ensure performance standards in contracts/service level agreements with independent service providers are clearly defined, monitored and achieve good outcomes for those who use their services.

14. Ensure the management of complaints within the division complies with HSC and Trust complaints procedures and are underpinned by transparency and a culture of continuous improvement.

**Service Planning and Modernisation**

15. Assist the Director of Mental Health and Disability Services with the development of a strategic plan for the delivery of mental health services to the Trust's population in line with regional strategies and priorities through an annual balanced scorecard which sets out clear, stretching and realistic objectives.

16. Promote innovation and change to underpin the modernization of the Mental Health and Disability In-patient services services in a co-produced manner.

17. Work closely with commissioners and relevant stakeholders to secure their commitment and involvement in the development and implementation of planning initiatives and service reforms.

18. Liaise closely with senior planning staff on service and capital development initiatives.

19. Act as a member of the Directorate's senior management team and contribute to its policy development processes.

20. Represent the Division and/or Directorate in Trust and/or regional planning teams as appropriate.

**Financial and Resource Management**

21. Ensure the delivery of a balanced budget / break even position.

22. Meet financial targets set for the Division.

23. Ensure the effective implementation of all Trust financial policies and procedures in the Division.

24. Participate in contract and service level negotiations with commissioners.

25. Ensure the effective management, use and maintenance of all physical assets in the Division.

**Leadership Behaviours**

26. Provide visible and effective leadership to the Division and assume responsibility and accountability for effective service delivery.

27. Role model effective leadership behaviours to team leaders and professional leads ensuring full team participation.

28. Develop effective multi-disciplinary teams across the Division that are fully inclusive of all professional groups.

29. Establish and monitor effective systems and processes of communication within the Division. Ensure regular service management meetings are in place with appropriate multi-disciplinary attendance.

30. Create a culture that fosters staff involvement, a progressive attitude to work/life balance issues, is free from harassment and bullying and respects the dignity and diversity of all staff.

**HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES**

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

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

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

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

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

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

## RAISING CONCERNS – RESPONSIBILITIES

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

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

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

## EMERGENCY PLANNING & BUSINESS CONTINUITY RESPONSIBILITIES

- Lead on the development, testing and review of relevant emergency response and business continuity plans to ensure a state of emergency preparedness for the provision of a proportionate, effective response to emergency situations and business continuity issues.

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

## PERSONAL AND PUBLIC INVOLVEMENT RESPONSIBILITIES (PPI)

- Lead on and be responsible for the planning, implementation, reporting and all other aspects relevant to the Trust's PPI Strategy within the Division or other sphere of responsibility. This will include ensuring robust arrangements are in place for active engagement with user groups and the voluntary and independent sectors in the design and delivery of services.

## GENERAL REQUIREMENTS

The post holder will be required to:

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

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

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

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

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

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

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

8. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom

he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

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

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

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# PERSONNEL SPECIFICATION

**JOB TITLE AND BAND** Assistant Director of Mental Health and Disability Services Band 8C

**DIRECTORATE** Mental Health and Disability Services

**SALARY**

**HOURS** Full time

**Ref No:** <to be inserted by HR> **January 2022**

**Notes to applicants:**

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

## ESSENTIAL CRITERIA

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

| Factor | | Method of Assessment |
|---|---|---|
| **Experience/ Qualifications/ Registration** | • Hold a University Degree or recognised Professional Qualification or equivalent qualification in a relevant[i] subject AND have a minimum of 2 years' experience in a Senior[ii] Role in a major complex organisation[iii] OR | Shortlisting by Application Form |

| | | |
|---|---|---|
| | have a minimum of 5 years' experience in a senior[ii] Role in a major complex organisation.[iii]<br>**AND**<br>• delivered against challenging performance management programmes meeting a full range of key targets and making significant improvements.<br>• worked with a diverse range of stakeholders, internal and external to the organisation, to achieve successful outcomes.<br>• experience of successfully leading major change in a challenging organisational environment.<br>• a proven track record of governance and risk management. | |
| **Other** | Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. *This criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post.* | Shortlisting by Application Form |
| **SECTION 2**: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage: | | |
| **Skills / Abilities** | Well-developed leadership, vision, strategic thinking and planning with highly developed political skills.<br><br>Demonstrated capability to plan over short, medium and long term timeframes and adjust plans and resource requirements accordingly.<br><br>Highly developed skills in leading teams, and motivating and inspiring staff. | Interview |
| **Knowledge** | Awareness of and understanding of how statutory functions e.g. adult safeguarding, self-directed support, MARAC relate to the provision of mental health services | Interview |

| | | |
|---|---|---|
| | Awareness and understanding of how specific mental health legislation e.g. Mental Health Order relates to the statutory provision of services.<br><br>Awareness of Mental Capacity legislation specifically relating to deprivation of liberty. | |

**Further Clarification on the terms used in the Specification is provided below:**

[i] *'Relevant' will be interpreted to mean any business, administrative, corporate function or health related qualification.*

[ii] *'Senior' will be interpreted to mean Band 8A or equivalent or above.*

[iii] *'Major complex organisation' is defined as one with at least 200 or more staff and/ 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.*

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

Particular attention will be given to the following dimensions:

- Inspiring Shared Purpose
- Leading with Care
- Evaluating Information
- Connecting Our Service
- Sharing the Vision
- Engaging the Team
- Holding to Account
- Developing Capability
- Influencing for Results

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

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

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

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

**THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER**

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

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

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#teamSHSCT
#bettertogether

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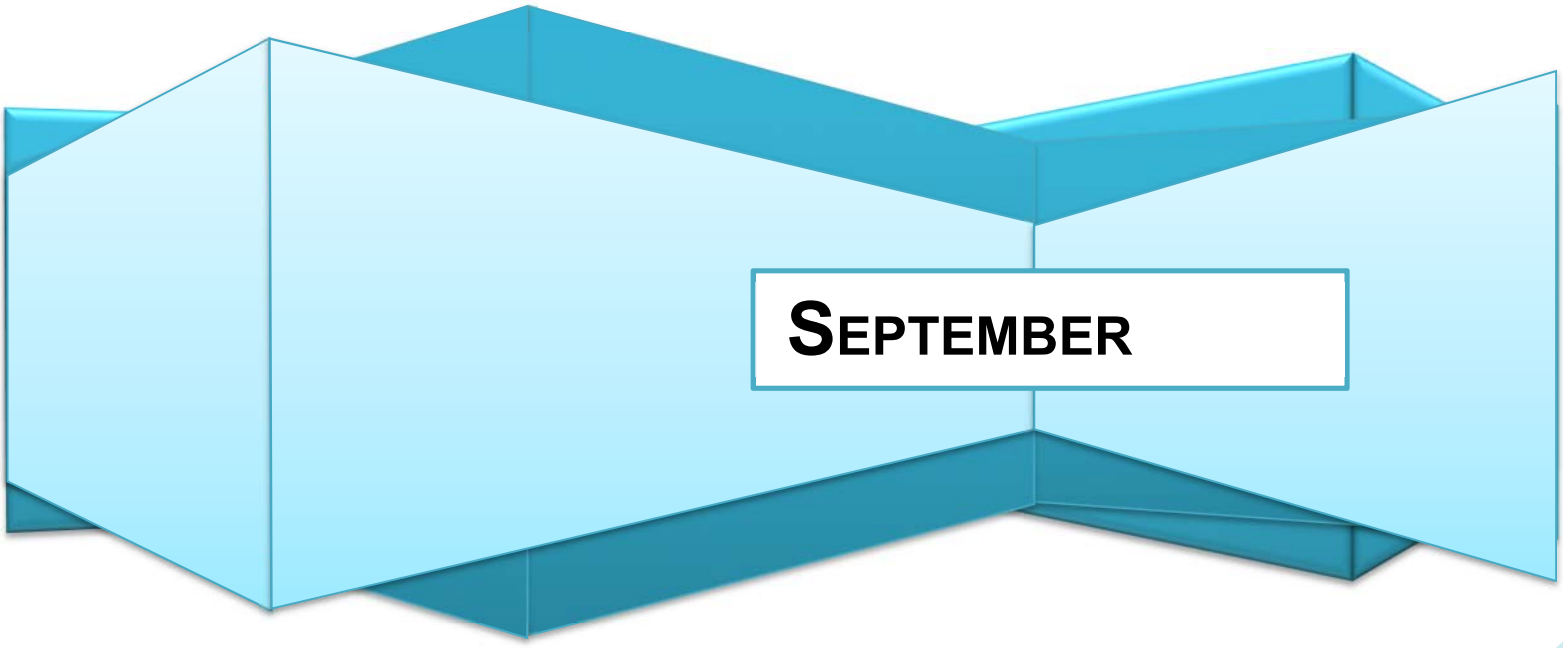
# ASSISTANT DIRECTOR OF MENTAL HEALTH
# Band 8C
## Applicant Information Pack




Working together · Excellence · Openness & Honesty · Compassion

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# Table of Contents

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## Invitation from the Director of Mental Health and Disability Services

Thank you for your interest in this role.

I have just finalised a revised structure for my senior management team which I believe will provide strong professional leadership to ensure the delivery of safe, high quality services within the portfolio of the Trust's Mental Health & Disability Directorate and which embraces collective leadership at its focus.

This is an exciting time to join our Directorate, where you will be contributing to a multi-disciplinary and collective leadership approach to decision making and service delivery.

We are currently seeking to recruit 4 key posts within the Directorate

- **Assistant Director of Mental Health**
- Assistant Director of Disability Services
- Directorate Professional Social Work Lead
- Directorate Professional Nurse Lead

These roles require highly effective, innovative and influential leaders who can ensure the needs of services users, clients and their carers are at the core of how the Trust delivers its services.

At this time of transformation of mental health, disability and dementia services, the successful applicants must have a proven track record of building strategic relationships and be highly skilled in managing change and leading teams to support and enable service users and clients to achieve their full health and well-being potential.

If you have:

- a strong value base of service to our service users, clients and community
- the drive and ambition to keep the Southern Health & Social Care Trust at the forefront of developments in health and social care;
- a compelling vision for ensuring the Directorate is a great place to work; and
- the passion and expertise to make a real contribution to our journey of continual improvement;

-then I look forward to receiving your completed application form.

For an **informal discussion about this post**, please contact me on Personal Information redacted by the USI or by email to Personal Information redacted by the USI

**Barney McNeany**
**DIRECTOR**

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# Profile of the Trust

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


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

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

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# Key Facts

- Second largest resident population compared to other Trusts in Northern Ireland at 370,000 (20% of population).

- Over the 10 year period from 2014 to 2024 - Armagh City, Banbridge and Craigavon Council Area population is projected to grow by 10.4 per cent (i.e. 21,400 people). Newry and Mourne Council Area population is projected to grow by 7.4% (i.e. 13,100 people). Both growth rates are projected above the Northern Ireland average (5.3%).

- Over the past 10 years, there has been a 15% increase in the number of births in the Southern Area compared to a regional increase of 8% for the same period.

- 14% of the Southern Trust population is over 65 years. By 2039 this is projected to grow by 60% which is higher than the NI expected growth rate of 54%.

- 16% of the Southern Trust population falls within the NI's most deprived quintile.

- The Trust has the highest level of children with statements of educational need in NI.

- Central & Eastern European migration accounts for 4.2% of the Trust population, compared to the NI average of 2.2%.

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

In 2017/18 the Southern Trust treated:

**147,829** Emergency Department Attendances

**59,879** Inpatients

**375,034** Outpatient Appointments

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

**6,050** people supported by Domiciliary Care Services in their own Home

**2,177** Residential and Nursing Home placements

**£1.5m** annual expenditure on community equipment

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# Vision, Values & Priorities of the Trust

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

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

The Trust is committed to its values in all our interactions with each other including colleagues, patients, carers and service users.

| | |
|---|---|
|  | We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all. |
|  | We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high-quality, compassionate care and support. |
|  | We are open and honest with each other and act with integrity and candour. |
|  | We are sensitive caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves. |

Our **Corporate Objectives** reflect our priorities for the delivery of health and social care services to our local population. Achieving our objectives and delivering saf

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quality care and services which are accessible and responsive to our patients and carers will remain our central focus:

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***Our Corporate Plan "Improving Together" 2017/18 - 2020/21***

It should be noted that we will shortly be entering a phase of agreeing a new corporate plan for the next 3-5 years

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

For further information on the documents below visit:
http://www.southerntrust.hscni.net/about/Publications.htm

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

***Southern Trust on Social Media***

Click here to view the Southern Trust's Facebook page.
Click here to view the Southern Trust's Twitter account.
Click here to view the Southern Trust's YouTube Channel.

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# Directorate Score Cards

| Corporate Objectives – DMHD Disability Division | |
|---|---|
| **Promoting safe, high quality care & Improving our services** | ▪ Implement Action Plans arising from regional Review of Learning Disability as per agreed milestones and funding..<br>▪ Streamline service Pathway for Service Users with Autism in conjunction with MH by 31 December 2019.<br>▪ Increase the number of RQIA reports with 0-<3 recommendations in-year by 4?<br>▪ Undertake 1 QI project in each service area in 2019-20 enhancing safety and/or Service User experience.<br>▪ Implement Day Service Review Recommendations per plan.<br>▪ Plan the Enhancement and extension of alternative housing models by Quarter 4.<br>▪ Review progress and develop action plan on implementation of Physical and Sensory Disability strategy by Quarter 4. |
| **Supporting people to live healthy lives** | ▪ Appoint an Acute Liaison Nurse to improve care for LD in Acute and promote uptake of Passport Scheme by 30 September 2019.<br>▪ Improve Tenant inclusion and independence in Supported Living schemes by 31 March 20.<br>▪ Pilot joint-working with MH colleagues in Addiction to improve services for users with complex disability by Quarter 3.<br>▪ Pilot CBT for those SUs with Tinnitus by Quarter 3.<br>▪ Robust plan for Improving our Short Break provision by Quarter 4.<br>▪ Review and evaluate Complex Care Pathway & Service by Quarter 3.<br>▪ Demonstrate 2 improvements in treatment services by Q3. |

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| Corporate Objectives | |
|---|---|
| **Being a great place to work** | ▪ Develop a Workforce plan for 2019-20 for Disability Services by 31 October 2019.<br>▪ Undertake team building events in each service at least once per year for all service areas.<br>▪ Undertake 3 staff recognition events in 2019-20 specific to Disability.<br>▪ Drive vacancy rate reduction by 10% across 6 key services by Quarter 4.<br>▪ Develop, analyse and utilise exit interviews to improve retention, recruitment and staff morale by Quarter 3.<br>▪ Enhance multi-disciplinary team working by Quarter 3.<br>▪ Develop and maintain professional fora e.g. LD Nursing Forum.<br>▪ Take forward a Disability supported employment scheme within Trust with target employment of 6 protected band 1 positions in year 1 of scheme for adults with Learning Disability. |
| **Working in partnership & making the best use of our resources** | ▪ Embed improvements in Carer involvement & engagement.<br>▪ Break Even by Quarter 4.<br>▪ Reduce Absence by 1% on April 2019 baseline by Quarter 4.<br>▪ Complete the implementation of PARIS and pilot hand-held devices in 1 area subject to Business Case approval.<br>▪ Review and evaluate 12 contracts with the C&V sector to improve services by Quarter 3.<br>▪ Embed revised accountability arrangement through the use of data by Quarter 2.<br>▪ Further develop & embed Co-Production by end of Quarter 4.<br>▪ Improve hospital/ community interface through 3 changes/ enhancements by Quarter 4. |

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| Corporate Objectives – DMHD Mental Health Division | |
|---|---|
| **Promoting safe, high quality care & Improving our services** | ▪ Implement Action plan from the Royal College of Psychiatrists Review of Bluestone, Dorsey and Gillis as per milestones.<br>▪ Undertake 2 QI projects in each service area in 2019-20 enhancing safety and/or Service User experience.<br>▪ Review, revise and implement a Service Model to better meet the needs of Service Users requiring Primary MH Services inc Step 2, Addictions, Well-mind hub and the Recovery College.<br>▪ Review service provision for Personality Disorder Services and identify priorities.<br>▪ Embed dementia pathway and revise service model for <65 years.<br>▪ Develop a revised process for SAIs and embedding learning.<br>▪ Implement Enhanced Liaison model & review by end of Quarter 4 2019-20. |
| **Supporting people to live healthy lives** | ▪ Develop the Carers Conversation Wheel across all service areas.<br>▪ Further physical health improvements for MH Service Users Quarter 3.<br>▪ Embed the Navigator model throughout services to improve health and wellbeing by Quarter 4.<br>▪ Further develop Rehabilitation Services including bids for 7 day working and alternative care arrangements by Q4 subject to funding.<br>▪ Develop a Band 4 Recovery Worker model and pilot in 1 area by the end of 2019-20.<br>▪ Further embed the MH Pathway across the year.<br>▪ Develop a supervision framework for Psychological Therapies by Quarter 3. |

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| Corporate Objectives | |
|---|---|
| **Being a great place to work** | • Develop a Mental Health Workforce Plan by end of Quarter 3.<br>• Undertake team building events in each service at least once per year for all service areas.<br>• Undertake 5 MH staff recognition events in 2019-20.<br>• Drive vacancy rate reduction by 10% across 6 key areas by Quarter 4.<br>• Develop, analyse and utilise exit interviews in areas with high turnover by end of Quarter 3.<br>• Co-design and implement a revised Peer Support Worker structure and increase the numbers of PSWs by 6 in 2019-20.<br>• Enhance multi-disciplinary team working across 4 services by Quarter 4.<br>• Develop a collective leadership model in MH&D. |
| **Working in partnership & making the best use of our resources** | ▪ Further embed CAPA across community services.<br>▪ Break even.<br>▪ Strive to meet and address Targets for access.<br>▪ Embed accountability arrangements through data/NHS B'markg<br>▪ Reduce Absence by 1% by Quarter 4 2019-20.<br>▪ Further develop C&V partners role in early intervention.<br>▪ Complete the implementation of PARIS and pilot hand-held devices in 1 key area subject to Business Case.<br>▪ Further develop Crisis work with LIFELINE by Quarter 3.<br>▪ Enhance joint working arrangements with the MH Forum by Quarter 2.<br>▪ Adopt Towards Zero Suicide objectives by Quarter 3. |

# SENIOR MANAGEMENT STRUCTURE

## Mental Health & Disability Services

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# JOB DESCRIPTION

**POST** **Assistant Director of Mental Health**

**BAND** **8c**

**DIRECTORATE** **Mental Health and Disability Services**

**INITIAL LOCATION** **Bannvale House**

**REPORTS TO** **Director of Mental Health and Disability Services**

**ACCOUNTABLE TO** **Director of Mental Health and Disability Services**

## JOB SUMMARY

Reporting to the Director of Mental Health & Disability, and as a member of the Directorate's Senior Management Team, the post holder will be responsible and accountable for the strategic, operational, performance and business management of the Mental Health Division.

- As the primary priority, s/he will ensure patient safety and excellent service quality across the Division, implementing and embedding the HSC values and collective leadership behaviours.
- Provide significant input in the shaping and development of the Directorate plan.
- Collaborate closely with senior clinicians/lead professionals to implement the objectives of the agreed divisional balanced scorecard and ensure effective multidisciplinary decision-making and service delivery.
- Provide strong operational leadership to all aspects of the Mental Health Division and ensure effective management and support for operational staff.
- Provide and develop a positive working environment and open culture which foster high morale and commitment amongst all staff and promotes their wellbeing, professional and personal development.
- Ensure that Mental Health services are developed in line with population needs, service demand and agreed regional priorities.
- Be accountable for the delivery of clinical care across all Mental Health services, and take responsibility along with the Associate Medical Director for effective clinical governance arrangements.Fully support the Director of Mental Health and Disability Services with long term strategic planning and service reform initiatives

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## 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 service users in the mental health division.
- Ensure the successful implementation of all DoH, HSCB and commissioning priorities and targets in the division.
- Work closely with senior clinicians/lead professionals and other senior managers in the Trust to secure an appropriate balance between hospital and community based services to achieve an integrated approach to maximize alternatives to hospital admission
- Lead multidisciplinary teams to deliver high quality mental health and social care services and achieve all relevant targets, with particular emphasis on the Mental Health 5 year plan, You In Mind Regional Care Pathway and other regional reform and modernization programmes.
- Ensure the effective engagement of user and carers' groups, voluntary groups and other sectors to enable their input to the design, delivery and review of service improvements.

### Quality and Governance

- Ensure that the needs of patients and their carers are at the core of how all services in the division are delivered, that they are safe and meet DOH Quality Standards for Health and Social Care and other relevant requirements.
- Ensure the Trust's mental health services comply with all professional, regulatory and requisite standards and the discharge of statutory functions.
- Ensure Quality Improvement is inclusive, data-driven and part of the culture of the division, maximized by the Assistant Director's leadership and example
- Ensure high standards of governance in the division, to include compliance with standards, the assessment and management of risk and the implementation of the DOH Safety First framework.
- Ensure the division's facilities have high standards of ambience and environmental cleanliness.
- Ensure the division's services adhere to guidance, standards and recommendations from RQIA, other professional regulatory bodies such as the GMC, NISCC, the NMC and the Royal College of Psychiatrists Centre for Quality.
- Ensure performance management processes are robust and are implemented.
- Ensure performance standards in contracts/service level agreements with independent service providers are clearly defined, monitored and achieve good outcomes for those who use their services.

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- Ensure the management of complaints within the division complies with HSC and Trust complaints procedures and are underpinned by transparency and a culture of continuous improvement.

**Service Planning and Modernisation**

- Assist the Director of Mental Health and Disability Services with the development of a strategic plan for the delivery of mental health services to the Trust's population in line with regional strategies and priorities through an annual balanced scorecard which sets out clear, stretching and realistic objectives.
- Promote innovation and change to underpin the modernisation of the division's services in a co-produced manner.
- 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.
- 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**

- Ensure the delivery of a balanced budget / break even position.
- Meet financial targets set for the Division.
- Ensure the effective implementation of all Trust financial policies and procedures in the Division.
- Participate in contract and service level negotiations with commissioners.
- Ensure the effective management, use and maintenance of all physical assets in the Division.

**Leadership Behaviours**

- Provide visible and effective leadership to the Division and assume responsibility and accountability for effective service delivery.
- Role model effective leadership behaviours to team leaders and professional leads ensuring full team participation.
- Develop effective multi-disciplinary teams across the Division that are fully inclusive of all professional groups.

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- Establish and monitor effective systems and processes of communication within the Division. Ensure regular service management meetings are in place with appropriate multi-disciplinary attendance.
- Create a culture that fosters staff involvement, a progressive attitude to work/life balance issues, is free from harassment and bullying and respects the dignity and diversity of all staff.

**Human Resource Management Responsibilities**

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

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

**Emergency Planning and Business Continuity Responsibilities**

- Actively promote the development of an emergency management strategy with the Directorate to ensure a state of preparedness to respond to a range of internal and external emergency situations.

**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.

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

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

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

- 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 Act 2018. Employees are required to be conversant with the Trust's policy and procedures on records management and to seek advice if in doubt.

- 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.

- 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.

- Available / able to work any 5 days out of 7 over the 24 hour period, which may include on-call / stand-by / sleep-in duties, shifts, night duty, weekends and Public Holidays if required immediately on appointment or at a later stage following commencement in response to changing demands of the service.

- Understand that this post may evolve over time, and that this Job Description will therefore be subject to review in the light of changing circumstances. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

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

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

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# PERSONNEL SPECIFICATION

**JOB TITLE:** Assistant Director of Mental Health

**DEPARTMENT:** Mental Health Division, Mental Health & Disability Directorate

**SALARY:** Band 8c

**HOURS:** Full time

**September 2019**

**Notes to applicants:**

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

## ESSENTIAL CRITERIA

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

| Factor | Criteria | Method of Assessment |
|---|---|---|
| **Experience / Qualifications/ Registration** | • Hold a University Degree or recognised Professional Qualification or equivalent qualification in a relevant[i] subject AND have a minimum of 2 years' experience in a Senior[ii] Role in a major complex organisation[iii] OR have a minimum of 5 years' experience in a senior[ii] Role in a major complex organisation.[iii]<br>AND<br>• delivered against challenging performance management programmes meeting a full range of key targets and making significant improvements. | Shortlisting by Application Form |

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| | | |
|---|---|---|
| | • worked with a diverse range of stakeholders, internal and external to the organisation, to achieve successful outcomes<br>• experience of successfully leading major change in a challenging organisational environment<br>• a proven track record of governance and risk management | |
| **Other** | Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. This criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post | Shortlisting by Application Form |

| **SECTION 2**: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage: | | |
|---|---|---|
| **Skills / Abilities** | Well-developed leadership, vision, strategic thinking and planning with highly developed political skills.<br><br>Demonstrated capability to plan over short, medium and long term timeframes and adjust plans and resource requirements accordingly.<br><br>Highly developed skills in leading teams, and motivating and inspiring staff. | Interview |
| **Knowledge** | Awareness of and understanding of how statutory functions e.g. adult safeguarding, self directed support, MARAC relate to the provision of mental health services<br><br>Awareness and understanding of how specific mental health legislation e.g. Mental Health Order relates to the statutory provision of services.<br><br>Awareness of impending changes to Mental Capacity legislation specifically relating to deprivation of liberty. | Interview |

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**Further Clarification on the terms used in the Specification is provided below:**

[i] *'Relevant' will be interpreted to mean any business, administrative, corporate function or health related qualification.*

[ii] *'Senior' will be interpreted to mean Band 8A or equivalent or above.*

[iii] *'Major complex organisation' is defined as one with at least 200 or more staff and/ 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.*

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

- Inspiring Shared Purpose
- Leading with Care
- Evaluating Information
- Connecting Our Service
- Sharing the Vision
- Engaging the Team
- Holding to Account
- Developing Capability
- Influencing for Results

| DESIRABLE CRITERIA | | |
|---|---|---|
| **SECTION 3:** These will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these criteria. Failure to do so may result in you not being shortlisted. | | |
| **Factor** | **Criteria** | **Method of Assessment** |
| **Experience** | Experience of leading and delivering a range of mental health services.<br><br>Experience of using quality improvement methodologies to support service change and development.<br><br>Experience of building and maintaining accreditation and benchmarking in relation to mental health. | Shortlisting by Application Form |

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

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# Terms & Conditions of Service

**Hours –** Full-Time. The set hours of work are 37.5 hours per week however the number and pattern of hours will reflect the demands of the post.

**Remuneration –** £58,504 - £71,243 per annum

**Annual Leave and Statutory / Public holidays –** the Trust offers excellent provision for annual leave and Public / Statutory Holidays. In addition to 10 statutory/public holidays, the annual leave allowance will be between 27 and 33 days.

**HSC Pension Scheme / HPSS Superannuation Scheme**

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

| Pensionable Pay from (£) | Pensionable Pay to (£) | Employee Contribution Tier % |
|---|---|---|
| - | 15,431.99 | 5.0% |
| 15,432.00 | 21,477.99 | 5.6% |
| 21,478.00 | 26,823.99 | 7.1% |
| 26,824.00 | 47,845.99 | 9.3% |
| 47,846.00 | 70,630.99 | 12.5% |
| 70,631.00 | 111,376.99 | 13.5% |
| 111,377.00 | and above | 14.5% |

**Human Resources Policies**

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

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

The HSC Code of Conduct is available on request.

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**Committed to Equality of Opportunity**

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

# Completing your Application Form

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

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

**Completing the Criminal Convictions / Offences Section**

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

The Trust is committed to the equality of opportunity for all applicants, including those with criminal convictions. We will undertake to ensure an open, measured and recorded discussion on the subject of any offences or other matters that might be considered relevant for the position concerned e.g. the individual is applying for a driving job but has a conviction history of driving offences. This will be conducted following the selection process

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if this applies to the successful candidate. Whilst the disclosure of information will not automatically prevent an individual from obtaining employment, it is essential that all convictions (other than protected convictions) are disclosed to allow the Trust to adequately consider their relevance to the post in question. The Trust considers failure by applicants to declare complete and accurate information about convictions to be a serious breach of trust.

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

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

**Completing the Medical History Section**

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

**Meeting the Criteria set out in the Personnel Specification**

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

**Completing the Reference Section**

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

**Completing Your Current / Previous Employment Details**

- Ensure that full details are provided.
- Be specific about all the dates that you provide, in the format DD.MM.YYYY.
- Explain any gaps between periods of employment and include reasons for leaving each post.

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- Provide a list of key duties that you have been responsible for in current post / previous posts.

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

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

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

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

**Advising us if you are not available to attend for assessment / interview**
If you have any planned holidays, it is useful to tell us about this by detailing it on your application form. However please note that the selection panel are under no obligation to take these into account when arranging assessment / interview dates.

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

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

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# Closing Date for Receipt of Completed Applications

The closing date for receipt of completed applications is **Friday 20th September 2019 at 12.00noon**

Applications can be submitted via www.jobs.hscni.net or in hard copy format to:

Recruitment Shared Service Centre
Business Services Organisation
Rosewood Villa
Longstone Hospital Site
73 Loughgall Road
Armagh
BT61 7PR

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

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

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# Selection Process

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

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

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

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

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

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

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# Useful Links / Further Information

Further details on the HSCNI may be obtained from;

**Southern Trust Website** - http://www.southerntrust.hscni.net/ or you can follow us on Facebook or Twitter

Click here to view the Southern Trust's Facebook page.
Click here to view the Southern Trust's Twitter account.
Click here to view the Southern Trust's YouTube Channel.

**Department of Health** www.doh.gov.uk

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# Assistant Director of Disability Services Band 8c

Working together Excellence Openness & Honesty Compassion

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# JOB DESCRIPTION

| | |
|---|---|
| **JOB TITLE** | Assistant Director of Disability Services |
| **BAND** | Band 8c |
| **DIRECTORATE** | Mental Health and Disability Services |
| **INITIAL LOCATION** | Bannvale House |
| **REPORTS TO** | Director of Mental Health and Disability Services |
| **ACCOUNTABLE TO** | Director of Mental Health and Disability Services |

**JOB SUMMARY**

Reporting to the Director of Mental Health & Disability, and as a member of the Directorate's Senior Management Team, the post holder will be responsible and accountable for the strategic, operational, performance and business management of the Disability Services Division.

- As the primary priority, s/he will ensure patient safety and excellent service quality across the Division, implementing and embedding the HSC values and collective leadership behaviours.
- Provide significant input in the shaping and development of the Directorate plan.
- Collaborate closely with senior clinicians/lead professionals to implement the objectives of the agreed divisional balanced scorecard and ensure effective multidisciplinary decision-making and service delivery.
- Provide strong operational leadership to all aspects of the Disability Services Division and ensure effective management and support for operational staff.
- Provide and develop a positive working environment and open culture which foster high morale and commitment amongst all staff and promotes their wellbeing, professional and personal development.
- Ensure that Disability Services are developed in line with population needs, service demand and agreed regional priorities.
- Be accountable for the delivery of clinical care across all Disability Services, and take responsibility along with the Associate Medical Director for effective clinical governance arrangements.Fully support the Director of Mental Health and Disability Services with long term strategic planning and service reform initiatives.

## 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 service users in the Disability Services Division.
- Ensure the successful implementation of all DoH, HSCB and commissioning priorities and targets in the division.
- Work closely with senior clinicians/lead professionals and other senior managers in the Trust to secure an appropriate balance between hospital and community based services to achieve an integrated approach to maximize alternatives to hospital admission
- Lead multidisciplinary teams to deliver high quality Disability and Social Care services and achieve all relevant targets, with particular emphasis on the Learning Disability Review, Physical and Sensory Disability strategy and other regional reform and modernization programmes.
- Ensure the effective engagement of user and carers' groups, voluntary groups and other sectors to enable their input to the design, delivery and review of service improvements.

### Quality and Governance

- Ensure that the needs of patients and their carers are at the core of how all services in the division are delivered, that they are safe and meet DOH Quality Standards for Health and Social Care and other relevant requirements.
- Ensure the Trust's Disability Services comply with all professional, regulatory and requisite standards and the discharge of statutory functions.
- Ensure Quality Improvement is inclusive, data-driven and part of the culture of the division, maximized by the Assistant Director's leadership and example
- Ensure high standards of governance in the division, to include compliance with standards, the assessment and management of risk and the implementation of the DOH Safety First framework.
- Ensure the division's facilities have high standards of ambience and environmental cleanliness.
- Ensure the division's services adhere to guidance, standards and recommendations from RQIA, other professional regulatory bodies such as the GMC, NISCC, the NMC and the Royal College of Psychiatrists Centre for Quality.
- Ensure performance management processes are robust and are implemented.
- Ensure performance standards in contracts/service level agreements with independent service providers are clearly defined, monitored and achieve good outcomes for those who use their services.
- Ensure the management of complaints within the division complies with HSC and Trust complaints procedures and are underpinned by transparency and a culture of continuous improvement.

**Service Planning and Modernisation**

- Assist the Director of Mental Health and Disability Services with the development of a strategic plan for the delivery of Disability Services to the Trust's population in line with regional strategies and priorities through an annual balanced scorecard which sets out clear, stretching and realistic objectives.
- Promote innovation and change to underpin the modernization of the division's services in a co-produced manner.
- 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.
- 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**

- Ensure the delivery of a balanced budget / break even position.
- Meet financial targets set for the Division.
- Ensure the effective implementation of all Trust financial policies and procedures in the Division.
- Participate in contract and service level negotiations with commissioners.
- Ensure the effective management, use and maintenance of all physical assets in the Division.

**Leadership Behaviours**

- Provide visible and effective leadership to the Division and assume responsibility and accountability for effective service delivery.
- Role model effective leadership behaviours to team leaders and professional leads ensuring full team participation.

- Develop effective multi-disciplinary teams across the Division that are fully inclusive of all professional groups.
- Establish and monitor effective systems and processes of communication within the Division. Ensure regular service management meetings are in place with appropriate multi-disciplinary attendance.
- Create a culture that fosters staff involvement, a progressive attitude to work/life balance issues, is free from harassment and bullying and respects the dignity and diversity of all staff.

**HUMAN RESOURCES MANAGEMENT RESPONSIBILITIES**

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

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

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

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

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

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

## EMERGENCY PLANNING AND BUSINESS CONTINUITY RESPONSIBILITIES

- Lead on the development, testing and review of relevant emergency response and business continuity plans to ensure a state of emergency preparedness for the provision of a proportionate, effective response to emergency situations and business continuity issues.

## RAISING CONCERNS - RESPONSIBILITIES

- The post holder will promote and support effective team working, fostering a culture of openness and transparency.
- The post holder will ensure that they take all concerns raised with them seriously and act in accordance with the Trust's 'Your Right to Raise a Concern (Whistleblowing)' policy and their professional code of conduct, where applicable.
- The post holder will, in the event of a concern being raised with them, ensure that it is managed correctly under the Trust's 'Your Right to Raise a Concern (Whistleblowing)' policy and ensure feedback/learning is communicated at individual, team and organisational level.

## PERSONAL AND PUBLIC INVOLVEMENT RESPONSIBILITIES (PPI)

- Lead on and be responsible for the planning, implementation, reporting and all other aspects relevant to the Trust's PPI Strategy within the Division or other sphere of responsibility. This will include ensuring robust arrangements are in place for active engagement with user groups and the voluntary and independent sectors in the design and delivery of services.

## GENERAL REQUIREMENTS

The post holder will be required to:

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

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

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

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

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

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

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

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

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

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

***March 2022***

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# PERSONNEL SPECIFICATION

**JOB TITLE AND BAND** Assistant Director of Disability Services Band 8c

**DEPARTMENT / DIRECTORATE** Mental Health and Disability Services

**SALARY**

**HOURS** **37.5**

**Ref No:** <to be inserted by HR> **March 2022**

**Notes to applicants:**

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

## ESSENTIAL CRITERIA

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

| Factor | | Method of Assessment |
|---|---|---|
| **Experience / Qualifications/ Registration** | 1. Hold a University Degree or recognised Professional Qualification or equivalent qualification in a relevant[i] subject AND have a minimum of 2 years' experience in a Senior[ii] Role in a major complex organisation[iii] OR have a minimum of 5 years' | Shortlisting by Application Form |

| | | |
|---|---|---|
| | experience in a senior[ii] Role in a major complex organisation.[iii]<br>AND<br>2. delivered against challenging performance management programmes meeting a full range of key targets and making significant improvements.<br>3. worked with a diverse range of stakeholders, internal and external to the organisation, to achieve successful outcomes<br>4. experience of successfully leading major change in a challenging organisational environment<br>*5.* a proven track record of governance and risk management | |
| **Other** | 6. Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. This criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post. | Shortlisting by Application Form |
| **SECTION 2**: The following are **ESSENTIAL** criteria which will be measured during the interview/ selection stage: | | |
| **Skills / Abilities** | 1. Well-developed leadership, vision, strategic thinking and planning with highly developed political skills.<br>2. Demonstrated capability to plan over short, medium and long term timeframes and adjust plans and resource requirements accordingly.<br>3. Highly developed skills in leading teams, and motivating and inspiring staff. | Interview |
| **Knowledge** | 4. Awareness of and understanding of how statutory functions e.g. Equal | Interview |

| | | |
|---|---|---|
| | Lives, Learning Disability Services Review, Physical and Sensory Disability Strategy relate to the provision of mental health services.<br><br>5. Awareness and understanding of how specific mental health legislation e.g. Mental Health Order relates to the statutory provision of services.<br><br>6. Awareness of impending changes to Mental Capacity legislation specifically relating to deprivation of liberty | |

| **DESIRABLE CRITERIA** | | |
|---|---|---|
| **SECTION 3:** these will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application | | |
| **Factor** | | **Method of Assessment** |
| **Experience** | 1. Experience of leading and delivering a range of disability services.<br><br>2. Experience of using quality improvement methodologies to support service change and development.<br><br>3. Experience of building and maintaining accreditation and benchmarking in relation to disability. | Shortlisting by Application Form |

**Further Clarification on the terms used in the Specification is provided below:**

[i] *'Relevant' will be interpreted to mean any business, administrative, corporate function or health related qualification.*

[ii] *'Senior' will be interpreted to mean Band 8A or equivalent or above.*

[iii] *'Major complex organisation' is defined as one with at least 200 or more staff and/ 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.*

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

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

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

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

**THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER**

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

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

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#teamSHSCT
#bettertogether

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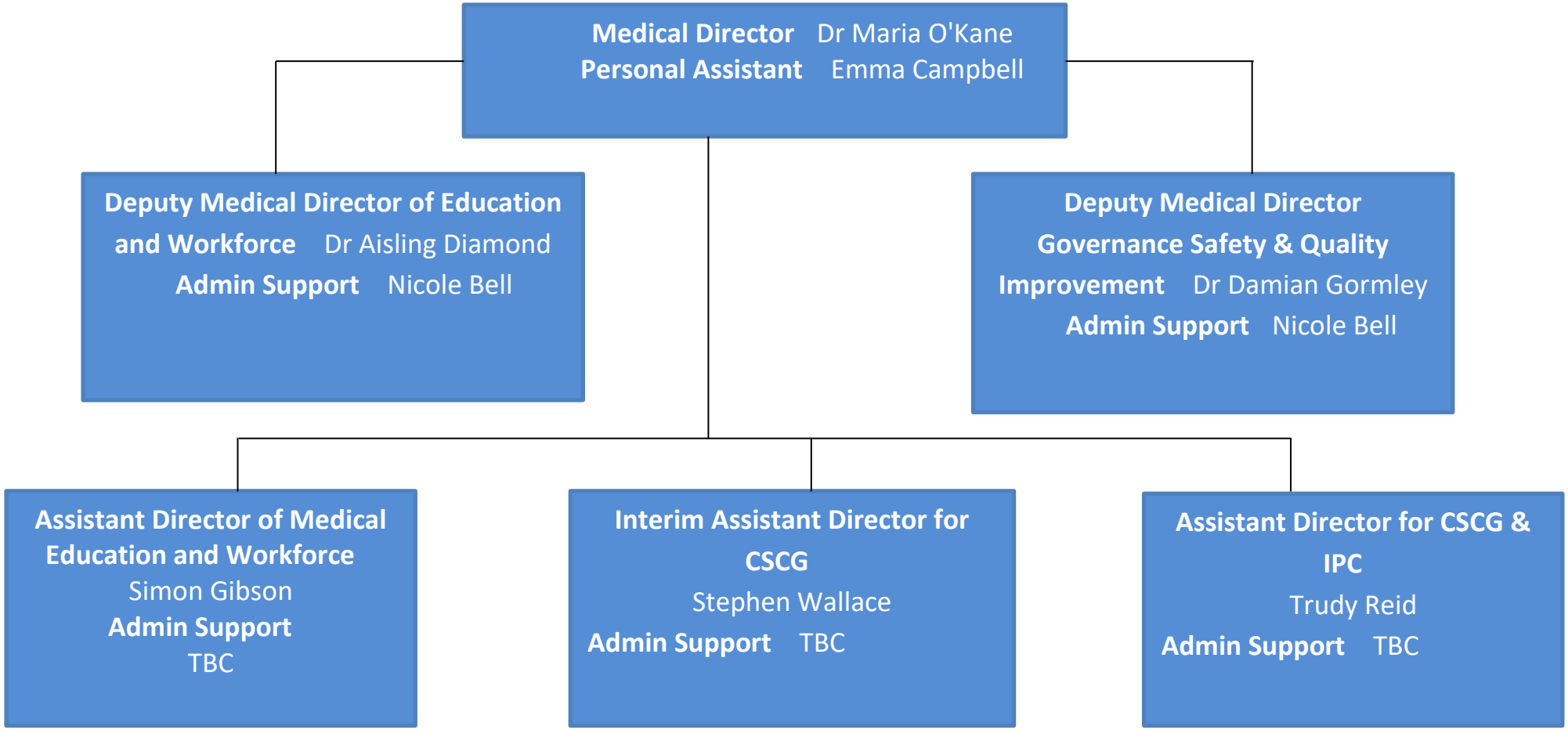
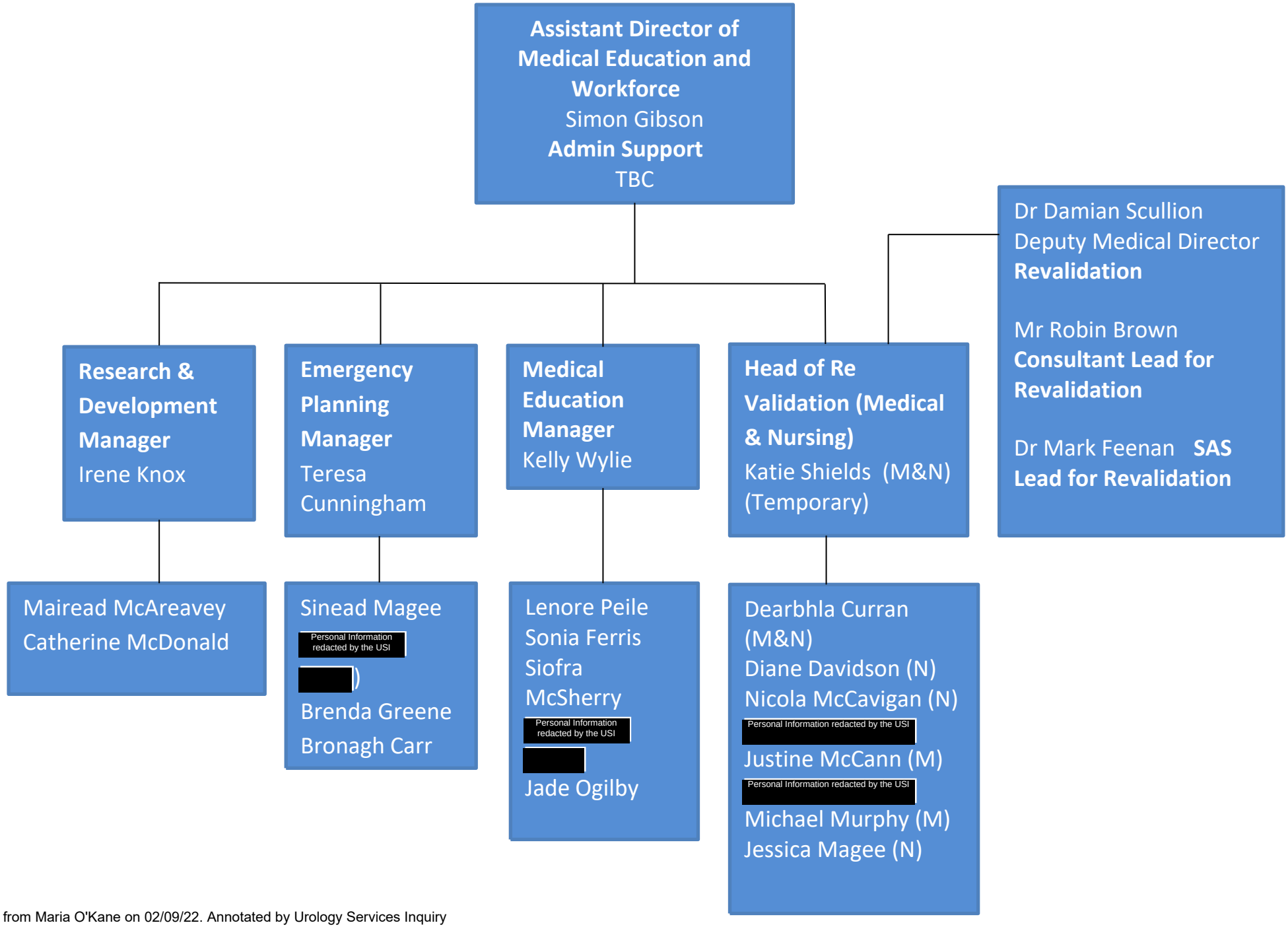
MEDICAL DIRECTORATE STRUCTURE FROM XXXXX TO 31 JANUARY 2021

# Medical Directorate



MEDICAL DIRECTORATE STRUCTURE FROM XXXXX TO 31 JANUARY 2021



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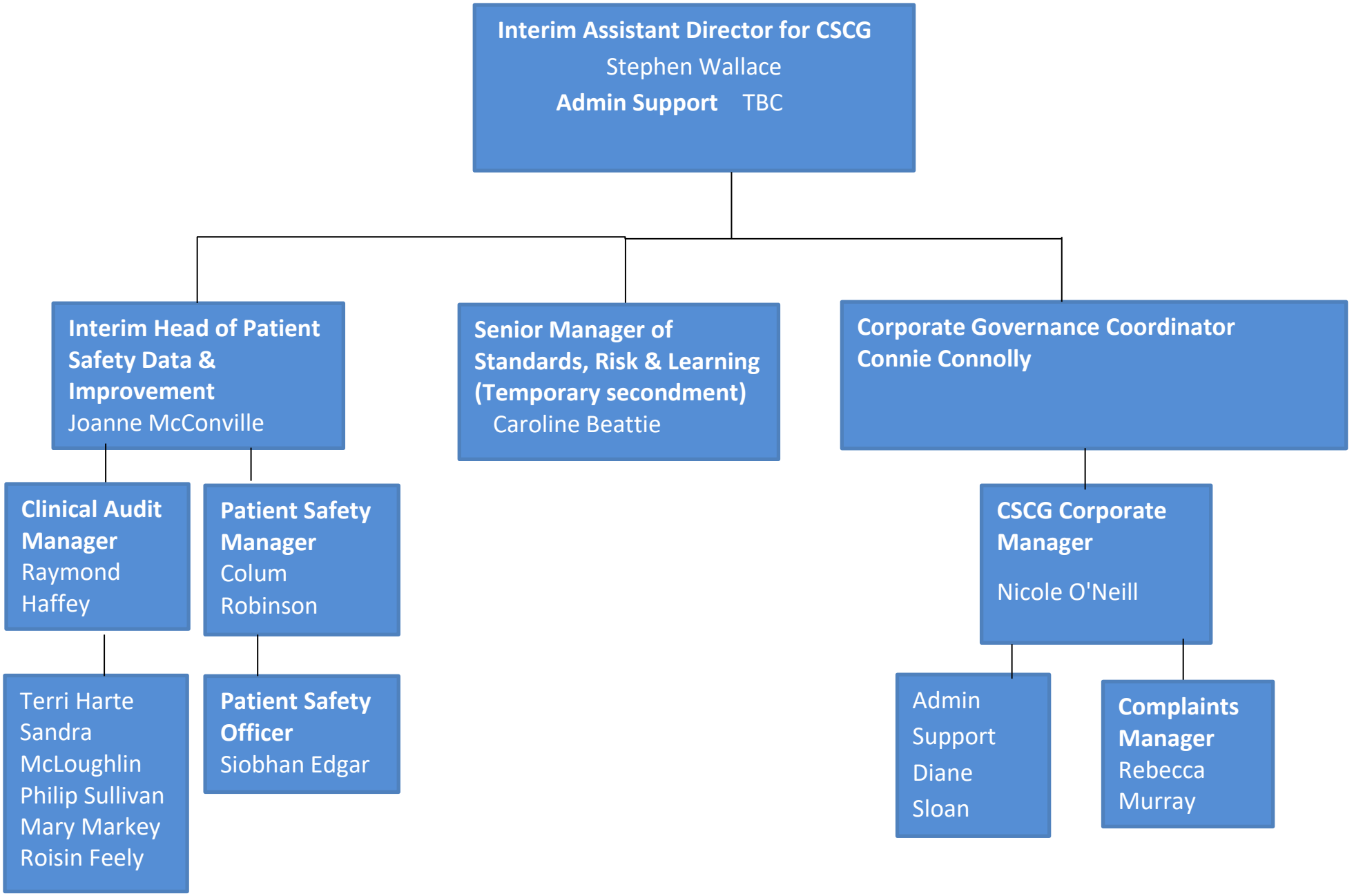

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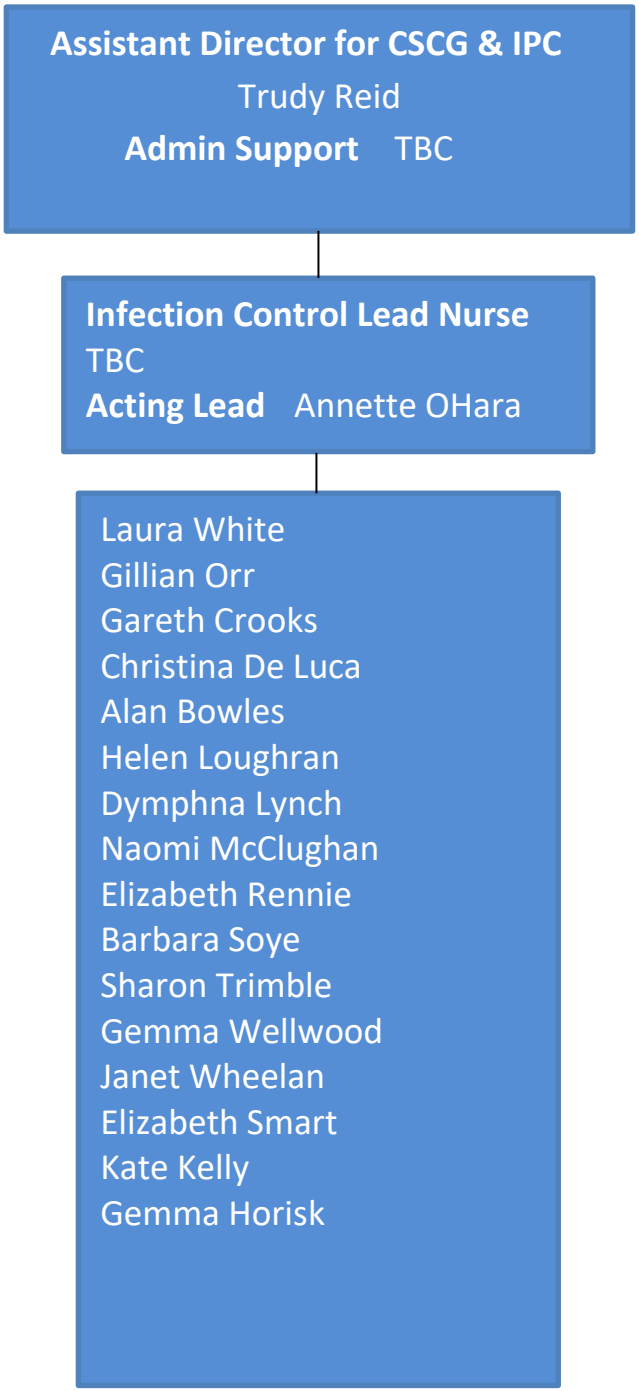
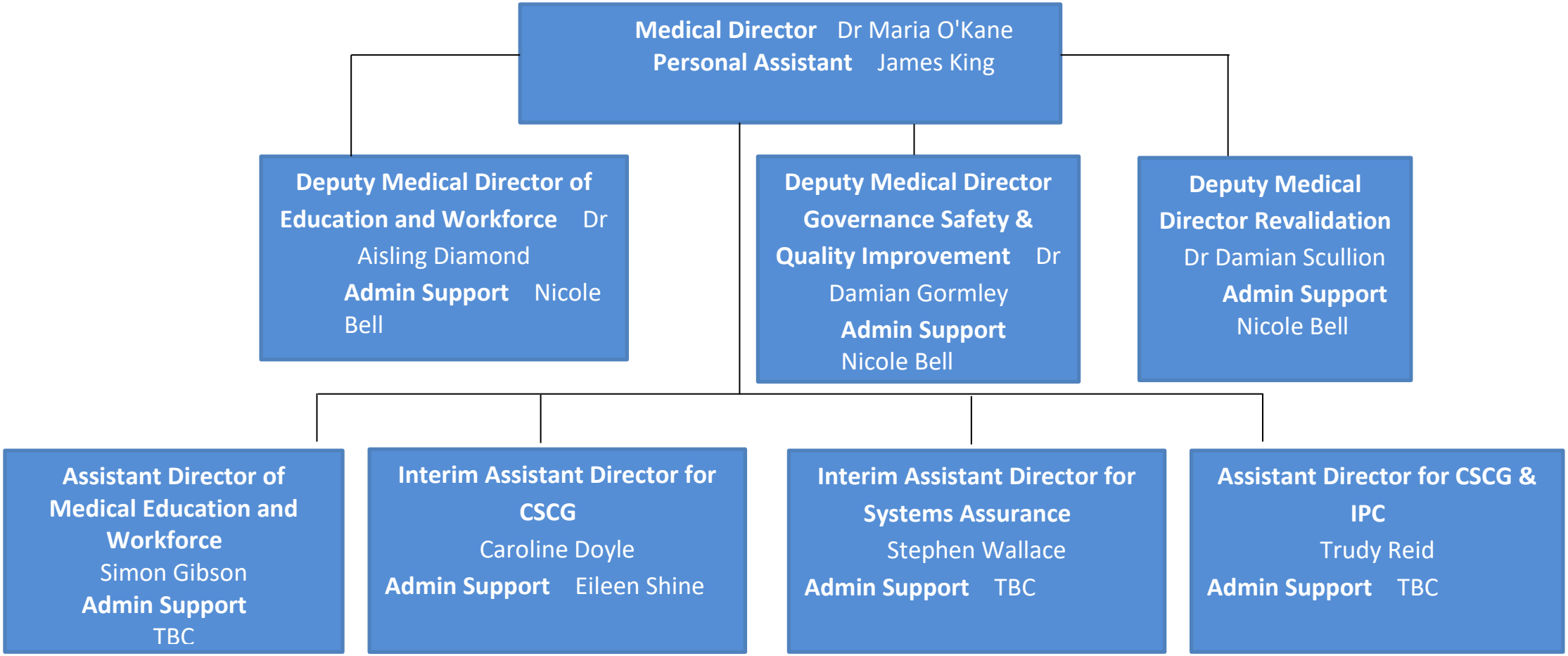
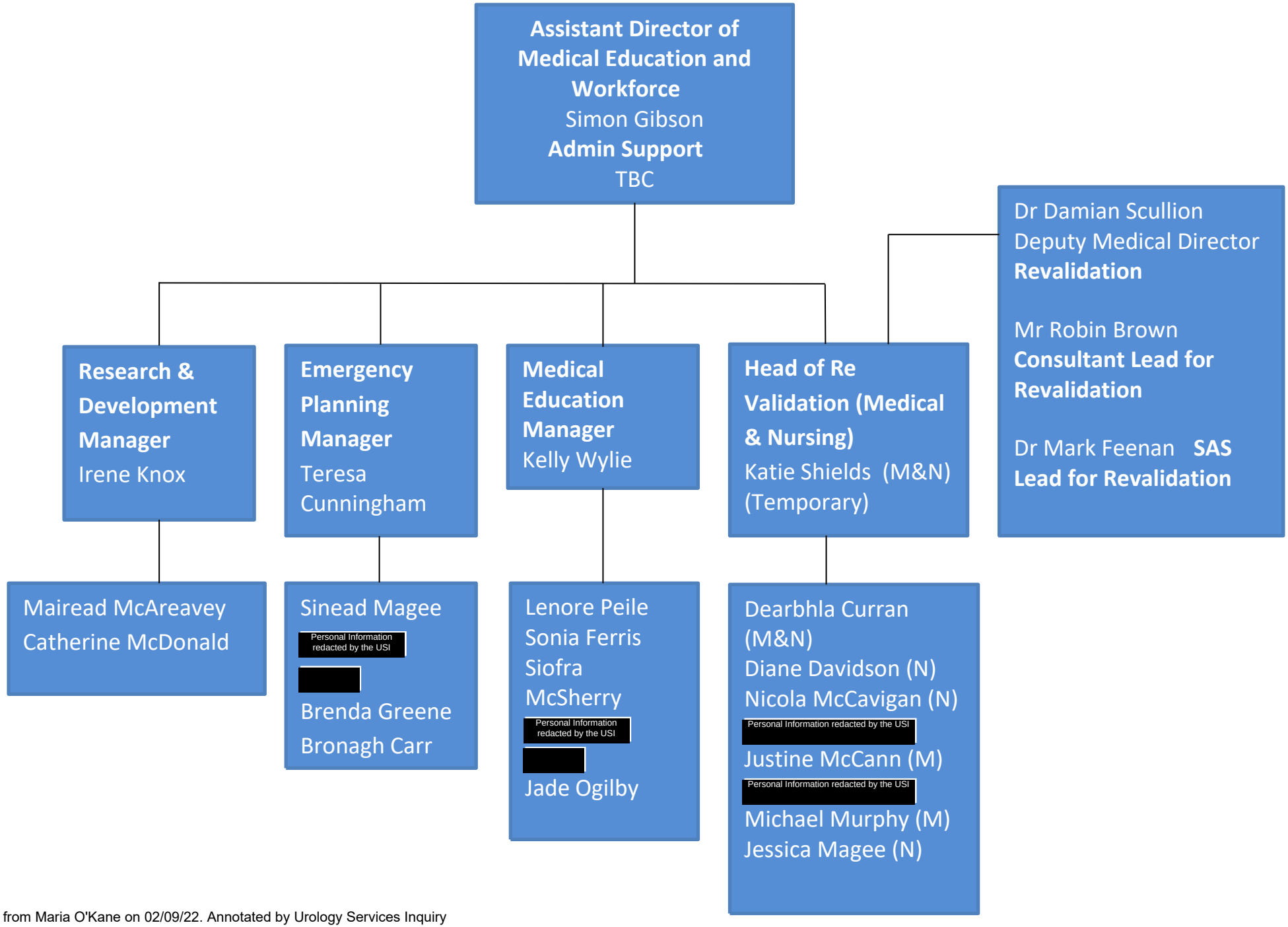


Medical Directorate Structure at April 2022

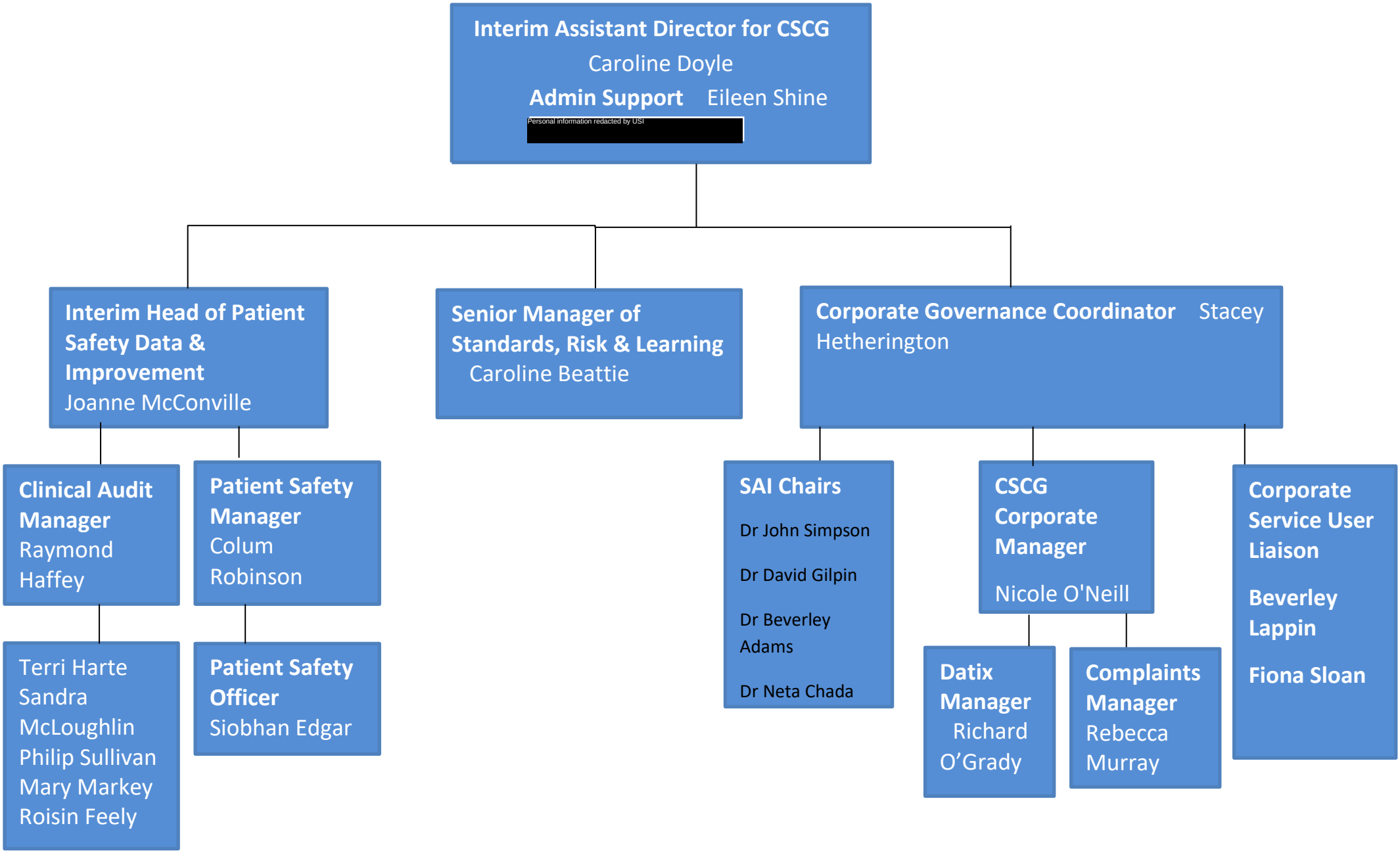
# Medical Directorate



Medical Directorate Structure at April 2022

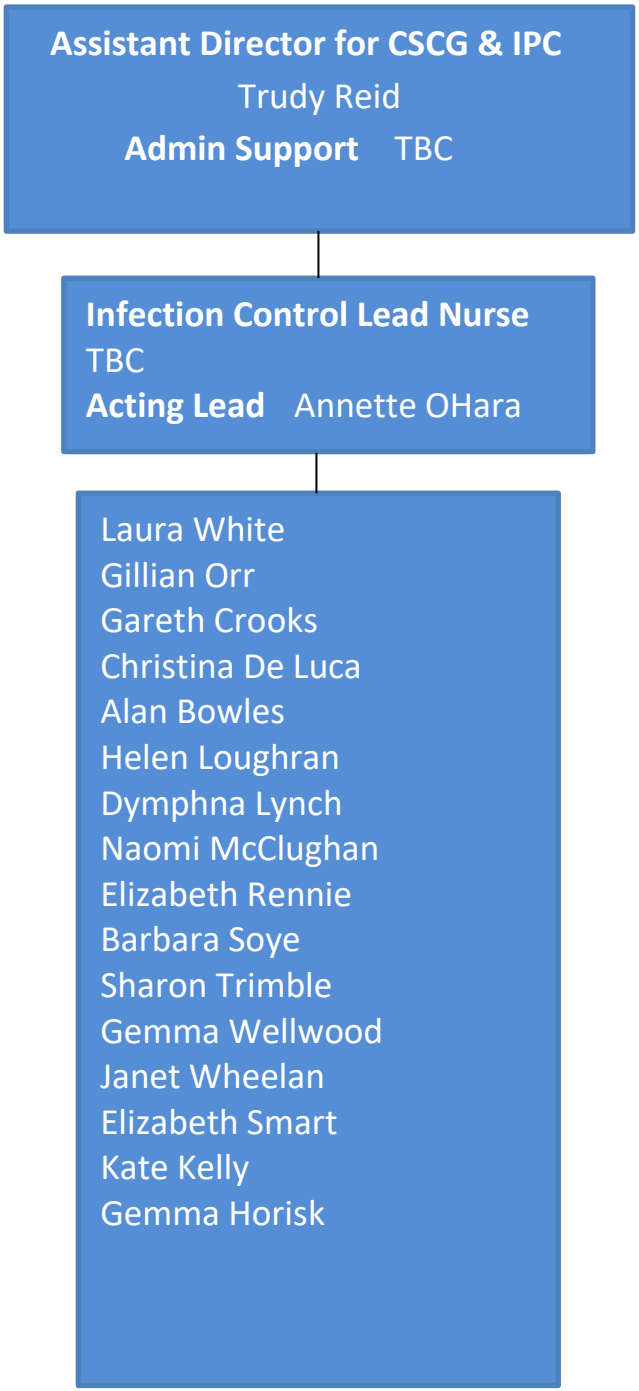


Medical Directorate Structure at April 2022




Received from Maria O'Kane on 02/09/22. Annotated by Urology Services Inquiry

Medical Directorate Structure at April 2022



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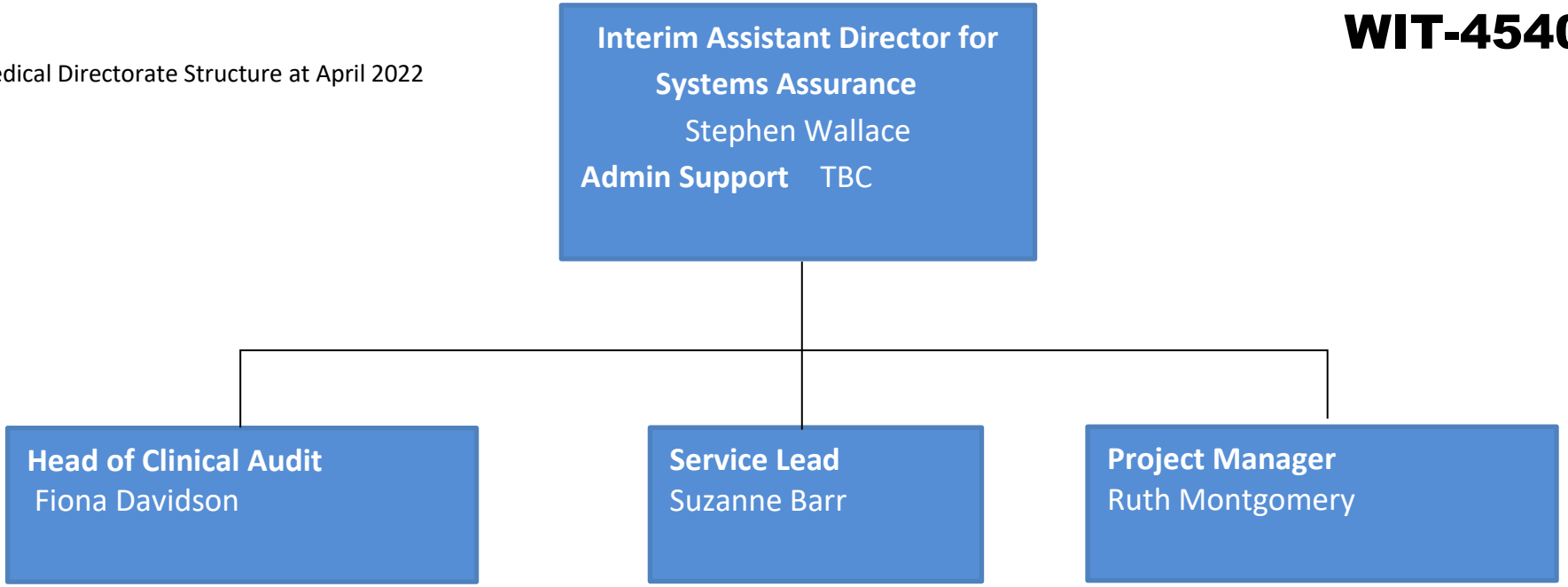

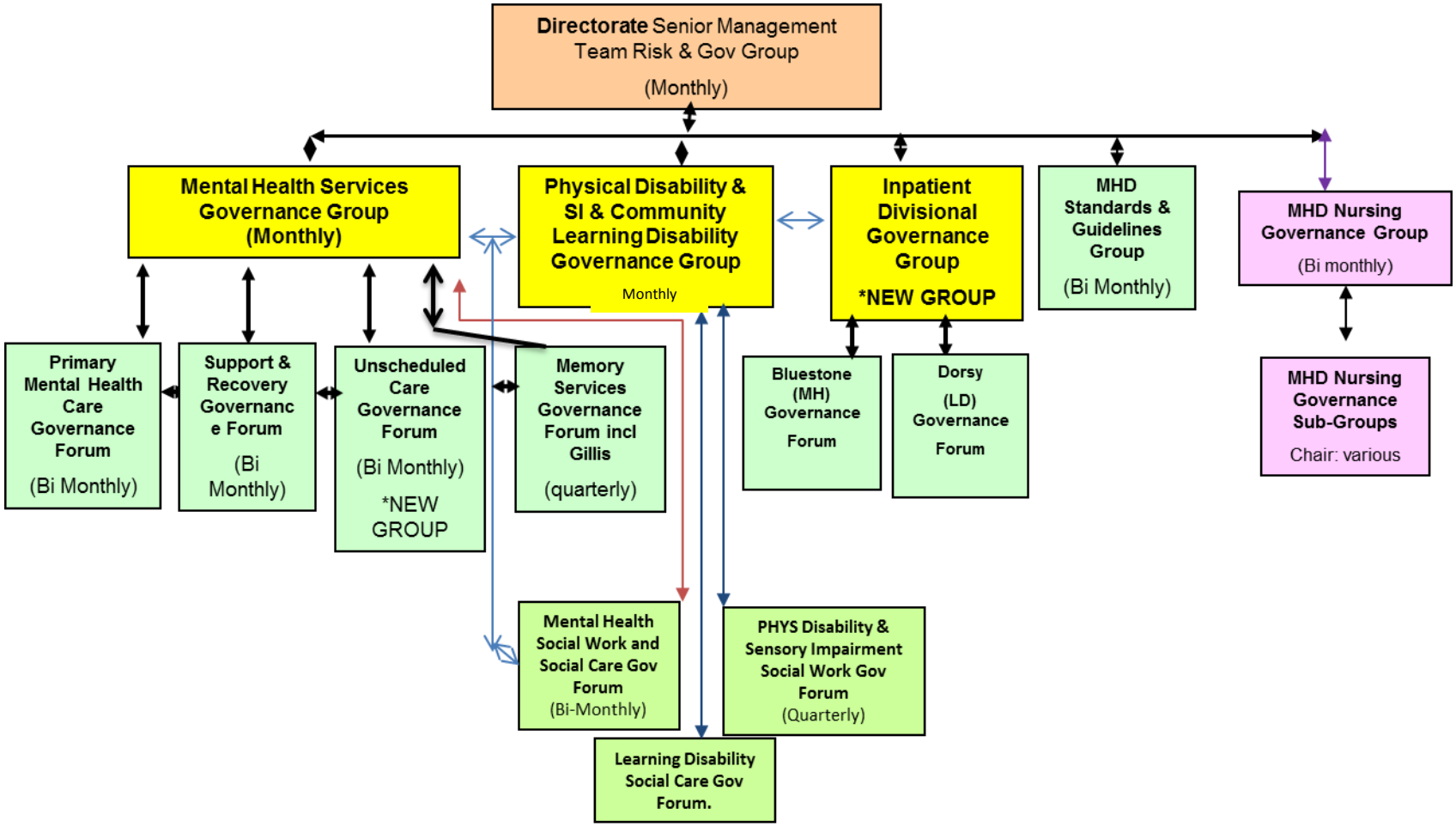

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| **COMMITTEE** | **SHSCT Morbidity & Mortality Strategic Oversight Group**<br>**Terms of Reference** |
| **CONSTITUTION** | The Medical Director hereby resolves to establish a sub-group to the Trust's Senior Management Team, to be known as the Mortality & Morbidity (M&M) Strategic Oversight Group. |
| **PURPOSE** | The purpose of the M&M Strategic Oversight Group is to:<br>• Provide high level oversight and assurance that effective systems and processes are in place for review of mortality and morbidity.<br>• Ensure the capturing, sharing and implementation of learning and good practice arising from M&M meetings<br>• Consider mortality reports i.e. SHMI / RAM I to identify early alerts or areas where more detailed review is required. |
| **MEMBERSHIP** | **Chair:**<br>• Medical Director<br>• Executive Director of Nursing / AHP (Co-Chair)<br>**Membership:**<br>• Non-Executive Director<br>• Associate Medical Directors x 2<br>• Assistant Directors, Operational Directorates x 2<br>• Clinical Directors x 2<br>• M&M Chairs x 2<br>• Assistant Director, Medical Director's team<br>• Assistant Director, Clinical & Social Care Governance<br>• Assistant Director, Nursing Governance<br>• Assistant Director, AHP Governance<br>• Head of Performance<br>• Head of Information and Data Quality<br>• SAS Lead<br>• Chief Registrar / Trainee doctor representative<br>• ADEPT Fellow, (as applicable)<br>• Head of Midwifery / Lead Midwife<br>• Clinical and Social Care Governance Co-Ordinator, MHLD<br>• Senior M&M Facilitator<br>• Head of Patient Safety Data & Improvement<br>• CYP Medical Representative<br>• Social Services Representative<br><br>Members should aim to attend all meetings. Should a member be unavailable to attend, they may nominate a deputy to attend in their place subject to the agreement of the Chair.<br><br>**In attendance:**<br>Any officer of the Trust or of an external agency such as the HSCB or PHA may, where appropriate, be invited to attend.<br><br>**Member appointments:**<br>The membership of the M&M Strategic Oversight Group shall be determined by the Medical Director, taking into account the skills and expertise necessary to deliver the Group's remit. |
| **DUTIES** | The **main responsibilities** of the group are to:<br>• Provide assurance to Trust Board that all hospital deaths are proactively |

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| | monitored, reviewed and reported, in line with regional guidance. This includes the arrangements for reviewing child deaths in line with the regional reporting requirements.<br>• Ensure arrangements are in place for sharing lessons learned and good practice, to improve outcomes.<br>• Have an overview function on the operation of the M&M system and M&M meetings<br>• Be the principal source of advice and expertise to the Trust on morbidity and mortality.<br>• Develop protocols/guidance on the levels of escalation within teams and for onward reporting through the Trust's management structures. Communicate and disseminate the protocols/guidance to M&M Chairs to ensure a standardised approach to escalation.<br>• Review the Standardised Hospital Mortality Index (SHMI) and chart the Trust's previous and current performance;<br>• Ensure the Trust's information systems on mortality surveillance and clinical coding are effective.<br>• Advise on the best approach for undertaking independent M&M audit reviews determined by the M&M Strategic Oversight Group.<br>• Report to and provide a quarterly exception report to Trust's Senior Management Team, Governance Committee and Trust Board.<br>• Explore and learn from other organisation's mortality review processes that have successfully reduced mortality rates.<br>• Each member is responsible for the oversight and assurance arrangements for M&M across the Trust. |
| **AUTHORITY** | The M&M Strategic Oversight Group is authorised by the Medical Director to act as outlined above and to facilitate communication of information to the Trust's Senior Management Team, Governance Committee and Trust Board. |
| **MEETINGS** | **Quorum:**<br>The quorum for the meeting will be no less than 50% of the clinical membership and must include as a minimum the Chair or deputy Chair and clinical representatives appropriate to the agenda items.<br><br>**Frequency of Meetings:**<br>The Group will meet quarterly.<br>**Administrative support to the group:**<br>The group shall be supported administratively by the corporate clinical audit / M&M team whose duties in this respect will include:<br>• Preparation and issue of agenda on behalf of the Chairperson;<br>• Collation and distribution of papers sufficiently one week advance of each meeting to facilitate their full consideration and discussion at the meeting;<br>• Ensuring appropriate arrangements are in place for the servicing of the group including the taking of minutes and keeping a record of matters arising and issues to be carried forward;<br>• Advising the group on pertinent issues.<br><br>**Conduct of meeting:**<br>All discussions will be conducted in an open and frank manner. Decisions will be taken by a simple majority of those present. It is intended that meetings will not last more than 2 hours.<br>In the event of a conflict of interest, the Chair may ask any or all of those who are in attendance to withdraw to facilitate open and frank discussion of a particular matter.<br>**Agenda items and papers for meetings:** |

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| | Agenda items should be submitted to the corporate clinical audit / M&M team ([redacted]) 10 days in advance of the meeting. Agenda items and papers should be approved by the Chair in advance of the meeting. The corporate clinical audit / M&M team will issue the agenda/papers for the meeting approximately 7 days in advance of the meeting, to enable the members to have the opportunity to read information in advance.<br><br>Should an item need to be raised after the agenda has been circulated, the Chair should be notified in writing of the background to the issue, at least 1 working day prior to the meeting. The Chair will decide whether the items are for inclusion on the agenda under Any Other Business and as far as possible, these additional papers will be circulated in advance of the meeting.<br><br>**Minutes of meetings:**<br>The corporate clinical audit / M&M team will provide the secretariat for the meeting. Minutes of meetings will be produced and agreed with the Chair prior to issue. These will be circulated as soon as possible after the meeting listing topics discussed, actions agreed and individuals responsible for undertaking those actions.<br><br>**Sub-group reporting arrangements:**<br>The group is directly accountable to the Trust's Senior Management Team and Trust Board for its performance in exercising the functions set out in these terms of reference.<br>The group, through its Chair and members, shall work closely with the other Trust structures, to provide advice and assurance to the Trust's Senior Management Team and Trust Board.<br><br>The group shall:<br>• Bring to the Trust's Senior Management Team and Trust Board specific attention any significant matter under consideration of the group.<br>• Ensure appropriate escalation arrangements are in place to alert the Trust's Senior Management Team, Trust Board, or Chairs of other relevant Committees / Steering Groups of any urgent/critical matters<br>• Provide a 6 monthly mortality report to the Trust's Senior Management Team, Governance Committee and Trust Board.<br><br>**Review of terms of reference:**<br>The M&M Strategic Oversight Group will review its terms of reference in six months' time. The Trust's Senior Management Team should endorse these. |
| **REPORTING** | The minutes of the group shall be formally recorded and distributed to the members of the group and presented to the next Senior Management Team meeting for information and noting.<br>Six monthly mortality reports will be submitted to the M&M Strategic Oversight Group, Trust's Senior Management Team and Governance Committee.<br><br>An annual performance report will be submitted to Trust Board. |
| **CONFLICT/ DECLARATION OF INTEREST** | |
| **Date of issue** | September 2019 |
| **Date of Review** | 12 months, or earlier if indicated. |

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| This is an official Southern Trust guidance and should not be edited in any way | | | | |
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| Please note that that the most up-to-date version of this guidance is on the Southern Guidelines website. | | | | |
| **Reference No:** | **CG0540 (1)** | | | |
| **Title:** | **Guidance for the Regional Mortality and Morbidity (M&M)Process:** recording, reviewing, monitoring and analysing hospital deaths at Specialty Mortality Review and Patient Safety meetings (SMR&PSm)<br>***Adopted regional guidance (DoH)*** | | | |
| **Authors:** | Medical Director, SHSCT<br>Dr J Johnston, Medical Adviser, Death Certification Policy & Legislation Unit, DoH<br>David Best, Head of Death Certification Policy & Legislation Branch, DOH<br>Sharon Wright, Death Certification Policy & Legislation Branch, DOH | | | |
| **Ownership and Responsible Director:** | The Medical Director in each Health and Social Care Trust will be given ownership of this document.<br><br>Each Health and Social Care Trust may add their own logo, but the aim is for one system to apply across all Trusts. | | | |
| **Guidance Type:** | Trust Wide ☒ | Division Specific ☐ | Clinical and/or social care ☒ | |
| **Guidance Replacement:** | Yes ☒ | Guidance for the Regional Mortality and Morbidity (M&M) process: recording, reviewing, monitoring and analysing hospital deaths at Specialty Mortality Review and Patient Safety meetings (SMR&PSm), CG0540 | | |
| **Directors/Divisions guidance to be issued to:** | All Operational Directorates, All M&M Chairs | | | |
| **Approved by:** | M&M Strategic Oversight Group | | 15 Oct 2018 | |
| **Operational Date:** | 15 Oct 2018 | **Review Date:** | 15 Oct 2019 | |
| **Version control** | V2.1 | Supersedes | CG0540 | |
| **Key words within policy (max 10 words)** | Mortality, death, morbidity, M&M lead, M&M meeting, patient safety meeting | | | |
| **Links to other policies or** [redacted] | [redacted] | | | |

| Date | Version | Author | Comments |
|---|---|---|---|
| 08/12/2015 | 0.1 | Lauren Megahey | Initial Draft |
| 18/08/2016 | 1.1 | JRJ | Changes 4.3.9, 4.4 |
| 25/8/2016 | 1.2 | JRJ | DB, Regional Consultation comments |
| 01/09/2016 | 1.3 | JRJ | CB comments, appendix 2; 4.3.9 |
| 14/10/2016 | 1.4 | Sharon Wright<br>JRJ | 4.3.9 Changes to Outcome gradings<br>Appendix 3 – Ground Rules |
| 02/11/2016 | 2.0 | | |
| 26/6/2018 | 2.1 | AnneM Quinn | SHSCT M&M Strategic Oversight Group's amendments |

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**The Southern Trust has adopted the Department of Health (DoH) Guidance for the Regional Mortality and Morbidity (M&M) Regional Process:** recording, reviewing, monitoring and analysing hospital deaths at Patient Safety / M&M meetings

Dr A Khan
Medical Director Interim

Mrs H Trouton
Executive Director of Nursing Interim

15 October 2018

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## Contents



## 1.0 INTRODUCTION / PURPOSE OF POLICY

### 1.1 Background

There are many different methods available for studying adverse events and hazards that arise within a healthcare system and each has its strengths and limitations. Their primary aim is to reduce the frequency of these incidents through learning from past experience and changing practice.

A study of mortality and morbidity (M&M) is one of the oldest quality assurance approaches in health care (appendix 1). It has become increasingly important for Trusts to demonstrate that they are systematically and continuously reviewing patient outcomes and especially mortality and morbidity.

There is a wide variation in how mortality and morbidity (M&M) cases are discussed across different hospital specialties and different Health and Social Care Trusts. There is a need for a standardised approach.

### 1.2 Purpose

This prime aims of this guidance are to provide,

- specific guidance for M&M leads; and
- regionally agreed guidance on how M&M meetings should be established, structured, managed and assured across all hospitals within Northern Ireland.

It aims to reduce variation across Trusts regarding the role of M&M leads and the structure and format of M&M meetings. This is in order to ensure consistency so that M&M meetings are effective, produce shared learning from incidents and patient care and, ultimately, improve patient safety throughout Northern Ireland.

## 2.0 DEFINITIONS AND SCOPE OF THE GUIDANCE

### 2.1 Definitions

Mortality – for the purpose of M&M meetings, mortality relates to all deaths occurring on a hospital site (including those being brought in deceased to the ED) ranked by ward, team and/or specialty.

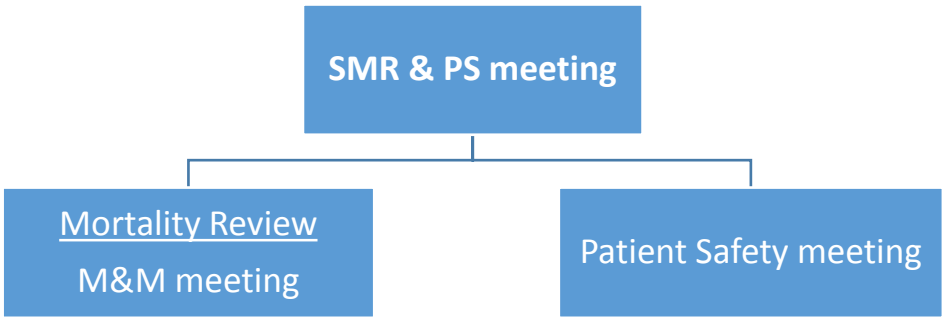
Morbidity – is a diseased state, disability, or poor health due to any cause and often relates to complications or adverse outcomes from care and/or treatment. It can be scored to determine disease severity and the need for medical intervention.

Complication - an additional problem that arises following a procedure, treatment or illness, is secondary to it and complicates the situation. This is often viewed in a similar fashion to morbidity.

Misadventure - Any injury or adverse reaction resulting from any medical treatment. Some examples are; medication errors, IV infection, surgical mistakes and postoperative septicaemia.

Patient Safety meeting / M&M meeting

Discussions regarding mortality and morbidity are increasingly combined with discussion of patient safety matters e.g. safety alerts, medication issues, recommendations from serious adverse incident (SAI) investigations. Combining these 2 broad topics into one meeting results in a PSM meeting; made up of 2 segments or sections. It has been agreed to formally call these meetings 'Specialty Mortality Review and Patient Safety Meetings – see section 4.2.




These SMR&PS meetings can be an efficient method of using the time and opportunity to discuss all these matters during the same meeting. However, some specialties and units may still wish to perform these discussions in separate meetings e.g. those with a large number of deaths to discuss.

However, it is accepted that custom and practice may lead to many continuing to use the term 'M&M meeting' for all of this type of clinical outcome and patient safety meeting.

For simplicity, this guidance will usually refer to 'M&M' meetings.

Mortality & Morbidity Meetings (M&Ms)

M&M meetings are *'a routine forum for the open examination of adverse events, complications and errors which have led to illness or death of a patient, and which are reviewed in order to learn from these events so as to improve the management and quality of care.'*[1]

They are a systematic activity designed to enable clinicians and managers at any level (preferably multidisciplinary) in the Trust to understand and learn from the underlying conditions that lead or contribute to death or harm to patients.

There is review and discussion of clinical cases, outcome data (clinician and patient reported) and related information (e.g. complaints, complications, misadventures, SAI or other benchmarking data).

Mortality and morbidity do not have to be reviewed in the same meeting.

*Mortality reviews* focus on the events of and learning from episodes where death has occurred.

*Morbidity reviews* could include the examination of re-admission rates, returns to theatre, specific complications of procedures, infections, falls or even prolonged length of stay. Morbidity reviews will vary from specialty to specialty.

Mortality & Morbidity Strategic Oversight Group

Evidence has shown that the development of a Mortality Review Committee can lead to measurable improvement in mortality associated with improvement initiatives.

The Mortality Review Committee is based at a corporate level in a hospital organisation. It can have different names in different Trusts e.g. Outcome Review Group. Health & Social Care Trusts should develop such a group to oversee M&M meetings. Its make-up can be drawn from senior medical and nursing management, along with Directors and governance senior staff.

M&M meetings within each specialty provide the ideal opportunity to identify areas for potential service improvement with the overall assurance for learning and action resting with the M&M Strategic Oversight Group. This group meets regularly, to review aggregated mortality data and information such as Standardised Hospital Mortality Ratios and Risk Adjusted Mortality Indexes (RAMI) for comparison purposes e.g. Summary Hospital-level Mortality Indicator (SHMI).

The group will also work with M&M leads to ensure that the composition of M&M groups is appropriate and to ensure that M&M meetings are occurring in a coordinated way, with appropriate case discussions, follow up from action points and sharing of learning. Any system issues highlighted by the M&M processes should be addressed.

It would be unusual for this group to consider individual patient information unless there were particular patient safety issues that are serious enough to warrant discussion at a corporate or management level. It will have overall corporate management responsibility for M&M meetings and act as forum for discussion of high level issues arising from the M&M meetings.

Within SHSCT this group will be referred to as the Mortality & Morbidity Strategic Oversight Group. The Chair and Deputy Chair are the Medical Director and Executive Director of Nursing respectively.

Regional Mortality and Morbidity Review system (RM&MRs)

The RM&MR system is hosted on the Northern Ireland Electronic Care Record (NIECR). It allows the;

- accurate **recording** of the details from all patient deaths, completion of the Medical Certificate of Cause of Death or notification to the Coroner;
- **review** by the Consultant, followed by the;
- **monitoring**, examination and scrutiny of any avoidable factors or areas of learning and subsequent actions associated with the patient's death by;

- 'ward or unit based' multidisciplinary (M&M) clinical teams, aimed at identifying and **analyzing** the causes of harm, learning and thus avoiding the repeating of harm.

## 3.0 ROLES/RESPONSIBILITIES

The SHSCT will take responsibility for ensuring M&M meetings occur according to the regional guidance.

### 3.1 Medical Director

The Medical Director is the ultimate Lead within the Trust for this process and has ownership of this document, and therefore responsibility.

The Medical Director should clarify and outline the formal requirements for M&M Leads / Chairs and M&M meetings and then ensure that the whole process outlined below is introduced throughout the Trust.

They should also incorporate the M&M process into the appraisal and revalidation process for Consultants and other clinical staff.

### 3.2 M&M Leads / Chairs

Each Trust should appoint an M&M 'Lead' or 'Chair,' for each specialty M&M meeting.

M&M Leads will take responsibility for the operational management of their specialty's meetings. It is accepted that establishing this process may be new to some specialty areas and in some specialties more onerous than others. Additional remuneration or 'PA' allowance should take this into account and be agreed within each Trust.

Responsibilities of M&M Leads will include:

- Working with their Clinical Director and Associated Medical Director[a] to ensure the format of their M&M Meetings allows robust discussion and learning.

- Ensuring that 'their' team is of a sufficient size to allow robust discussion i.e. not too big or too small and which also contains the right mix of staff to allow a degree of robust scrutiny of cases. It is advised that a team with less than 5 senior medical members would be viewed as being too small. Achieving this should be done in conjunction with corporate bodies such as the Mortality & Morbidity Strategic Oversight Group.

- Ensuring that there is a multidisciplinary format to meetings, by facilitating regular attendance by medical (consultants, trainees and other grades), nursing, governance, management, pharmacy and other staff.

[a] or equivalent grade of Senior Clinician in a management role.

- Ensuring, along with their Consultant colleagues, that every death within their specialty area is recorded on the Regional Mortality and Morbidity Review system (RM&MRs) and reviewed by a Consultant.

- Coordinating, along with their Consultant colleagues, how all their patient deaths, after being tabled for discussion, are reviewed at their M&M meeting. Some teams will review every patient death in detail while others, depending on their specific specialty, may have to prioritise those deaths which will capture valuable learning.

- Reviewing the monthly performance statistics of recording deaths.

- Coordinating M&M meetings along with the patient safety, audit and educational elements which may be discussed concurrently – the SMR&PS meeting.

- Preparation for meetings and using the standardised agenda/record of meeting template should be used (appendix 2).

- Reviewing outstanding learning and action points from previous M&M meetings.

- Chairing discussion on Mortality Review, with a focus on producing learning, including:
    - Contributing knowledge and experience to those meetings.
    - Openly looking for prevention strategies, without resorting to blaming others.

- Helping colleagues to deliver safer care on the basis of:
    - Fostering an open culture for discussion of cases;
    - Learning from discussion;
    - Building safeguards into existing practice; and
    - Challenging practice that has been demonstrated to be unsafe.

- Producing a record of the review of each death on the RM&MR system.

- Collation of review findings, learning points and actions for improvement from each M&M meeting.

- Reporting significant findings to Associate Medical Directors[b] / Clinical Directors and onwards to Governance Systems within their Division, and escalation of concerns as appropriate.

- Assisting communication with other specialties by the onward referral of M&M cases for discussion and also by introducing cases from other specialties for discussion.

[b] or equivalent grade of Senior Clinician in a management role.

- Escalating concerns to their Clinical Director / Associate Medical Director[b]/ Medical Director if consultants or teams are not recording or reviewing deaths.

- Acting as (potentially) a first point of observation of the performance of medical staff, including senior staff, and escalation of any concerns. The M&M Lead's role is to observe and warn, and the Clinical Director / Associate Medical Director's role is to manage performance.

- Including the performance in this M&M role as part of their appraisal and revalidation.

- Being accountable to their Clinical Director and Associate Medical Director[b] within this role.

- Appointment of a 'deputy' chair who would fulfill these duties in the absence of the M&M lead or if the lead was involved in a case to be discussed.

### 3.3 Attendees

While each M&M team has a 'core membership' of permanent medical staff, the agreed regional view is that all of these teams are to evolve into multidisciplinary M&M teams (see section 3.4).

**All attendees** at M&M meetings are expected to:

- Attend meetings whenever possible, and stay for the full duration of the meetings. Some Trusts may elect to rule that credit for attendance at an M&M meeting requires attendance for all of the M&M section of that particular meeting.
- If unable to attend meetings, ensure the record of the meeting is read and any learning points are addressed.
- Adhere to agreed 'ground rules.'
- Actively participate in discussions.
- Raise any concerns to seniors / supervisors.
- Ensure any action points agreed are followed up.
- Contribute to shared learning as appropriate.
- Feedback any relevant learning from attendance at regional events.
- Keep up to date with changes or updates to relevant guidelines.

In addition to this, specific attendee roles will include, but are not limited to:

<u>Consultants</u>

- Use and respond to any Trust emails or Electronic Care Record (ECR) message alerts that are used by the RM&MRs as its method of communication. This includes ensuring that they can log in to their Trust's email system regularly, especially if they have joint employment e.g. University.
- Complete the 'consultant review' sections within the RM&MRs for patients named under their care, within agreed timeframes, to enable

the discussion of deaths or incidents at M&M meetings within 6 – 8 weeks of occurrence.
- Attend discussions regarding all patients named under their care whenever possible, including when invited to attend another specialty's meeting.
- Provide peer review and robust but responsible challenge during discussion of cases, raising concerns in a non-confrontational manner.

Specialty Doctors (SAS Grades)
- Attend discussions regarding all patients under their care whenever possible, including when invited to attend another specialty's meeting.
- Provide peer review and robust but responsible challenge during discussion of cases, raising concerns in a non-confrontational manner.

Trainee Doctors
- Attend discussions regarding all patients for whom the trainee doctor has been involved with, whenever possible, including when invited to attend another specialty's meeting.
- Contribute to discussions and raise concerns when appropriate.
- Ensure that any incidents are reported to clinical and educational supervisors, as well as declared on 'Form R.' – their self-declaration form completed for the purposes of registration and revalidation.

Locum Doctors
It is also advised that locum doctors, if at all possible, attend discussions relating to cases they have been involved with, particularly if there have been any concerns raised regarding level of care. 'Longer term' locum doctors should contribute to meetings as per the above lists, depending on their grade.

### 3.4 Multidisciplinary membership

Traditionally, M&M meetings have been medically led. However, it is now recognised that input from other disciplines is imperative. M&M meetings that function as a 'multidisciplinary' meeting and that hold the concept of the 'team' as a core value are regarded as a best practice model.

Clinicians do not work in isolation – multidisciplinary teams care for patients and avoidable incidents are most often multifactorial (and therefore multidisciplinary) in causation. All team members can bring valuable insights and information to case discussions, and can also learn from these discussions, in order to improve future patient care. It can also be easier to effect change and complete actions when all the relevant professionals are present at case discussions.

Therefore, they should always work towards encouraging team membership and include senior nursing staff, governance, pharmacy, allied health professionals, relevant senior technical and other senior support staff.

Nursing Staff
Nursing input can be particularly valuable, as nursing staff spend significant amounts of time with patients. An example of useful multidisciplinary

discussion would include a deteriorating patient not being seen by the medical team promptly, either due to delay by nursing staff in contacting doctors, or due to delay by doctors in responding.

It is acknowledged that time can be a barrier for nursing staff attending meetings, as can the size of available meeting venues. Each specialty should agree the level of nursing input into meetings. Suggestions include rotation of nursing staff attendance at meetings, having a nursing representative attend from each ward, or having ward managers / Heads of Service attend initially.

Roles of nursing staff include:

- Attend discussions regarding all patients under their care, whenever possible, particularly when a concern has been raised. This includes when invited to attend another specialty's meeting.
- Contribute to presentations, providing information on care.
- Contribute to robust discussion, challenging care where appropriate.
- Present summaries of relevant nursing meetings to the group.
- Feedback discussions and action points to colleagues.
- Specialist nursing staff may provide expertise to a number of hospital departments, as relevant.

Administration Staff (also see section 4.4)

- Work with M&M leads to agree meeting agendas, ensuring case presentations have been prepared and are available for the meeting.
- Ensure that, wherever possible, clinical notes are available to aid discussion, if requested by the M&M Lead.
- Take a note of the discussions, send these to M&M Leads for approval, and then disseminate as appropriate.
- Ensure a central repository of all meeting records is held securely.

Other professionals

M&M Leads should decide on the appropriate frequency at which to invite other professionals, such as pharmacists, governance team members, Allied Health Professionals, microbiologists, laboratory staff etc. as this will vary across specialties. It may be appropriate to invite some professionals to attend for the full duration of meetings, or for an identified time 'slot.' Some professional groups may rotate around the various specialty meetings, while others may choose to send a representative to each meeting.

Roles of other professionals include but are not limited to,

Governance Leads

Governance professionals can perform a vital 'conduit' function by bringing learning from Serious Adverse Incidents to the meetings and also by:

- Relaying outwards any learning points raised at meetings that require circulation and further action elsewhere in the Trust and beyond;

- Flagging up if any of the cases being discussed have already been reported as a Serious Adverse Incident (SAI) and this is not known by the M&M Lead/Team.
- Providing, on occasion, short (5 - 10 minute) teaching sessions e.g. SAI processes, incident reporting procedures.
- Ensuring SAI and Coroner's reports and their recommendations are cascaded once investigations are completed.
- Reconciling M&M discussions with SAIs – possibly have reports or else a list of screened cases available for the M&M Lead. (This would be a joint effort with the M&M Lead.)
- Considering agreeing a formal process of how cases should be flagged up / should be checked for SAIs.

Pharmacists

Pharmacists may already attend more corporate, divisional governance and/or medicine safety meetings. However, attendance at M&M meetings will offer an opportunity to bring pharmacy communication to ward, unit or specialty level as well. It is not expected that every M&M team would have to have such an attendance at every meeting.

Scheduling of expected timings during the SMR&PS meeting will allow pharmacists to attend only their section of the meeting, thus providing a more efficient use of their time.
Attendance at M&M meetings will allow or enable,

- Dissemination of 'local' learning from clinical pharmacist(s) working in specialty wards and who know the frequent errors or error categories.
- Review of medication incidents and share learning points as appropriate.
- Identify and present good practice topics, review medication incidents, identify main learning points, produce regular learning bulletins and then present these at M&M meetings.
- Provide expertise during case discussions, challenging and raising concerns as appropriate.
- Advise on medication updates, as appropriate.
- Provide short teaching sessions, when relevant.

Resuscitation Officers

- Present a summary review of cardiac arrest calls.
- Participate in case discussions as appropriate, providing expertise.
- Raise concerns or suggestions to improve practice.
- Consider whether decisions regarding resuscitation status are appropriate.
- Consider whether escalation of NEWS scores appropriately carried out.
- Provide updates as relevant.

Microbiologists / Infection Prevention and Control Team

- Provide updates when relevant, including information about healthcare associated infections (HCAI) within each department, antibiotic wards rounds, audits and any new or updated guidelines.
- Provide expertise in the discussion of cases as appropriate.

- Deliver occasional short teaching sessions.

Others
Others, including but not limited to, Allied Health Professionals, laboratory staff, haemovigilance teams, blood transfusion services, specialist liaison services etc.:

- Provide updates and expertise as appropriate.
- Deliver short teaching sessions when relevant.

It may be beneficial to collate a list of all professionals who may add value to case discussions at M&M meetings, along with their contact details. M&M Leads can then approach each professional and agree a suitable frequency of attendance at meetings. This list may include professionals in the fields of pharmacy, resuscitation, infection prevention and control, patient experience, governance leads and others as appropriate.

### 3.5 Patient Experience & Personal and Public Involvement (PPI)

M&M teams may consider bringing information from patient experience questionnaires to meetings.

Regarding personal and public involvement, it is considered likely that any proposed future PPI participation in M&M discussions will only occur at a corporate level where they might view aggregated information rather than detailed material related to individual patients.

### 3.6 Governance – Local and Corporate

Establishing links internally to other governance committees in the organisation is an essential constituent of successful and meaningful M&M meetings. This will allow the 2 way communication of governance issues both 'upwards' and 'downwards' within the organisation.

Attendance and indeed participation of Operational and Governance Managers in meetings, as well as regular reporting and feedback mechanisms, will enable two-way communication with frontline staff.

## 4.0 KEY GUIDANCE PRINCIPLES

This guidance applies to the discussion of all patient deaths and morbidity cases that occur within any hospital site in Northern Ireland. All inpatient deaths should be discussed in at least one M&M Meeting. Deaths under the care of the Acute Care at Home Team and child deaths occurring in the community should also be discussed in at least one M&M meeting.

Based on available evidence, the factors considered to be important for the success of M&M meetings are detailed in the table below[1].

**Table 1**

| **Factors considered important for an effective M&M case review** |
|---|
| Facilitation of the case review by a moderator |
| Mandatory department members attendance |
| Audience participation in the process |
| Decreasing defensiveness and blame |
| Focused analysis of error |

| |
|---|
| Integration of evidence-based literature into the M&M discussion |
| Providing educational points related to the complication |
| Allowing for a consensus to be met with respect to analysis of the cases presented |
| Improving the efficacy of the case presentations |
| Use of slides |
| Use of radiographic images |

Following this advice, the principles outlined below aim to establish how these factors can be incorporated to produce a successful M&M meeting programme.

### 4.1 M&M Leads

The role and responsibilities of M&M Leads are covered in section 3.2 and, could be regarded as a 'job description' for such a posting.

The chair of the meeting is responsible for enabling an open and constructive discussion that can fulfil the meeting's purpose. They will be aided in this by the commitment to the meeting of all the participants and the quality of their interactions plays a crucial role in the effectiveness of an M&M meeting.

Therefore, an M&M lead needs to foster an environment in which all participants can contribute to constructive and non-judgemental discussion without fear of criticism from their peers. On the other hand, all participants have a shared responsibility to also behave in a way that is conducive to learning and supports service improvement and to challenge conduct that may be detrimental to those shared goals.

Training

M&M Leads should be supported within each Trust and receive any relevant training opportunities, where appropriate. Training in areas such as Human Factors and Root Cause Analysis may be useful.

Support

Each Trust should ensure that M&M Leads meet together regularly to provide peer support, as well as to discuss M&M processes, identify areas of good practice and identify areas for improvement.

It is likely that there would be a benefit in M&M Leads from the different Trusts meeting to discuss items of interest and to help with development of the RM&MRs.

### 4.2 Specialty Mortality Review & Patient Safety Meeting (SMR&PS)

As covered in section 2.1 and as the dual title suggests, Specialty Mortality Review & Patient Safety Meetings encompass both a mortality review function (M&M meeting) and a patient safety function. This allows discussion of patient mortality, morbidity and safety issues; enabling robust discussion and peer challenge. It is accepted that they may continue to be called by the shorter name – 'M&M meeting'.

### 4.2.1 SMR&PS meeting Agenda/Record of meeting

To facilitate the standardisation of meetings across all M&M teams, a SMR&PS meeting Agenda/Record of Meeting Template (appendix 2) has been developed and agreed by all HSCT Medical Directors. This will be modified from time to time, as this policy document is updated.

The SMR&PS meeting Agenda/Record of Meeting Template will be used by every M&M Lead / Chair to determine the areas of discussion at each SMR&PS meeting. Some of the topics to be covered during the meeting will include,

1. Review of last meeting
    a. Verification of M&M meeting report
    b. Outstanding actions from last M&M meeting
2. Mortality & Morbidity (M&M) review of deceased patients
3. Review of Safety Graphs
    a. Crash Call Review
    b. Safety graphs
4. Shared learning from Complaints / Serious Adverse Incidents / other M&M meeting / any other source.
5. Shared learning from Litigation / Coroner Cases
6. Safety Alerts – DoH, HSCB, PHA, Trust
7. Medication issues
8. NCEPOD / National / Speciality
    a. Consultant Outcome data.

While the SMR&PS meeting is functionally made up of 2 segments; it is acknowledged that each specialty may have slightly different issues to discuss at meetings, especially of the patient safety segment. Time spent on each agenda section may vary considerably between specialties, depending on clinical caseloads, and so these headings can be adapted as necessary.

It is suggested that each SMR&PS meeting should last for 2-3 hours in total, with a recommendation that each segment i.e. mortality review and patient safety discussion being afforded equal time. Some teams may elect to hold the 2 segments on different days and may also elect to have different leads for each segment.

If M&M meetings are organised in a way which departs significantly from the suggested agenda template, this should be reviewed by the Mortality & Morbidity Strategic Oversight Group in the Trust.

As every specialty will be using the same agenda/record of meeting template the following naming convention should be used:

M&M Team Name - Venue - Date of Meeting

It will be the responsibility of the M&M Lead / Chair (or their alternate) to set a date for each meeting and therefore establish the agenda for each meeting.

All relevant documentation for discussion should be appended to the agenda/record of meeting template and/or signposted by hyperlinks by the relevant lead (i.e. Governance, Litigation, Pharmacy, Safety Alert).

A copy of the suggested SMR&PS meeting Agenda/Record of Meeting Template is attached at appendix 2.

### 4.3 M&M meeting

The mortality section of the meeting should be timely, within 6-8 weeks of deaths, incidents or events, to ensure that details remain clear in the minds of those involved. Meetings should be dynamic, with an open and transparent culture. Blame should be avoided, and everyone should feel able to speak up and challenge others when appropriate, in a non-confrontational manner.

Learning should be shared, in order to prevent unnecessary repetition of errors, and to optimise patient care. Frontline staff can work together with governance teams to develop solutions to issues that arise.

As well as a platform for review, M&M meetings also have a valuable role in medical education. It is also important to highlight areas of good practice, from which others could learn.

#### 4.3.1 How to set up an M&M team

Many hospitals in Northern Ireland already have M&M teams and meetings in place, although these often vary in structure and format between specialties and sites. The aim of this guidance is for a standardised approach to M&M meetings across the region.

For those hospital teams that do not currently have any meetings, the first step is to form M&M teams:

- Identify teams and specialties that do not participate in M&M meetings.
- Discuss (with all involved) the rationale and evidence for M&M meetings (see appendix 1).
- Establish specialties and team units that could form an M&M team and hold meetings.
- Decide on the size of teams required - this will depend on the size of the specialties involved.
    - Teams should not be too big as they will be difficult to manage and have time to discuss all their deaths within the 6 – 8 week period.
    - Teams should not be too small because this will limit the robustness and degree of challenge of peer review. It is advised that a team with less than 5 senior medical members would be viewed as being too small.
- Appoint an M&M Lead for each team and meeting.

Once the teams are all established, the following steps need taken:

- Set dates for (approximately) monthly meetings, ensuring suitable venues are booked and that appropriate IT equipment is available.
- Always remember to include the appropriate multidisciplinary team members, as well as others, to invite to meetings. This should include Ward/Nurse Managers, Pharmacists, Governance and managerial staff. Some teams may include certain technical staff. See section 3.4.

- Screen cases, to decide those that are to be discussed in a greater level of detail.
- Adopt an agenda for meetings, using the suggested Agenda / Record of Meeting Template (appendix 2) provided in this guidance, adapting this as appropriate.
- Arrange for a note of the meeting to be taken using the suggested Agenda / Record of Meeting template (appendix 2) provided in this guidance, and adapting this as appropriate.
- Ensure learning points are noted on the RM&MRs and that action points from meetings are followed up.

### 4.3.2 Code of Conduct

All participants in the M&M meeting share a responsibility for creating and maintaining an environment which is conducive to an objective, honest and non-judgmental review.

It may be helpful to establish a code of conduct or 'ground rules' for each meeting. These should be agreed by the team and approved by the M&M Lead. It is advised that M&M Leads remind the group of the ground rules at the beginning of each meeting e.g. by showing a standard slide of the rules to remind everybody (appendix 3).
The precise content of the code of conduct will vary according to the setting and it is important that participants are involved in developing the code before committing to it. Suggested principles to incorporate include:

- mutual respect and trust between participants;
- commitment to the task of an objective review of adverse outcomes;
- encouragement of contributions from all participants;
- constructive discussion and debate;
- valuing different opinions;
- challenging those in the group who do not adhere to these principles.
- focussing on the adverse outcomes, their causes and the learning rather than on personalities and 'who did what and why'.

Some suggestions of ground rules include:

- Discussions should be open and transparent.
- Listen to others when they are talking and do not interrupt them.
- All attendees should be given the opportunity to speak.
- Avoid a blame culture.
- Show professional courtesy and respect for everyone.
- Presentations should be factual and objective. They should focus on the issues and the learning; not on personalities or the actions of individuals.
- Style and tone of presentations should be respectful.
- As far as possible, the clinicians involved in the management of a difficult or complex case should be aware in advance and be present when the (their) case is being discussed at M&M.

### 4.3.3 Support for Staff

Although patients are the prime concern when an error has been made they are often not the only victim of a medical mishap. The healthcare worker or

workers involved are also affected; they can be the second victims. They can feel personally responsible and having failed the patient. The severity of this reaction is obviously related to the severity of the error itself but is also affected by the culture within the Trust, the attitude of colleagues and the conduct of any enquiry and/or legal proceedings. This can have long term consequences in maintaining a suitably open and transparent culture necessary in a safety orientated clinical environment.

Therefore, sitting alongside the necessary systems to recognise and learn from medical mishaps and processes of support for patients, carers and families, there must be systems of support for the affected staff.

To support any staff affected, a Trust should:

- actively promote an open and fair culture that fosters peer support and discourages the attribution of blame.
- create an environment in which staff are encouraged to report patient safety incidents but should also feel supported throughout any incident investigation process.

Some tools that Trusts might have available to help promote this culture are,

- an active and supported '*Being Open'* policy.
- an attuned Occupational Health Department who are aware of the processes being encouraged within an M&M process.
- other programmes which can be of use in supporting staff, offering strategies to help cope with stress e.g. *Here4you*.

### 4.3.4 Suggested calendar of dates

An important guiding principle is for cases to be discussed within 6-8 weeks of death / incident. In order to achieve this, it is recommended that M&M meetings occur regularly, on a monthly basis.

The rationale behind having a regional standardised calendar for M&M meetings is as follows:

- To ensure time for meetings is protected, with sufficient notice to rearrange clinical work.
- To enable shared learning and cross-specialty and cross-site participation when required.
- To enable trainee doctors to return to meetings from previous posts, to present and take part in discussions regarding cases in which they have had involvement.

It is recommended that M&M meetings follow the GAIN[3] Regional Audit Dates. This will facilitate the participation in Regional Meetings. These dates are planned well in advance and can be found at https://www.rqia.org.uk/RQIA/media/RQIA/Resources/Rolling-Audit-Calendar-2017-2023.pdf
by searching for 'rolling audit calendar.'

It is recognised that some specialties may wish to have meetings on a more regular basis, such as weekly. If this is the case, it is recommended that these groups ensure they pay attention to the GAIN Regional Audit dates and

coordinate their weekly meeting on these dates each month, to facilitate cross-specialty discussions where necessary.

### 4.3.5 Inputs and Outcomes of Meetings

The standardised SMR&PS agenda headings are detailed in appendix 2.

A record of a meeting should be made onto the Agenda / Record of Meeting template. This record should be circulated to members of each meeting, to verify the note at the next meeting and so that action points can be followed up.

The note of the M&M discussion is to be kept on the RM&MRs i.e. on NIECR, as evidence of case discussion and learning outcomes.

### 4.3.6 Specialty input

*Intraspecialty 'split' meetings*

In order to facilitate case discussions within larger specialties, this may require having 'split' meetings. For example, Surgical M&M meetings may alternate each month, between a large meeting that includes all surgical specialties, and multiple smaller sub-specialty M&M meetings.

Experience has found that, on average, approximately 60 - 90 minutes is required to discuss 10 cases. A balance needs to be achieved between meetings being small enough to be able to discuss all deaths, while being large enough to ensure there is robust and challenging discussion.

*Interspecialty 'joint' meetings*

Some specialties that work closely together may find value in holding 'joint' meetings. These can be organised to occur regularly or once a cohort of interesting cases have built up to allow discussion. The RM&MRs will allow the organisation of 'joint' meetings.

*Specialty interfaces*

Regarding interfaces between specialties, the case will usually be discussed by the team looking after the patient immediately prior to death (or prior to any incident) i.e. the primary team. If discussions are potentially going to involve 'criticism' of another specialty, they should be given the opportunity to respond. This could be by,

- being invited to the M&M meeting;
- enrolling them as an 'Additional Team' using that function in the RM&MRs and forwarding them the discussion for their input; or
- holding 'joint' meetings as above.

On some occasions, it may be valuable for health professionals from another specialty to attend case discussions during SMR&PS meetings e.g. if a patient's care has involved input from multiple specialties.

Having all professionals involved present at the case discussion can be very useful, as the full picture of events is then available. This can also prevent the need for multiple discussions at different meetings regarding the same patient.

It is up to the M&M Lead to decide the appropriate course of action to take and, if necessary, who should be invited to each case discussion. They may discuss this with the named Consultant and other health professionals in order to make this decision.

If requesting a health professional from another specialty to attend, sufficient notice should be given for this. The request should be made as early as possible. If requested to attend a case discussion at another specialty's meeting, this should be facilitated wherever possible. A mutually convenient time slot in the meeting should be agreed, in order to minimize disruption to other meetings. It is advisable that joint cases be discussed at the beginning of the meeting, if possible.

### 4.3.7 Selecting cases for detailed discussion

**All** deaths should be offered for discussion to at least one M&M meeting, but, in certain specialties, it may be appropriate and permissible, in certain individual cases, to limit the discussion and thus discuss some cases in greater detail than others. This may not be allowed in some specialties and in some categories of cases e.g. where an incident has occurred or a death is unexpected.

The use of 'trigger lists' can be helpful to set the rules to identify cases that may require more detailed discussion, including morbidity cases. Appendix 4 provides a suggested template 'trigger list', although each specialty may need to adapt this to include additional relevant triggers.

### 4.3.8 How to present cases: Using the SBAR format

For brief case discussions, the following points need to be covered:

- What was the diagnosis and cause of death?
- What were the circumstances leading up to the death?
- Were there any issues of concern in the management of the patient leading up to the death?
- What learning points have come from this case?
- How will these learning points be implemented?

However, a recent review of the evidence-base on M&M meetings concluded that, '*the lack of a consistent approach contributed to substantial variation in presentation quality and educational outcomes achieved*'[1]. Therefore, it is important, where possible, to minimise potential barriers to the discussion arising from attendees' different communication styles. In order to facilitate this, participants should adopt a standardised model for presenting cases.

Based upon the factors outlined in Table 2, a standardised

**S**ituation,
**B**ackground,
**A**ssessment,
**R**ecommendation

(SBAR) communication format is recommended. The aim is to maximise the learning value of the M&M meeting by using this structured format for

presenting cases at M&M meetings, thus improving presentation quality and learning outcomes for attendees[4].

SBAR is a structured communication technique for providing patient information. An enhanced form for use as a presentation tool for M&M meetings is described below (table 2) with a much more detailed version provided in appendix 5.

Template slides for the structure of M&M presentations can be downloaded freely from the Royal College of Anaesthetists and the Association of Anaesthetists of Great Britain and Ireland websites[4].
https://www.aagbi.org/sites/default/files/SALG-M%26M-TOOLKIT-2013_0(1).pdf

**Table 2**

**Components of an M&M presentation[4]**

| Components of SBAR | Items considered important to enhancing the educational value of the M&M presentation |
|---|---|
| **S** Situation | Brief description of the case presented – statement of the problem(s). |
| **B** Background | Essential clinical information pertinent to the death. |
| **A** Assessment and Analysis | Focused error analysis and summary of factors contributing to the death. |
| **R** Review of literature | Identify learning points for the case with review of the literature pertinent to the death. |
| Recommendations | Propose actions for prevention of future similar problem. |

Mitchell et al[5] conducted a prospective observational study to develop a psychometrically robust assessment tool based on the SBAR format, to be used to assess cases presented at M&M meetings. This was validated to identify and improve the overall quality and educational value of the surgical M&M conference. It is easy to use, requires little training, and is potentially applicable to other specialties (appendix 5).

Time is limited at each M&M meeting and the agenda is often busy. So to facilitate timeliness of presentations, the following may be helpful:

- Aim to keep each presentation to a maximum of 10 minutes.
- For case presentations, use the SBAR format.
- For other presentations, such as audit reports, pharmacy updates, infection control updates etc. aim to keep to main points.
- If using slides, aim for no more than 5-7 slides. Avoid excessive amounts of words / data on each slide. Only include content that is informative and relevant.
- Having 2-3 key messages / take home points will be more effective than a lot of information, as people will be more likely to remember these.
- Please note that more detailed information can be sent to the M&M Lead, for inclusion in meeting record, so that all relevant health professionals can access this.

Entry onto the Regional M&M Review system

The format for the recording of a patient death onto the RM&MRs follows the principles behind the SBAR technique. There are data entry boxes to allow the structured entry of,

1. Situation - statement describing the admitting diagnosis, cause of death
2. Background – Clinical information pertinent to the death: past medical history, clinical course, procedural details and investigations.
3. Assessment – If required, a statement of the cause of any avoidable incident or complication; an evaluation of what happened and why it happened.
4. Recommendation – If required, a statement of what needs to be done to avoid a repeat; proposed actions.

It is expected that items 1 & 2 i.e. Situation and Background, will be completed when entering the *Initial Record of the Death* onto RM&MRs.

Items 3 & 4 i.e. Assessment and Recommendation, may wait to be completed, if thought necessary, until the peer review is performed at the M&M meeting. Assessment will then be completed under the section regarding Learning Lesson and Recommendation(s) will be completed under the section detailing Actions.

### 4.3.9 Final Grading of Outcome and Care

One of the core components of a case based mortality review is to grade or score the overall quality of care. NCEPOD[6] recently considered these core components and found strong support for including a data point related to considering overall quality of care - a quality of care score was strongly or very strongly supported. However, there were concerns a grading of care would lead to performance management and negative publicity.

There are a range of grading schemes already available or in development, which have variations in their complexity.

a. Preventability of Death scale or score.
b. Overall Quality of care scale.
c. Scale/Score based upon Learning and identification of Improvement.

The Regional Mortality and Morbidity Review system (RM&MRs) adopts the latter approach with a scale based upon learning, improvement and identification of good practice while still acknowledging where the care provided needs investigation and perhaps change. Section 4.3.9 provides details of this scheme.

It is expected that when a score is used indicating that the quality of care provided could have been better, that that is done responsibly and is accompanied by,

- a note explaining the reasoning behind the score;
- learning and action being taken to prevent a repeat;
- informing Trust governance structures, if necessary; and
- informing the family and next of kin, in keeping with ‘Being Open’.

Therefore, following discussion of each case, the attendees at the M&M meeting should reach a consensus as to which of the following statements best describes the overall care provided:

The care provided in the management of this patient,

| | |
|---|---|
| 1 | was Satisfactory. There were no particular Learning Lessons. |
| 2 | contained aspects that COULD* be improved (learning identified); the patient's eventual outcome was NOT affected. |
| 3 | contained aspects that SHOULD¥ be improved (learning identified); the patient's eventual outcome was NOT affected i.e. Near Miss. Consider referring to Trust Incident Reporting System unless already considered or reported. |
| 4 | contained aspects that have already been, or SHOULD¥ be, referred to Trust Incident Reporting System. |
| 5 | contained aspects that were Exemplary and the learning SHOULD¥ be shared appropriately. |

* Opinion may be divided and there may be issues that required debate.
¥ General agreement that issues and learning have been identified and change is needed.

### 4.4 Record of the M&M meeting

Taking a note and therefore making a record of the meeting is a vital element of the process of reviewing a patient death. Without that note there is no record that the discussion took place, the issues were aired or that learning was identified and action(s) taken. It is not a requirement that there is a verbatim 'minute' of the meeting; it is however necessary that there is a factual and objective note which focuses on the issues, learning and actions identified, not on personalities or the actions of individuals.

The note of the meeting will provide a mechanism to monitor the effectiveness of meetings in terms of patient safety driven change. It also ensures that mortality review and patient safety discussions are open and transparent. Remember that some of these details could be discoverable.

There are various models available for making a record or note of the meeting. Teams may choose to:

- type them live at the meeting which ensures everybody is content with the record immediately, although verification will be required at the next meeting.
- take notes and type them up afterwards; these will need verified at the next meeting.
- arrange administrative support from within each specialty rotating this role; again to either type the record live or at a later date.

It is advised that each team and Trust reviews the various methods remembering that each M&M Lead needs to review the record for accuracy and completeness prior to distribution with full verification occurring at the next M&M meeting.

The gmr&ps
SMR&PS Agenda / Record of Meeting template has been designed to allow for a note to be recorded against each agenda item. By incorporating the

agenda items into one document, this makes all the accompanying documents for the meeting available for review.

A copy of the suggested Agenda / Record of Meeting Template is attached at appendix 2.

### 4.5 Shared Learning

Learning from M&M meetings is vital, as the whole purpose of meetings is to learn from incidents and events in order to avoid the unnecessary repetition of mistakes and improve patient care in the future. Learning needs to be simple, relevant and not just a tick-box exercise.

Regional shared learning letter templates are available (example at appendix 6) and should be used, particularly when a learning point has been identified that is applicable across specialties and / or Trusts. In order for learning letters to be effective, it is advised that Trusts ensure they are not only disseminated to the relevant professionals, but they should also be discussed at M&M meetings to review how action points may apply to each specialty.

Other methods of sharing learning points arising from M&M meetings should also be considered, for example:

- Targeting particular groups with regards to relevant learning, such as trainee doctors at induction to new posts.
- Incorporating learning points into local and regional teaching sessions.
- Making use of available technology, such as having a 'lesson of the week' on the Trust intranet sites.
- Incorporating learning into regional learning events, in collaboration with other organisations.

It is also important to consider systemic issues, therefore giving the opportunity to look for systemic solutions, with the aim of preventing incidents and poor practice from recurring.
A suggested procedure for using learning letter templates to disseminate learning points identified at M&M meetings is as follows:

### 4.6 Assurance

Mortality & Morbidity Strategic Oversight Group will provide assurance about a second level of scrutiny for a percentage of cases, to ensure robust discussions have occurred. This may include independent review of a number of cases in the future e.g. by another Trust team or other external agency.

One suggestion is use of the Institute for Healthcare Improvement's Global Trigger Tool for Measuring Adverse Events[7]. A UK version is available[8]. This tool advises the use of small samples over time, choosing ten samples every two weeks. The maximum time spent by the review team on each chart is twenty minutes. Case notes are reviewed for given triggers, and then, if these are present, to determine if an adverse event has occurred[8]. It may be useful to then look back over the M&M discussion note, to see if identified incidents had been discussed.

It is acknowledged that some Trusts may prefer to use other methods of reviewing case discussions for assurance purposes. One suggestion is for 'cross-Trust' peer review of discussions.

### 4.7 Appraisal and Revalidation

During annual appraisals, doctors are expected to use supporting information to demonstrate that they are continuing to meet the principles and values set out in *'Good Medical Practice'*[9]. Doctors must demonstrate that they undertake a review of their practice by evaluating the quality of their professional work. The General Medical Council defines a number of mechanisms for this, including regularly reflecting on standards of practice and care provided[9].

Attendance and participation in M&M meetings should play an important role in appraisal and revalidation. This should include:

- the timely completion of Consultant mortality reviews;
- satisfactory attendance at meetings; and
- active participation in learning and discussion at meetings.

With the development of Nursing Revalidation, attendance and participation in M&M discussions should also be considered at nursing appraisals.

It is suggested that each Trust clarifies formal requirements for successful appraisal and revalidation. This should occur at Medical Director level.

## 5.0 IMPLEMENTATION OF GUIDANCE

### 5.1 Dissemination

This guidance currently applies to all deaths physically occurring in hospitals within Northern Ireland. It therefore applies to all hospital teams across Northern Ireland, and will be disseminated across all Health and Social Care Trusts.

**5.2 Resources**

This guidance will be distributed in a digital format. A named team or department in each Trust should assume responsibility for disseminating this guidance, raising awareness, and ensuring that it is adapted to meet local needs, as required.

**5.3 Exceptions**

This guidance currently excludes deaths that occur outside of a hospital setting. In the Southern Health & Social Care Trust, deaths under the care of the Acute Care at Home Team and child deaths occurring in the community are included in this guidance.

## 6.0 MONITORING

The Mortality & Morbidity Strategic Oversight Group will monitor the effectiveness of this policy. The Medical Director has overall responsibility.

Also see section 4.6.

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## 7.0 EVIDENCE BASE / REFERENCES


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## 8.0 CONSULTATION PROCESS

Consultation for version 1.0 was managed as part of the ADEPT programme where identified 'M&M champions' from each of the five HSC Trusts had direct input followed by circulation across the five Trusts for further comments. All comments and suggestions received during the consultation period were adopted. There was also consultation through the Death Certification Implementation Working Group (DCIWG).

This version has also been regionally circulated for consultation and comments to the 5 Trusts which have been incorporated.

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## 9.0 APPENDICES

Appendix 1 = M&M Meetings: Historical background, evidence for and future development
Appendix 2 = G&PS meeting agenda and record of meeting
Appendix 3 = Ground Rules shown at beginning of M&M meeting
Appendix 4 = Triggers for a detailed review of Death
Appendix 5 = SBAR Template
Appendix 6 = Shared Learning Letter Template
Appendix 7 = Management of RM&MR system, How to Guides

## 10.0 ACKNOWLEDGEMENTS

Version 1.0 of this guidance was primarily written by Dr Lauren Megahey during a year as an 'ADEPT Clinical Leadership Fellow,' based in the Southern Health and Social Care Trust supervised by the Medical Director, Dr Richard Wright. This has built upon previous work already done by Mr Stephen Wallace, Project Manager, and Dr John Simpson, the previous SHSCT Medical Director.

Particular acknowledgement is given to the 'Medical Champions' in each Health and Social Care Trust:

- Dr Aidan Cullen, Consultant Anaesthetist, SHSCT.
- Dr John Harty, Consultant Nephrologist, SHSCT
- Mr Lloyd McKie, Consultant Surgeon, BHSCT
- Dr Alan McKinney, Associate Medical Director, WHSCT
- Dr William Donaldson, Consultant Anaesthetist, NHSCT
- Dr David Hill, Associate Medical Director, SEHSCT

The Regional Morbidity & Mortality Review system (RM&MRs) has been developed by the Department of Health in partnership with all five Health and Social Care Trusts and the BSO.

## 11.0 EQUALITY STATEMENT

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1998), Targeting Social Need Initiative, Disability discrimination and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.

The outcome of the Equality screening for this policy is:

**Major impact** ☐
**Minor impact** ☐
**No impact.** ☒

## SIGNATORIES

**Name** Personal information redacted by USI

_____ _____ **Date: _____ August 2016_____**

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Appendix 1

## M&M Meetings: Historical background, evidence for and future development

The first antecedents of M&M meetings are difficult to trace. During the Crimean War of 1853-1855, Florence Nightingale and her team played a role in reducing the mortality rate of ill or injured soldiers from 40% to 2%, by applying strict hygiene standards and keeping records of mortality.

In 1900, the American Dr Amory Codman conceived his 'end result idea,' that each hospital should study long-term patient outcomes, with the aims of improving treatment[10]. Dr Codman faced intense opposition, but his ideas ultimately contributed to the standardisation of hospital practices by the American College of Surgeons in 1916[10].

Precursors to M&M meetings developed, such as the 'Anesthesia Mortality Committee' in Philadelphia, in 1935, involving Dr Henry Ruth. Dr Ruth described the value of open discussion of problematic cases, but also noted tension between educational goals and fear of incrimination[10].

In the intervening years, M&M meetings have evolved and are now widespread. However, across the world and even within a small country like Northern Ireland, there is significant variation in the structure and format of meetings.

There has been debate in the United States over M&M meetings being supplanted by 'Quality Assurance' meetings. Medico-legal constraints, such as Florida's Sunshine Law allowing for 'full access' of data from M&M proceedings has led to much discussion[7]. However, it is agreed that our common goal should be to learn from our complications, mistakes and adverse events, to improve future outcomes[11].

The Berwick Report[12] 2013, was commissioned to distil lessons learned and changes needed following the tragedy of Mid-Staffordshire. It identified that in the vast majority of cases it is the systems, procedures, conditions, environment and constraints that NHS staff face that lead to patient safety problems[12]. It states that 'the most important single change in the NHS in response to this report would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.' Berwick is clear that transparency is essential and should be insisted upon[12].

Studies have shown that for M&M meetings to facilitate improvement, they need to be structured and systematic[13]. It has been shown that the introduction of a standardised mortality review process is beneficial, to reduce variation in the way that deaths are reviewed and improve integration of meetings into governance frameworks[13].

A 2009 review[2] of the literature around M&M meetings found evidence to support key strategies to contribute to quality improvement and learning processes. These include commitment from senior staff, a safe and supportive environment, consistency in organisation, an inclusive approach, a structured process and detailed feedback and follow-up.

Learning from discussions at M&M meetings is a vital part of medical education. As described by Epstein in 2012, if physicians do not attend M&M meetings, 'they fail to educate themselves and others, while also imparting the message to their staff and patients that they simply do not care or do not assume responsibility for what has occurred'[14].

Over 100 years on from Florence Nightingale's work, there continues to be evidence[15] of reduced mortality due to M&M meetings, which showed that their use as a mandatory review process resulted in a 40% decrease in gross mortality over 4 years[15]. It is therefore vital that all teams attend and actively participate in M&M meetings, in order to learn from adverse events and errors, reduce repetition of these and improve patient care.

Opportunities for further development.

Although there has been significant progress achieved in Northern Ireland regarding the improvement of M&M meetings, there will always be opportunity for further improvement and development.

Donaldson et al published[16] a thematic analysis of 2,010 incidents (deaths) reported to the UK National Health Service database between 2010 – 2012. These were classified into broad areas of service failure, capable of being addressed by stronger policies, procedures and practices[16]. He also advised that there is an important role for specialty-specific teams or mortality review committees to review their own incidents and implement solutions locally, and to draw attention to generalisable, national risk reduction action. They advised that use of a classification system such as theirs would allow hospital boards and clinicians to identify and prioritise areas for greater scrutiny and intervention[16]. Indeed, this classification of learning from cases discussed at M&M meetings could be mirrored within the RM&MRs.

The improvement of shared learning should be a priority, and there is a need to develop new and innovative ways to achieve this. One idea is to link learning with Continued Professional Development (CPD), for example, by developing a regional website to include relevant shared learning for each specialty, with reflective templates, accrediting CPD points for time spent on this.

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Appendix 2

## Governance & Patient Safety meeting
## Agenda / Record of meeting

| M&M team | | Date | | Time | |
|---|---|---|---|---|---|
| Venue | | | | | |

Estimated time

1. Welcome, Attendance, Apologies Received by Chair
   Note:
2. Review of last G&PS meeting - Outstanding Issues
   Note:
   Action(s):
3. Mortality & Morbidity Review – RM&MRs on NIECR.
   a. Verification of last meeting report
   Note:
4. Safety Graphs
   a. Crash Call Review
   b. Safety Improvement graphs: e.g. HCAIs, Falls, VTE review, avoidable pressure ulcers
   Note:
   Action(s):
5. Local incident themes : Ward, Unit issues
   Note:
   Action(s):
6. Pharmacy issues, incidents and medicine/safety alerts
   a. *Insert list of documents discussed*
   Note:
   Action(s):
7. Shared learning from Complaints / SAIs / other M&M meeting / any other source.
   a. *Insert list of documents discussed*
   Note:
   Action(s):
8. Shared learning from Litigation / Coroner Cases/PM reports
   a. *Insert list of documents discussed*
   Note:
   Action(s):
9. Safety Alerts and Circulars– NICE, NCEPOD, DHSS, HSC (SGSD), HSCB, PHA, BHSCT.
   a. *Insert list of documents discussed*
   Note:
   Action(s):
10. Local Audit reports (Specialty Specific)
    a. *Insert list of documents discussed*
    Note:
    Action(s):

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11. Consultant Outcome data - NCEPOD / National / Specialty

| |
|---|
| Note: |
| Action(s): |

12. A.O.B.

| |
|---|
| Note: |
| Action(s): |

13. Date of Next Meeting

| |
|---|
| |

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Appendix 3

## Ground Rules shown at beginning of M&M meeting

1. The Chairs of M&M are responsible for highlighting these values and principles at the commencement of each M&M.
2. There must be professional courtesy and respect for everyone.
3. Presentation should be factual and objective.
4. Style and tone of presentation should be respectful.
5. Respect others when they are talking and do not interrupt them.
6. There should be a pause following presentation of difficult or complex cases, prior to discussion from the floor.
7. As far as possible, clinicians involved in the management of a difficult or complex case should be aware in advance and present when the case is being discussed at M&M.

   However, where it is not possible for all relevant clinicians to be present, as a minimum their consent and input should be sought in advance.
8. Where there is a perceived significant and potential ongoing risk arising from cases which may be undergoing serious adverse incident or internal review, the learning points / overarching issues should be presented to M&M as soon as possible, with engagement as outlined in the above point.
9. M&M meetings are not a forum for axe grinding, witch hunts or soap box issues.
10. The Chair of M&M has authority to terminate discussions where appropriate.

Acknowledgements to Dr J Harty, Daisy Hill Hospital.

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Appendix 4

| | Triggers for a Detailed Review of Death. |
|---|---|
| 1. | Unexpected death e.g. following a fall in hospital or a pulmonary embolism. |
| 2. | Following Complications / Misadventure / Incident. The following are examples:<br>• Due to treatment / procedure / operation<br>• Associated with transfer e.g. between ED & CT scanner, intrahospital.<br>• Cardiac arrest / crash calls<br>• Medicine related incident e.g.<br>- Prescription error<br>- Over coagulation related to warfarin prescription<br>• Surgical: e.g.<br>- Unplanned return to theatre<br>- Change in planned procedure<br>- Unplanned removal / Injury/ repair of organ.<br>• Infection e.g.<br>- MRSA bacteraemia<br>- C. difficile<br>- VRE (vancomycin-resistant enterococcus)<br>- Wound infection, deep surgical sepsis<br>- Nosocomial pneumonia.<br>• Readmission to Intensive Care or High Dependency Care<br>• Unplanned transfer to Intensive Care or High Dependency Care<br>• Readmission within 30 days of previous hospitalisation. |
| 3. | Unexpected deaths following elective admission – except cancer / haematology. |
| 4. | All deaths in low risk HRGs i.e. unexpected. For example:<br>• Minor ENT procedure<br>• Tonsillectomy<br>• Hernia Repair<br>• Arthroscopy<br>• Minor skin procedures<br>• Vasectomy<br>• Varicose vein surgery |
| 5. | All paediatric deaths (18 years or less), all neonatal deaths and all obstetric deaths |
| 6. | Cases referred to the Coroner's Office* |
| 7. | Complaints received which are M&M related* |

* Note that these cases should be revisited once the outcomes of investigations are known.

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Appendix 5

## SBAR Template[2]

| SBAR-STANDARDISED FORMAT FOR M&M PRESENTATIONS | |
|---|---|
| **Situation**<br>Statement of the problem | Admitting diagnosis<br>Statement of procedure or operation<br>Statement of adverse outcome |
| **Background**<br>Clinical information pertinent to adverse outcome | **Patient History:**<br>Present pertinent HPI/PMH/PSH/Meds<br><br>**Indication for intervention:**<br>Describe reason for intervention<br><br>**Labs and imaging studies:**<br>Present studies relevant to outcome<br><br>**Procedural details:**<br>Describe technical or physiological details related to outcome<br><br>**Hospital course:**<br>Present non-procedural events related to outcome<br><br>**Recognition of the complication:**<br>State how/when complication was recognised<br><br>**Management of the complication:**<br>Describe how the complication was managed |
| **Assessment and Analysis**<br>Evaluation of what happened and why it happened | **What happened? Error analysis:**<br>Describe sequence of events leading to adverse outcome<br><br>**Why did it occur? Root Cause Analysis:**<br>Provide description of fundamental cause(s) of the adverse outcome in relationship to:<br><br>**1 Human Errors**<br>Error in diagnosis, technique, judgment, communication<br><br>**2 Systems Errors**<br>Error(s)/problems in care system/organisation (e.g. poor supervision, low staffing, inadequate co-ordination of care, etc.)<br><br>**3 Patient related factors**<br>Patient disease or non-compliance |
| **Review of Literature**<br>Evidence-Based Practice | Present literature pertinent to the complication |
| **Recommendations**<br>Proposed actions to prevent future similar problem | Identify how problem could have been prevented or better managed<br>Identify learning point(s) from case |

*Note: HPI, history of present illness; PMH, past medical history; PSH, past surgical history.*

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Appendix 6

## Shared Learning Letter Template

| Trust Logo<br><br>**Shared Learning** | **Incident / SAI / Complaint / Compliment / Audit / External Letter / M&M Review / CMR / Litigation**<br><br>**Ref. No:** "Insert text and Type" | **Date issued:** |
|---|---|---|

**Safety Message:**
"Insert text and Type"

**Summary of Event**

"Insert text and Type"

**Learning Points**

"Insert text and Type"

**Learning applicable to:**

| | | | |
|---|---|---|---|
| Specific Directorate(s) (specify):<br>"Insert text and Type" | | Trustwide | |
| Other (specify):<br>"Insert text and Type" | | Regional | |

**Action Required** *(for discussion and agreement at Learning from Experience Steering Group / SAI Group or other appropriate group)*

"Insert text and Type"

| Approved by: | Designation: | Date approved: |
|---|---|---|

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# Regional Mortality & Morbidity Review System
## Recording a death

Appendix 7

**Logon to NIECR**

- Using your Trust NIECR logon details, logon to NIECR.
- If you do not have NIECR logon credentials, they have to be obtained using the details in the final box below.

**Access to RM&MRS and Finding Patient**

- Ensure you know the deceased patient's name and H&C number.
- Identify the deceased patient by using the 'Patients' tab from the Home Page.
- If the patient record is locked down, contact NIECR Team to release.
- Once you have entered the patient summary click on 'Pathways' tab along the top of the screen.
- Click on 'Enroll in Pathway' (located just below 'Pathway Enrollment' heading at top of page).
- From the drop-down list select 'Mortality Pathway' and click on 'Enroll'.
- If you enroll the wrong patient into the pathway, you can deactivate the pathway.

**Record a death**

- A form will pop up on the left hand side under 'Mortality Pathway' entitled 'Mortality Initial Record of Death'. Click on this.
- Enter required information on form. Some information will be pre-populated.
- Please note that when indicating the place of death this must either be selected from the last patient encounter or manually selecting the hospital and ward.
- Also, when entering date and time of death, please ensure these are the same as recorded in the handwritten notes as verification of life extinct.
- Then, the appropriate Consultant and M&M team must be selected to review the death.
- If you do not know the correct Consultant, select the M&M lead for that team. The M&M lead is identified within the team descriptor when you select the M&M team.
- Complete all the required boxes and click 'Complete' at bottom of form.

**Printing MCCD and/or Clinical Summary**

- Once you have clicked '*complete*' on the Initial Record of Death Form there may be output documents for you to print, depending on the outcome you have chosen. These will be an MCCD, a Clinical Summary (for the Coroner), or both.
- To access these, click on the *'Patient Summary'* tab along the top of your screen, followed by 'Notification & Legal Documents' on the left-hand-side. If you would prefer this to appear in a separate window you can select *'Patient Summary Popup'* at the top of the screen.
- After you have clicked on the relevant document there is an option to *Print* at the top of the screen.
- When printing, in the PRINT dialog box ensure that 'Fit to Size' is selected. Otherwise the borders of the MCCD will be cut off.
- Similarly for printing the Clinical Summary.

**Amending an Incorrect MCCD**

- An MCCD should only be amended if it has not yet been provided to the family or left the ward. If the MCCD has already been issued, an MCCD Correction Form should be completed by the Consultant under the 'Consultant Review Form'.
- To amend the MCCD – enter the patient record, click on the 'Pathways' tab, click 'All' at the top left of the screen under 'Patient Tasks' and click on 'Initial Record of Death' (which will have a ticked green circle beside it). Click 'Re-Open Task' at the top-right of the screen.
- Make the necessary changes to the Cause of Death section & click 'Complete' at the bottom. The amended MCCD will appear under 'Notification & Legal documents' as before.
- Print the MCCD as before. Ensure the original incorrect MCCD is retained & destroyed.

**Contact details**

If you are experiencing any issues accessing the RM&MR system or problems registering a death please contact: NIECR via the Infra portal (SHSCT, SEHSCT & NHSCT) or [redacted] (BHSCT & WHSCT)

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# Consultant Reviewing a Death

**Access to RM&MRS / Selecting patients for review**

- Once a death has been recorded onto the system & submitted for review, an email/message will be sent to the named Consultant – to their TRUST email account.
- When the email/message has been received, the review should be completed within 48 hours.
- The Consultant should log on to the ECR system.
- Click on M&M Review along the left hand side, then on Deaths Review.
- Simply clicking on 'Search' will show all the deaths for your M&M team; filters at the top of the page can be used to narrow it down to your deaths awaiting Consultant Review.
- If you are a member of more than one team you can filter your searches by selecting the appropriate team.
- Click on the relevant patient, select 'Pathways' at the top of the screen (if necessary) and click 'Mortality Consultant Review Task' along the left hand side.

**If you are NOT the Reviewing Consultant**

If you are NOT the correct Reviewing Consultant for a case:

- Follow the above steps, select the patient & access the patient Consultant Review form.
- At the top of the form there is an option to change either the team or Consultant or both.
- Complete the necessary changes and click on the 'Save Draft' button at the bottom of the page. This will re-assign the death.

**If you ARE the Reviewing Consultant**

If you ARE the reviewing consultant, select the case awaiting review.

- Answer relevant questions and review content submitted by recording Doctor. You should check information recorded in the Initial Record of Death, particularly information recorded for the MCCD. To see this click 'All' under 'Patient Tasks' at the top-left of the screen. The Initial Record of Death form will appear under 'Mortality Pathway' along the left-hand-side.
- Details entered previously by recording Doctor in the SBAR boxes can be amended however a record of what was previously entered will be retained for audit purposes. Further notes can be entered under the Consultant Notes section.
- Deaths will automatically default to 'Yes' for detailed review at M&M meeting. If a detailed review is not required this should be changed to 'No'.

**Completing**

- You must declare that you have reviewed the patient entries and accept them as correct.
- If you click 'No', you will be asked to enter your reasons and select which element you would like to correct.
- To finish, click 'Complete' at bottom of the screen.
- The case is then ready for review by the M&M team at the next team Governance & Patient Safety meeting (M&M meeting).

**Contact Details**

If you are experiencing any issues accessing the RM&MR system or problems registering a death please contact: NIECR via the Infra portal (SHSCT, SEHSCT & NHSCT) or [redacted] (BHSCT & WHSCT)

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# Regional Mortality & Morbidity Review System
## Setting Up a Mortality and Morbidity Meeting

**Setting Up Mortality & Morbidity Meeting**

- Access through logging into ECR system.
- Along left-hand-side of screen click on 'M&M Review', then click on 'Scheduled M&M Meetings'.
- At the top of the screen click on 'Add New Meeting'.
- Fill out the details and click 'Complete'. Room venue should be included under 'Meeting Details'.

- Meetings can be created in advance or at the time of the meeting.

**Setting up Joint Meeting**

- If you wish to hold a joint meeting with another team or teams these must be added under 'Additional Team(s)'.
- The meeting will appear on top of the list when 'Scheduled M&M Meetings' is clicked on.

Please note that this will not inform the rest of the team of the details of the M&M meeting. This should be done separately e.g. via Outlook.

**Contact Details**

If you are experiencing any issues accessing the RM&MR system or problems registering a death please contact: NIECR via the Infra portal (SHSCT, SEHSCT & NHSCT) or [redacted] (BHSCT & WHSCT)

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# Regional Mortality & Morbidity Review System
## Running an M&M Meeting

### Opening Meeting

- For setting up an M&M meeting, see previous how-to guide.
- To open an M&M meeting, log on to NIECR and click on 'M&M Review' along the left hand side and then click 'Scheduled M&M Meetings'.
- You will see a list of scheduled M&M meetings with the newest at the top. Select the meeting you wish to conduct.
- The first tab is 'Meeting Details'. Here you can amend the Chair of the meeting, add further details and add or remove attendees. It is recommended that you complete this tab at the end of the meeting and click 'Complete'. Please note that once the 'Complete' button has been clicked the attendees for the meeting are locked.

### Deaths NOT for detailed Review

- The M&M lead is responsible for showing the list of deaths which have not been selected for detailed review to the attendees of the meeting.
- To do this click on the 'Deaths for Review' tab at the top, select 'No' for 'Death Awaiting for Review', select 'Pending Patient M&M Review' for 'Status' and click the 'Search' button. This will bring up the full list of deaths which have not been selected for detailed review.
- If everyone is content that these are not for detailed review, the M&M lead should click into each death, then on 'Patient M&M Review'. These will be defaulted to 'Not for Detailed Review' and M&M lead should simply click 'Complete'. The M&M lead may choose to complete these at the end of the meeting.
- To change the status of a death to needing a detailed review, click into the death from the list, click on 'Patient M&M Review Task' and change the Death for Detailed Review status from 'No' to 'Yes'. This will bring up the full Patient M&M Review Task Form.

### Reviewing a Death

- To bring up a list of deaths awaiting detailed review, select 'Yes' beside 'Death Awaiting for Review', select 'Pending Patient M&M Review' for 'Status' and click 'Search'. This will bring up the list of deaths remaining to be reviewed by your team.
- To review a death, click on the relevant patient, then click 'Mortality Patient M&M Review Task' along the left hand side.
- Complete this form, including any lessons learned and actions identified, select the relevant outcome and click 'Complete'.
- To move quickly to the next death for review click on the three small horizontal bars at the top right of the screen (between two arrows) which will bring up a quick list. Otherwise click the 'X' at the top right and go back into the meeting.

### Signoff

- Once a death has been reviewed, it requires sign-off at the next meeting, once the record of the meeting has been distributed.
- Assuming that all attendees are content that they are a true record, the M&M lead should click on the pending signoff tab. Each death should be clicked on, then 'Mortality Patient M&M Signoff'. The M&M lead should then select 'Yes' and click 'Complete'.
- All steps for the recording and review of this death have now been complete and the death is now signed off.

### Record of Meeting

- Once all deaths have been reviewed and relevant deaths have been signed off, the M&M lead should review the attendance, then click 'Complete' under the 'Meeting Details' tab. This meeting has now been completed and no further deaths can be reviewed as part of this meeting.
- To view a record of deaths discussed, including lessons learned and action points, click on the 'Previous M&M Meetings' tab. When you click on a particular meeting, a record of the meeting will pop-up. This can be exported as a PDF or Excel file.

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

# Regional Mortality & Morbidity Review System
## Process for Additional Review Teams

### Finding Deaths when Nominated as Additional Review Team

- On some occasions your M&M team may be nominated as an additional review team for a death. This may be because your team was previously involved in the care of the patient or for other reasons.
- If your team has been nominated to conduct an additional review, RM&MRS will allow you to conduct a review at an M&M meeting without having to complete an Initial Record of Death or Consultant Review Form.
- Deaths for which you have been selected to review as an additional team will appear on your deaths review list for your team.
- This can be accessed by clicking on 'M&M Review' along the left-hand-side followed by 'Deaths Review'. For these deaths your team will appear under the 'Additional Review Teams' column.
- If you are selected as an additional review team, the M&M review should be conducted as an 'ad-hoc task'.

### Additional Review Teams

- If you are selected as an additional review team, the M&M review should be conducted as an 'ad-hoc task'.
- To do this, click on the patient on the death review list followed by 'Pathways' at the top if necessary.
- Click on the '+' at the top left of the screen beside 'Patient Tasks' and a drop down menu will appear. Select 'Mortality Additional Patient MM Review Task' and click 'Add Task'.
- The 'Mortality Additional Patient MM Review Task' form will then appear on the left-hand side of the screen under 'Mortality Pathway'.
- Discussions on this death should be recorded in the usual way.
- However as an additional team you will not be recording an outcome or grading of care for the death. Click 'Complete' once the form has been finished.
- If you are an additional review team, you should always use the ad-hoc task function as it will be up to the primary/initial team to conduct the pathway Patient M&M Review task.

### Contact Details

If you are experiencing any issues accessing the RM&MR system or problems registering a death please contact: NIECR via the Infra portal (SHSCT, SEHSCT & NHSCT) or [redacted] (BHSCT & WHSCT)

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# Regional Mortality & Morbidity Review System
# Process for Attaching a Document

## Reasons for Attaching Document

- As part of the review of some deaths you may wish to attach a document to the patient RM&MRs record, this must be a PDF document.
- Anyone with the relevant access to 'Pathways' within ECR may attach a document including consultants, trainees, other medical staff and governance staff.
- Types of document you may wish to attach to a patient's RM&MRs pathway include: Coroner's verdicts, SAI reports, pathology reports, Post Mortem report etc.
- Please note that only records centred on a patient should be attached to that patient's pathway. ECR is a patient based system so wider ranging documents e.g. safety alerts/graphs should not be attached to a patient pathway.

## Attaching a Document

- Find the patient you wish to attach a document to either through the 'Patient Search' or 'Recently Viewed Patients' tabs along the left-hand side.
- Once you have selected the patient, if you are an information governance or litigation staff member, you must complete the consent screen to obtain access to the patient record – choosing Information Governance as the subject and completing the additional details box with the reason access is required, access will then be granted.
- Once the patient summary appears, click on the 'Pathways' tab along the top of the screen.
- The patient should already be on the Mortality pathway as they need to be on the pathway for the death to have been registered.
- Click on the '+' button at the top-left of the screen beside 'Patient Tasks', select 'Attach a Document' from the drop-down list and click 'Add Task'.
- An 'Attach a Document' tab will pop-up on the left-hand side of the screen under the 'Mortality Pathway' heading. Click on this.
- Select the document type from the drop-down list then click 'browse'.
- Select the document you want to attach then either double-click on it or click 'Open' and the document should appear. Click 'Complete' to attach this.
- The document will be saved under that particular 'Attach a Document' tab where it can be accessed at any time.

## Contact Details

- If you are experiencing any issues attaching a document please contact: NIECR via the Infra portal (SHSCT, SEHSCT & NHSCT) or [Irrelevant redacted by the USI] (BHSCT & WHSCT

# Agenda

## Combined Surgical Anaesthetics M&M / Patient Safety Meeting

## 11th March PM session

1. **Welcome, attendance and apologies**:
2. **Previous Minutes**
3. **Matters Arising / review of last meeting**
    a) Laryngectomy - Difficult airway (Dr Winter/Mr Gurunathan)
    b) Mortality - Mr O' Donoghue
4. **Microbiology Update – Dr S Hedderwick**
5. **Pharmacy issues, incidents and medicine safety alerts – Jillian Redpath**
    a) Learning from Medication Incidents Oct -Dec 2021
    b) Audit of intravenous paracetamol prescribing Nov 21 – Feb 22
6. **Items for consideration from Medical M&M - Nil**
7. **Items for consideration from other M&M Forums - Nil**
8. **Deaths within 30 days Discharge**
9. **Mortality reporting – IME prototype**
10. **Morbidity - Nil**
    - SAI Personal Information - Deferred
11. **Safety Graphs /Local incident themes -Nil**
12. **Shared learning from SAI/ IR1 forms / Learning Letters/Litigation / Ombudsman/SEA**
    - SAI Personal Information –CALL & SEND
13. **Safety alerts and Circulars (Safety Quality Reminder)**
    - Refusal of blood products
14. **Clinical Audits/Quality Improvement**
    - Electronic Patient Resource (https://view.pagetiger.com/bmrxesq/1) – Dr Laura McLoughlin
    - Preoperative Nutrition (QI project)– Dr Alison Blair
    - Audit of G&H for laparoscopic appendectomies – Mr Justin Ong ST7, Dr Donal McKeever F2
15. **Any Other Business**
16. **Date of Next Meeting**

Tuesday 12th April 2022 - speciality specific M&M (AM session)
Wednesday 15th June 2022 – Combined M&M (AM session)

# Agenda
# Patient Safety Meeting / M&M Meeting Urology
# Friday 18th February 2022 AM session

1. **Welcome , attendance and apologies received by Chair**:

2. **Review of Previous Minutes / Verification of last meeting report**
   a. Matters Arising / outstanding issues

3. **Deaths within 30 days Discharge**

FOR INFORMATION
DEATHS OUTSIDE H

4. **Mortality Reporting**

   See NIECR

5. **Morbidity**

Personal Information pdf

6. **Local incident themes : Ward / Unit issues**

7. **Pharmacy issues, incidents and medicine safety alerts**

8. **Shared learning from Complaints / SAI/ IR1 forms / Other meetings / Learning Letters**

9. **Shared learning from Litigation / Coroners cases / PM reports / Ombudsman**

10. **Safety alerts and Circulars (Safety Quality Reminder) sent to M&M chairs**

    a. Safety and Quality Reminders
    b. E-Alerts
    c. PHA Letters

## Issued Standards & Guidelines Circulars: for Dissemination, Review & Implementation

| Title of Correspondence | Date of Issue from External Agency | Reference | Guidance Type | NICE Assurance 3 month | Full Implementation Date for S&G |
|---|---|---|---|---|---|
| PALIVIZUMAB_RSV in At Risk Preterm Infants *Provision of Palivizumab passive immunisation to the existing and additional cohorts should be stopped at the end of January 2022. Updates and replaces letter issued on 16/07/2022* | 28/01/2022 | HSS MD 03 2022 | CMO Correspondence | n/a | 31/01/2022 |
| Inducing Labour *Updates and replaces CG 70 that was previously issued on 01/07/2009* | 27/01/2022 | NG 207 | NICE Clinical Guideline | 27/04/2022 | 27/01/2023 |
| Sodium Zirconium Cyclosilicate_Hyperkalaemia | 26/01/2022 | TA 599 | NICE Technology Appraisal Update | n/a | 26/04/2022 |
| Glaucoma Diagnosis and Management *Clinical Guideline was initially endorsed by DOH on 21/12/2017* | 26/01/2022 | NG 81 | NICE Clinical Guideline Update | n/a | 26/04/2022 |

| Title of Correspondence | Date of Issue from External Agency | Reference | Guidance Type | Deadline Date for Implementation |
|---|---|---|---|---|
| Management HSC Staff_Confirmed Cases COVID 19<br>*Previous version of this CMO letter was issued on 21/01/2022*<br><br>The Trust's COVID19 Toolkit (Version 4) [click here] has been updated to reflected these recent changes from the Chief Medical Officer. It may now be possible to return to work after 5 days of isolation after testing positive for COVID 19 provided staff adhere to stringent lateral flow testing. | 25/01/2022 | HSS MD 02-2022 (revised) | CMO Correspondence | With Immediate Effect |
| Updated guidance_Care Homes_COVID 19 | 25/01/2022 | n/a | PHA Correspondence | With Immediate Effect |
| PHA Letter - Testing for HCAI | 24/01/2022 | n/a | PHA Correspondence | With Immediate Effect |

| Title of Correspondence | Date of Issue from External Agency | Reference | Guidance Type | Deadline Date for Implementation |
|---|---|---|---|---|
| Managing COVID | 27/01/2022 | NG 191 | NICE COVID-19 Rapid Guideline Update | n/a |

| Title of Correspondence | Date of Issue from External Agency | Reference | Guidance Type | NICE Assurance 3 month | Full Implementation Date for S&G |
|---|---|---|---|---|---|
| Antenatal care (updates and replaces CG62) | 13/01/2022 | NG 201 | NICE Clinical Guideline | 13/04/2022 | 13/01/2023 |
| Foreign Body Aspiration During Intubation, Advanced Airway Management or Ventilation<br><br>*Regional Circulation – Clear Your Clutter Poster* | 12/01/2022 | HSC (SQSD) 17/20 | Patient Safety Alert | n/a | n/a |

| Title of Correspondence | Date of Issue from External Agency | Reference | Guidance Type | Deadline Date for Implementation |
|---|---|---|---|---|
| Visiting with Care – A Pathway | 14/01/2022 | n/a | CNO Correspondence | N/A |

| Title of Correspondence | Date of Issue from External Agency | Reference | Guidance Type | NICE Assurance 3 month | Full Implementation Date for S&G |
|---|---|---|---|---|---|
| Budesonide_Eosinophilic Oesphagitis | 11/02/2022 | TA 708 | NICE Technology Appraisal | 11/05/2022 | 11/11/2022 |
| Andexanet alfa_Reversing anticoagulation_Apixaban_Rivaroxaban | 11/02/2022 | TA 697 | NICE Technology Appraisal | 11/05/2022 | 11/11/2022 |
| Bempedoic Acid with Ezetimibe | 11/02/2022 | TA 694 | NICE Technology Appraisal | 11/05/2022 | 11/11/2022 |
| Dapagliflozin_Chronic Heart Failure | 11/02/2022 | TA 679 | NICE Technology Appraisal | 11/05/2022 | 11/11/2022 |
| Mepolizumab_Severe Eosinophilic Asthma | 11/02/2022 | TA 671 | NICE Technology Appraisal | 11/05/2022 | 11/11/2022 |
| Naldemedine for treating opioid-induced constipation | 11/02/2022 | TA 651 | NICE Technology Appraisal | 11/05/2022 | 11/11/2022 |
| NOT RECOMMENDED_Fostamatinib_Chronic Immune Thrombocytopenia | 10/02/2022 | TA 759 | NICE Technology Appraisal | n/a | 10/03/2022 |
| Updated DoH Guidance_Death Certification<br>*Previous HSS MD 01/2019 has been superceded*<br><br>*Recipients of this circular must ensure that all Medical Practitioners are informed of this updated guidance which can be found at 'Guidance surrounding Death' under the heading 'Death Certification and Completing a MCCD'. Refer to link below:* | 09/02/2022 | HSS MD 07/2022 | CMO Correspondence | n/a | n/a |

| | | | | | |
|---|---|---|---|---|---|
| Guidance surrounding Death \| Department of Health (health-ni.gov.uk) | | | | | |
| TERMINATED - Pembrolizumab_Metastatic Urothelial Cancer | 01/02/2022<br><br>(SHSCT did not receive this notification hence delay in issue) | TA 674 | NICE Technology Appraisal | Not Applicable to SHSCT | |

| Title of Correspondence | Date of Issue from<br><br>External | Reference | Guidance Type | Deadline Date for Implementation |
|---|---|---|---|---|

| | Agency | | | |
|---|---|---|---|---|
| Updated_HSS MD 06-2022_nMABs_non hospitalised patients with COVID<br><br>*Please note the published Interim Clinical Commissioning Policy 'Antivirals or neutralising monoclonal antibodies (nMABs) for non-hospitalised patients with COVID-19' and associated clinical guide have been updated since the issue of the above letter on 1 February 2022.* | 11/02/2022 | HSS MD 06-2022 | CMO Correspondence | n/a |
| Updated_HSS MD 04-2022 COVID 19 Alert_antivirals nMABs_treatment of COVID patients<br><br>*Please note the published Interim Clinical Commissioning Policy 'Antivirals or neutralising monoclonal antibodies (nMABs) in the treatment of COVID-19 in hospitalised patients' and associated clinical guide have been updated since the issue of the above letter on 31 January 2022.* | 11/02/2022 | HSS MD 04-2022 | CMO Correspondence | n/a |
| Updated PHA Guidance_Testing to reduce HCAI<br>*Updates guidance issued on 24/01/2022 and 09/02/2022* | 11/02/2022 | n/a | PHA Correspondence | With Immediate Effect |

| Title of Correspondence | Date of Issue from External | Reference | Guidance Type | NICE Assurance 3 month | Full Implementation Date for S&G |
|---|---|---|---|---|---|

| | Agency | | | | |
|---|---|---|---|---|---|
| Revised HSCB Letter_Nivolumab Ipilimumab Chemotherapy_untreated metastatic non-small-cell lung cancer - NOT RECOMMENDED<br><br>*There was an error in the previous HSCB letter dated 20/12/2021 (wrong cancer type stated). Assurance has been already provided that the Trust is compliant with the recommendation not to recommend this regime for the treatment of this condition* | 21/01/2022 | NICE TA 724 | NICE Technology Appraisal | n/a | n/a |
| Pentosan Polysulfate Sodium_ Bladder Pain Syndrome | 21/01/2022 | NICE TA 610 | NICE Technology Appraisal | 21/04/2022 | 21/10/2022 |
| Xeomin_Treating chronic sialorrhoea | 21/01/2022 | NICE TA 605 | NICE Technology Appraisal | 21/04/2022 | 21/10/2022 |
| Updated Never Events Guidance - Never Event Number 4 | 20/01/2022 | HSC SQSD 04-22 | CMO Correspondence | n/a | n/a |
| Myalgic encephalomyelitis (or encephalopathy)/chronic fatigue syndrome: diagnosis and management<br>*(Updates and replaces NICE CG 53 previously* | 19/01/2022 | NG 206 | NICE Clinical Guideline | 19/04/2022 | 19/01/2023 |

| | | | | | |
|---|---|---|---|---|---|
| *endorsed on 31/08/2008)* | | | | | |
| MBRRACE UP Perinatal Mortality Surveillance Report Jan to Dec 2019 | 18/01/2022 | n/a | MBRRACE | n/a | n/a |
| MBRRACE UK Learning from Standardised Reviews when Babies Die | 18/01/2022 | n/a | MBRRACE | n/a | n/a |
| Rehabilitation after Traumatic Injury<br><br>Forms part of the regional Equality Screening consultation process (6 weeks) | 18/01/2022 | NG 211 | NICE Equality Screening Questionnaire | n/a | 28/02/2022 |
| Children Young Persons experience of Healthcare | 17/01/2022 | NG 204 | NICE Clinical Guideline | 18/04/2022 | 18/01/2023 |

**NICE Technology Appraisals Issued by the HSCB (29th January to 4 February 2022)**

| Title of Correspondence | Date of Issue from External Agency | Reference | Guidance Type | NICE Assurance 3 month | Full Implementation Date for S&G |
|---|---|---|---|---|---|
| Guselkumab_Active psoriatic arthritis after inadequate response to DMARDs | 31/01/2022 | TA 711 | NICE Technology Appraisal | 30/04/2022 | 31/10/2022 |
| Ravulizumab_Atypical Haemolytic Uraemic Syndrome | 31/01/2022 | TA 710 | NICE Technology Appraisal | 30/04/2022 | 31/10/2022 |
| Pembrolizumab_Metastatic Colorectal Cancer with High Microsatellite | 31/01/2022 | TA 709 | NICE Technology Appraisal | 30/04/2022 | 31/10/2022 |
| Ofatumumab_Relapsing Multiple Sclerosis | 31/01/2022 | TA 699 | NICE Technology Appraisal | 30/04/2022 | 31/10/2022 |
| Ravulizumab_Paroxysmal Nocturnal Haemoglobinuria | 31/01/2022 | TA 698 | NICE Technology Appraisal | 30/04/2022 | 31/10/2022 |
| Carfilzomib with dexamethasone and lenalidomide_Multiple Myeloma | 31/01/2022 | TA 695 | NICE Technology Appraisal | 30/04/2022 | 31/10/2022 |
| Ribociclib_Advanced Breast Cancer after Endocrine Therapy | 31/01/2022 | TA 687 | NICE Technology Appraisal | 30/04/2022 | 31/10/2022 |
| Pembrolizumab with Pemetrexed and Platinum Chemotherapy_ NSC Lung Cancer | 31/01/2022 | TA 683 | NICE Technology Appraisal | 30/04/2022 | 31/10/2022 |
| Baricitinib_Moderate to severe Atopic Dermatitis | 31/01/2022 | TA 681 | NICE Technology Appraisal | 30/04/2022 | 31/10/2022 |

11. **Local Audit reports/Quality Improvement**

**a)** All clinical audits to be registered via clinical audit registration form. DAA form to be completed also.


Data Access Agreement (v4.0) Ju


Clinical And Social Care Audit Registrati

12. **Consultant outcome data (NCEPOD / National / Regional / Speciality)**

13. **Any Other Business**

14. **Date of Next Meeting -** Friday 11th March 2022, PM, Combined

15. **Calendar 2022**


1.Combined Surgical Anesthetics MM [redacted]

## Stinson, Emma M

**From:** Haffey, Raymond
**Sent:** 28 January 2022 11:48
**To:** Arava, Shiva; Campbell, John; Charnock, Rob; Korda, Marian; ODonoghue, JohnP; Thompson, Richard; Watson, Bruce
**Cc:** Doyle, Caroline; McConville, JoanneE; Harte, Terri; McLoughlin, Sandra E; Markey, Mary; Feely, Roisin; Haffey, Raymond
**Subject:** FOR INFORMATION: DEATHS OUTSIDE HOSPITAL - DEATHS RECORDED ON PAS AFTER LAST DISCHARGE REPORT:NOVEMBER - DECEMBER 2021
**Attachments:** Anaesthetics and Surgery mortality post discharge (December 2021 report).xlsx; Anaesthetics and Surgery mortality post discharge (January 2022 report).xlsx; Anaesthetics and Surgery mortality post discharge (November 2021 report).xlsx

Dear all

Please find attached report for Deaths Outside a SHSCT Hospital Where the Patient had a Hospital Discharge for periods 01/10/2021 – to 17/11/2021, 01/11/2021 to 15/12/2021 and 01/12/2021 to 12/01/2022. Reports are ran by the Information Team based in Bannvale primarily for the CAH Medical M&M. The CAH medical cases are shared with the Chair for the meeting. I have filtered the Anaesthetics / Surgery cases out of the main report for each time period.

Regards

Raymond Haffey
Senior Audit Facilitator
Southern Health & Social Care Trust
Tel: Personal Information redacted by the USI. Mobile Personal Information redacted by the USI
e-mail Personal Information redacted by the USI

**DEATHS OUTSIDE A SHSCT HOSPITAL SITE WHERE THE PATIENT HAD A HOSPITAL DISCHARGE BETWEEN 01/11/2021 – 15/12/2021 (Run Date 16/12/2021)**

| Date of Death | HCN | Casenote | Forenames | Surname | Date of Discharge Only | Days post Discharge | Timeband | Hospital on Discharge | Specialty On Discharge Descript (R) | Consultant on Discharge - Name | Ward on Discharge | Method of Discharge | Comment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information redacted by the USI | | | | | | 4 | <30 Days | CRAIGAVON AREA HOSPITAL | TRAUMA AND ORTHOPAEDICS | Roberts V Miss | Trauma Ward | Normal | |
| | | | | | | 12 | <30 Days | CRAIGAVON AREA HOSPITAL | GENERAL SURGERY | Epanomeritakis E Mr | 4n - Emergency Surgical Ward | Normal | |
| | | | | | | 3 | <30 Days | CRAIGAVON AREA HOSPITAL | UROLOGY | Young M Mr | 4s - Progressive Care Ward | Nurse Disc - Normal | |
| | | | | | | 2 | <30 Days | CRAIGAVON AREA HOSPITAL | GENERAL SURGERY | Epanomeritakis E Mr | 4n - Emergency Surgical Ward | Normal | |
| | | | | | | 16 | <30 Days | DAISY HILL HOSPITAL | GENERAL SURGERY | Malik M Mr | Dhh Elective Admissions Ward | Discharged-Self/Rel | |
| | | | | | | 12 | <30 Days | DAISY HILL HOSPITAL | GENERAL SURGERY | Mahmood M S Mr | Dhh Elective Admissions Ward | Normal | |
| | | | | | | 26 | <30 Days | CRAIGAVON AREA HOSPITAL | GENERAL SURGERY | Neill A K Mr | Ward 4 Ramone | Normal | |
| | | | | | | 12 | <30 Days | DAISY HILL HOSPITAL | GENERAL SURGERY | Mahmood M S Mr | Female Surgical | Normal | |
| | | | | | | 1 | <30 Days | CRAIGAVON AREA HOSPITAL | UROLOGY | Omer S Dr | 1 West Admissions Ward | Normal | |
| | | | | | | 31 | 31 - 60 Days | CRAIGAVON AREA HOSPITAL | UROLOGY | Young M Mr | 4s - Progressive Care Ward | Normal | |

**DEATHS OUTSIDE A SHSCT HOSPITAL SITE WHERE THE PATIENT HAD A HOSPITAL DISCHARGE BETWEEN 01/12//2021 – 12/01/2022 (Run Date 13/01/2022)**

| Date of Death | HCN | Casenote | Forenames | Surname | Date of Discharge Only | Days post Discharge | Timeband | Hospital on Discharge | Specialty On Discharge Descript (R) | Consultant on Discharge - Name | Ward on Discharge | Method of Discharge | Comment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Personal Information redacted by the USI | | | | | | 1 | <30 Days | CRAIGAVON AREA HOSPITAL | UROLOGY | Omer S Dr | 1 West Admissions Ward | Normal | |
| | | | | | | 10 | <30 Days | DAISY HILL HOSPITAL | GENERAL SURGERY | Thompson R Mr | Female Surgical | Normal | |
| | | | | | | 1 | <30 Days | CRAIGAVON AREA HOSPITAL | ANAESTHETICS | Stewart D Dr | Recovery Ward | Transfer-Other Hosp | |
| | | | | | | 21 | <30 Days | CRAIGAVON AREA HOSPITAL | UROLOGY | Young M Mr | Ward 4 Ramone | Normal | |
| | | | | | | 5 | <30 Days | CRAIGAVON AREA HOSPITAL | GENERAL SURGERY | Hewitt G.R. Mr | 4s - Progressive Care Ward | Normal | |

**DEATHS OUTSIDE A SHSCT HOSPITAL SITE WHERE THE PATIENT HAD A HOSPITAL DISCHARGE BETWEEN 01/10/2021 – 17/11/2021 (Run Date 18/11/2021)**

| Date of Death | HCN | Casenote | Forenames | Surname | Date of Discharge Only | Days post Discharge | Timeband | Hospital on Discharge | Specialty On Discharge Descript (R) | Consultant on Discharge - Name | Ward on Discharge | Method of Discharge | Comment |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| [redacted] | | | Personal Information redacted by the USI | | | 37 | 31 - 60 Days | CRAIGAVON AREA HOSPITAL | GENERAL SURGERY | Epanomeritakis E Mr | Ward 4 Ramone | Normal | |
| | | | | | | 6 | <30 Days | CRAIGAVON AREA HOSPITAL | GENERAL SURGERY | Hewitt G.R. Mr | 4n - Emergency Surgical Ward | Normal | On previous list also |
| | | | | | | 22 | <30 Days | CRAIGAVON AREA HOSPITAL | UROLOGY | Khan N Mr | Ward 4 Ramone | Normal | |
| | | | | | | 12 | <30 Days | CRAIGAVON AREA HOSPITAL | GENERAL SURGERY | Neill A K Mr | 1 West Admissions Ward | Normal | |
| | | | | | | 9 | <30 Days | CRAIGAVON AREA HOSPITAL | ANAESTHETICS | Shevlin C Dr | Intensive Care Unit | Transfer-Other Hosp | |

Southern Health and Social Care Trust

***UROLOGY DEPARTMENT***
***THORNDALE UNIT***
***CRAIGAVON AREA HOSPITAL***

Personal Information redacted by the USI

Dear DR Personal Information

**Re: Name:** MR Personal Information redacted by the USI
**D.O.B:** Personal Information redacted by the USI
**Address:** Personal Information redacted by the USI
**Hospital No:** Personal Information redacted by the USI **H&C No:** Personal Information redacted by the USI

Personal Information redacted by the USI

Past medical history: Personal Information redacted by the USI

Personal Information redacted by the USI

Personal Information redacted by the USI

Yours sincerely,

*Dictated but not signed by*

**Mr Matthew Tyson**
**Consultant Urologist**

| Date Dictated: 21/01/2022 | Date Typed: 25/01/2022-TL |
|---|---|

**CRAIGAVON AREA HOSPITAL, 68 LURGAN ROAD, PORTADOWN, BT63 5QQ**
**Secretary:** Miss Teresa Loughran **Telephone:** Personal Information redacted by the USI
**E-mail:** Personal Information redacted by the USI

**From the Chief Medical Officer**
Professor Sir Michael McBride

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

**HSS(MD) 3/2022**

**FOR ACTION**
Chief Executives, Public Health Agency/Health and Social Care Board/HSC Trusts/ NIAS
GP Medical Advisers, Health and Social Care Board
All General Practitioners and GP Locums (for onward distribution to practice staff)
OOHs Medical Managers (for onward distribution to staff)

**PLEASE SEE ATTACHED FULL CIRCULATION LIST**

Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

Tel: 028 9052 0563
Email: Michael.McBride[redacted]

Our Ref: HSS(MD) 3/2022
Date: 28 January 2022

Dear Colleagues

**PALIVIZUMAB PASSIVE IMMUNISATION AGAINST RESPIRATORY SYNCYTIAL VIRUS (RSV) IN AT-RISK PRE-TERM INFANTS**

**ACTION REQUIRED**

**HSC trusts and primary care teams are asked to note:**

**Provision of palivizumab passive immunisation to at risk pre-term infants within the cohorts recommended by the Joint Committee on Vaccination and Immunisation (JCVI) and the additional cohorts recommended under the previously published UK clinical policy statement should be stopped at the end of January 2022.**

Palivizumab, administered as an intramuscular injection, is used to provide protection against respiratory syncytial virus (RSV) in at-risk patients. Palivizumab is currently part of a UK-wide immunisation schedule under guidance issued by the Joint Committee on Vaccination and Immunisation (JCVI), which recommends its use in premature infants with severe conditions affecting the lungs and/or heart, and some children with impaired immune systems.

My letter of 16 July 2021 (HSS(MD) 46/2021) advised that an updated UK rapid policy statement published in June 2021 extended the eligibility criteria for passive immunisation with palivizumab to a further group of at-risk infants and allowed for up to 7 doses to be administered. This decision was made in the context of the COVID-19 pandemic and was informed by the unusual seasonal presentation of the virus being observed.

A UK-wide National Expert Group comprising relevant specialist clinicians, national clinical leads, the devolved administrations, JCVI, the Royal College of Paediatrics and Child Health, and the UK Health Security Agency (UKHSA) has now reviewed the latest available data, noting a decline in RSV related hospitalisation and rates of infection, which are now below the seasonal norm. The unanimous recommendation of the National Expert Group is that provision of palivizumab passive immunisation to the existing and additional cohorts should be stopped at the end of January 2022.

Based on the latest clinical and epidemiological data in Northern Ireland, the Department has accepted this recommendation and, as such, provision of palivizumab passive immunisation to the existing and additional cohorts should now be stopped at the end of January 2022.

I would like to thank all staff involved in the delivery of the palivizumab programme this season. Even though RSV arrived in Northern Ireland earlier than usual this year, your work ensured that our most vulnerable infants were protected by palivizumab throughout the season. Thank you again for this.

Yours sincerely


**PROF SIR MICHAEL McBRIDE**
**Chief Medical Officer**

**Circulation List**

Director of Public Health/Medical Director, Public Health Agency (*for onward distribution to all relevant health protection staff*)
Assistant Director Public Health (Health Protection), Public Health Agency
Director of Nursing, Public Health Agency
Assistant Director of Pharmacy and Medicines Management, Health and Social Care Board *(for onward distribution to Community Pharmacies)*
Directors of Pharmacy HSC Trusts
Director of Social Care and Children, HSCB
Family Practitioner Service Leads, Health and Social Care Board *(for cascade to GP Out of Hours services)*
Medical Directors, HSC Trusts *(for onward distribution to all Consultants, Occupational Health Physicians and School Medical Leads)*
Nursing Directors, HSC Trusts *(for onward distribution to all Community Nurses, and Midwives)*
Directors of Children's Services, HSC Trusts
RQIA (*for onward transmission to all independent providers including independent hospitals*)
Medicines Management Pharmacists, HSC Board *(for cascade to prescribing advisers)*
Regional Medicines Information Service, Belfast HSC Trust
Regional Pharmaceutical Procurement Service, Northern HSC Trust

Professor Donna Fitzsimons, Head of School of Nursing and Midwifery QUB
Professor Sonja McIlfatrick, Head of School of Nursing, University of Ulster
Siobhan Murphy, CEC
Donna Gallagher, Open University
Professor Paul McCarron, Head of School of Pharmacy and Pharmaceutical Sciences, UU
Professor Colin McCoy, Head of School, School of Pharmacy, QUB
Professor Colin Adair, Postgraduate Pharmacy Dean, NI Centre for Pharmacy Learning and Development, QUB
Joe Brogan, Assistant Director of Integrated Care, HSCB
Michael Donaldson, HSCB *(for distribution to all General Dental Practitioners)*
Raymond Curran, Head of Ophthalmic Services, HSCB *(for distribution to Community Optometrists)*
Trade Union Side
Clinical Advisory Team
Louise McMahon, Director of Integrated Care, HSCB

This letter is available on the Department of Health website at
https://www.health-ni.gov.uk/topics/professional-medical-and-environmental-health-advice/hssmd-letters-and-urgent-communications

Deputy Chief Medical Officer
**Dr Lourda Geoghegan**

**Circular HSC (SQSD) (NICE NG207) 7/22**

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

**Subject: NICE Clinical Guideline NG207 – Inducing labour (updates and replaces CG70)**

**Circular Reference: HSC (SQSD) (NICE NG207) 7/22**

**Date of Issue: 27 January 2022**

**Related documents:**
HSC (SQSD) 3/13
HSC (SQSD) (NICE NG201) 2/22
HSC (SQSD) (NICE NG192) 26/21
HSC (SQSD) (NICE CG190) 4/15

**For action by:**
Chief Executive of HSC Board – **for distribution to:**
All HSC Board Directors – for cascade to relevant staff

Director of Integrated Care, HSC Board – **for cascade to**:
Head of Dental Services
Head of Ophthalmic Services
Head of Pharmacy and Medicines Management
Family Practitioner Services Leads – for cascade to relevant Family Practitioner groups

Chief Executive of Public Health Agency – **for distribution to:**
Director of Public Health and Medical Director – for cascade to relevant staff
Director of Nursing and AHPs – for cascade to relevant staff

Chief Executives of HSC Trusts – **for distribution to:**
Medical Directors – for cascade to relevant staff
Directors of Nursing – for cascade to relevant staff
Heads of Pharmaceutical Services – for cascade to relevant staff
Directors of Acute Services – for cascade to relevant staff
HSC Clinical and Social Governance Leads
Directors of Social Services – for cascade to relevant staff
Directors of Finance – for cascade to relevant staff
AHP Leads – for cascade to relevant staff

Chief Executive, Regulation & Quality Improvement Authority – **for cascade to:** relevant independent healthcare establishments

Chief Executives of HSC Special Agencies and NDPBs

**For Information to:**
Chair of HSC Board
Chair of Public Health Agency
Chairs of HSC Trusts
Chair of RQIA
NICE Implementation Facilitator NI
Members of NI NICE Managers' Forum

**Superseded documents**
HSC (SQSD) (NICE CG70) 36/2009

**Summary of Contents:**
This guideline covers the circumstances for inducing labour, methods of induction, assessment, monitoring, pain relief and managing complications. It aims to improve advice and care for pregnant women who are thinking about or having induction of labour.

**Status of Contents:**
Action

**Enquiries:**
Any enquiries about the content of this Circular should be addressed to:
Quality Regulation and Improvement Branch
Department of Health
Room D1.4
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

SGU-NICEGuidance@health-ni.gov.uk

**Implementation:**
As per circular. Generally, Clinical Guidelines should be implemented within 12 months of endorsement.

**Additional copies:**
Available to download from
https://www.health-ni.gov.uk/topics/safety-and-quality-standards/national-institute-health-and-care-excellence-nice

**Dear Colleagues**

**NICE Clinical Guideline NG207 - Inducing labour (updates and replaces CG70) -** https://www.nice.org.uk/guidance/ng207

The Department has recently reviewed the above NICE guidance and has formally endorsed it as applicable in Northern Ireland.

In accordance with the process outlined in circular HSC (SQSD) 3/13, the following actions should be taken (https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/hsc-sqsd-3-13.pdf)

1. HSC Board / PHA
    a. Identify a Professional Lead who will consider the commissioning implications of the Clinical Guideline and co-ordinate with any other relevant commissioning teams. This Lead will identify any areas where regional planning / investment / commissioning are required, or where there is material risk to safety or quality. These will then be actioned immediately through normal commissioning arrangements or through bespoke arrangements reflecting the nature of the issue / risk.
    b. Ensure that relevant guidance is sent to the appropriate Family Practitioners and other Integrated Care Services as appropriate/relevant.
    c. Seek positive assurance from the HSC Trusts and Integrated Care that the required initial actions have been undertaken within a 3 month period, and that the Guideline has been implemented within a further 9 months (unless otherwise notified by the HSC Trusts).
    d. Where significant investment/ commissioning needs cannot be met within the usual timeframe, agree appropriate arrangements with HSC Trusts. Report to DoH as required at 6 monthly accountability meetings.

2. HSC Trusts
    a. Proceed with targeted dissemination, agree a clinical/management lead to coordinate implementation and consider what has to be done to achieve implementation using a risk based assessment and baseline review as appropriate to support planning. These initial actions should be undertaken within a three month period.
    b. Implement the Guideline within a further 9 months (apart from any elements where significant issues have been raised with the HSC Board/PHA).
    c. Provide positive assurances to the HSC Board that required initial actions have been taken within the 3 month planning period and that the Guideline has been implemented within a further 9 months, where appropriate.
    d. Where significant investment/ commissioning needs cannot be met within the usual timeframe, notify the HSC Board/PHA at the earliest opportunity through the bi-monthly director level meetings and agree appropriate arrangements with them to achieve implementation.

3. RQIA
    a. Disseminate the Guideline to the independent sector as appropriate.

4. HSC Special Agencies and NDPBs
    a. Take account of this Guideline in training and other developments as appropriate.

To inform the planning process, please find attached details from the Departmental review. You should consider and take account of other relevant Departmental policies and strategies in your planning, as well as any legislative / policy caveats identified in the course of the Departmental review.

A full current list of NICE guidance endorsed for application in Northern Ireland can be found on the Department's website at https://www.health-ni.gov.uk/topics/safety-and-quality-standards/national-institute-health-and-care-excellence-nice


**Dr Lourda Geoghegan**
**Deputy Chief Medical Officer**

**Appendix 1**

**Endorsed NICE guidance - Details from Departmental review**

| | |
|---|---|
| Reference Number | NICE Clinical Guideline – NG207<br>https://www.nice.org.uk/guidance/ng207 |
| Title | **Inducing labour** |
| Summary of guidance | This guideline updates and replaces NICE Clinical Guideline CG70 - Induction of Labour (endorsed by DoH in July 2009).<br><br>The guideline covers the circumstances for inducing labour, methods of induction, assessment, monitoring, pain relief and managing complications. It aims to improve advice and care for pregnant women who are thinking about or having induction of labour.<br><br>This guideline includes new and updated recommendations on:<br>• information and decision making<br>• induction of labour in specific circumstances<br>• methods for induction of labour<br><br>It also includes recommendations on:<br>• methods that are not recommended for induction of labour<br>• assessment before induction, monitoring and pain relief<br>• outpatient induction<br>• prevention and management of complications<br><br>In this guideline the terms 'woman' and 'women', are used based on the evidence used in its development. The recommendations will also apply to people who do not identify as women but are pregnant or have given birth. |
| Related strategically relevant DoH/ HSC policies | Maternity Strategy for Northern Ireland (2012-2018)<br>https://www.health-ni.gov.uk/articles/maternity-strategy-northern-ireland-2012-2018 |
| Inter-Departmental interest | None |

| | |
|---|---|
| Legislative / policy caveats | This advice does not override or replace the individual responsibility of health professionals to make appropriate decisions in the circumstances of their individual patients, in consultation with the patient and/or guardian or carer. This would, for example, include situations where individual patients have other conditions or complications that need to be taken into account in determining whether the NICE guidance is fully appropriate in their case.<br><br>Where this guideline refers to information on the NHS website. The equivalent resource in Northern Ireland is available at: https://www.publichealth.hscni.net/publications/pregnancy-book-0<br><br>It should be noted that this guidance contains some recommendations for off-label use of medicines. Trusts and practitioners must be aware of their responsibilities and ensure that appropriate polices are in place when medicines are used off-label. |

NICE National Institute for Health and Care Excellence

NICE guideline

# Inducing labour

NICE guideline

Published: 4 November 2021 www.nice.org.uk/guidance/ng207

# Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

# Contents

This guideline replaces CG70.

This guideline is the basis of QS60.

# Overview

This guideline covers the circumstances for inducing labour, methods of induction, assessment, monitoring, pain relief and managing complications. It aims to improve advice and care for pregnant women who are thinking about or having induction of labour.

In this guideline we use the terms 'woman' and 'women', based on the evidence used in its development. The recommendations will also apply to people who do not identify as women but are pregnant or have given birth.

# Who is it for?

- Healthcare professionals
- Commissioners and providers
- Pregnant women, their families and carers

# Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

## 1.1 Information and decision making

This section should be read in conjunction with the NICE guidelines on antenatal care, caesarean birth and intrapartum care for healthy women and babies.

1.1.1 Discuss preferences about mode of birth with women early on in their pregnancy. Take into account their individual circumstances, and discuss that options for birth can include:

- expectant management, or
- induction of labour, or
- planned caesarean birth (see the NICE guideline on caesarean birth).

Record these discussions and the woman's preferences in her notes. [2008, amended 2021]

1.1.2 Confirm a woman's preferences for birth at antenatal visits towards the end of pregnancy, as these may have changed since earlier discussions. [2008, amended 2021]

1.1.3 Explain to women that induction of labour is a medical intervention that will affect their birth options and their experience of the birth process. This could include that:

- vaginal examinations to assess the cervix are needed before and during induction, to determine the best method of induction and to monitor progress
- their choice of place of birth will be limited, as they may be recommended interventions (for example, oxytocin infusion, continuous fetal heart rate monitoring and epidurals) that are not available for home birth or in midwife-led birth units
- there may be limitations on the use of a birthing pool
- there may be a need for an assisted vaginal birth (using forceps or ventouse), with the associated increased risk of obstetric anal sphincter injury (for example, third- or fourth-degree perineal tears)
- pharmacological methods of induction can cause hyperstimulation – this is when the uterus contracts too frequently or contractions last too long, which can lead to changes in fetal heart rate and result in fetal compromise
- an induced labour may be more painful than a spontaneous labour • their hospital stay may be longer than with a spontaneous labour. [2021]

1.1.4 Discuss with women being offered induction of labour:

- the reasons for induction being offered
- when, where and how induction could be carried out
- the arrangements for support and pain relief (see also recommendations on pain relief)
- the alternative options if the woman chooses not to have induction of labour, or decides at a later stage that she no longer wishes to proceed with the induction process
- the risks and benefits of induction of labour in specific circumstances, and the proposed induction methods
- that induction may not be successful, and how this would affect the woman's options (see the recommendations on unsuccessful induction). [2008, amended 2021]

1.1.5 When offering induction of labour:

- give women time to discuss this information with others (for example, their partners, birthing companion or family) if they wish to do so before making a decision

 

- encourage women to look at other information (for example, by providing written information leaflets or encouraging them to look at information on the NHS website)
- ensure women have the opportunity to ask questions, and time to think about their options
- recognise that women can decide to proceed with, delay, decline or stop an induction. Respect the woman's decision, even if healthcare professionals disagree with it, and do not allow personal views to influence the care they are given. Record the woman's decision in her notes. [2008, amended 2021]

1.1.6 Provide information on induction of labour in line with the NICE guideline on patient experience in adult NHS services. [2021]

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on induction of labour for pregnancy lasting longer than 41 weeks.

Full details of the evidence and the committee's discussion are in evidence review C: induction of labour for prevention of prolonged pregnancy.

# 1.2 Induction of labour in specific circumstances

## Pregnancy lasting longer than 41 weeks

1.2.1 Give women with uncomplicated pregnancies every opportunity to go into spontaneous labour. [2008]

1.2.2 Explain to women that labour usually starts naturally before 42+0 weeks, based on the gestational age estimated by their dating scan (see table 1). [2008, amended 2021]

Table 1. Gestational age at which labour started, as a proportion of labours which started spontaneously

| Gestational age (weeks) | Proportion of spontaneous labours that started at this gestational age | Cumulative proportion of spontaneous labours that started by this gestational age |
|---|---|---|
| 31 weeks and under | 2.4% | 2.4% |
| 32+0 to 36+6 weeks | 5.3% | 7.7% |
| 37+0 to 37+6 weeks | 5.1% | 12.8% |
| 38+0 to 38+6 weeks | 12.1% | 24.9% |
| 39+0 to 39+6 weeks | 25.4% | 50.3% |
| 40+0 to 40+6 weeks | 32.5% | 82.8% |
| 41+0 to 41+6 weeks | 16.2% | 99.0% |
| 42+0 weeks and over | 0.9% | 100% |

Data from NHS Hospital Episode Statistics/Maternity Services Data set 2019-20.

1.2.3 Using the information in appendix A, explain to women that some risks associated with a pregnancy continuing beyond 41+0 weeks may increase over time and these include:

- increased likelihood of caesarean birth
- increased likelihood of the baby needing admission to a neonatal intensive care unit
- increased likelihood of stillbirth and neonatal death. [2021]

1.2.4 Discuss with women that induction of labour from 41+0 weeks may reduce these risks, but that they will also need to consider the impact of induction on

their birth experience (see recommendations on information and decision making) when making their decision. [2021]

1.2.5 Be aware that, according to the 2020 MBRRACE-UK report on perinatal mortality, women from some minority ethnic backgrounds or who live in deprived areas have an increased risk of stillbirth and may benefit from closer monitoring and additional support. The report showed that across all births (not just those induced):

- compared with white babies (34/10,000), the stillbirth rate is
  - more than twice as high in black babies (74/10,000)
  - around 50% higher in Asian babies (53/10,000)
- the stillbirth rate increases according to the level of deprivation in the area the mother lives in, with almost twice as many stillbirths for women living in the most deprived areas (47/10,000) compared with the least deprived areas (26/10,000). [2021]

1.2.6 If a woman chooses not to have induction of labour, discuss the woman's options from this point on with her (for example, expectant management or caesarean birth) and record the woman's decision in her notes. [2008, amended 2021]

1.2.7 Discuss with women who choose not to have their labour induced if they wish to have additional fetal monitoring from 42 weeks. Advise women that:

- monitoring only gives a snapshot of the current situation, and cannot predict reliably any changes after monitoring ends, but provides information on how their baby is at the moment and so may help them make a decision on options for birth
- adverse effects on the baby (including stillbirth), and when these events might happen, cannot be predicted reliably or prevented even with monitoring
- fetal monitoring might consist of twice-weekly cardiotocography and ultrasound estimation of maximum amniotic pool depth. [2008, amended 2021]

1.2.8 Offer women who choose to await the spontaneous onset of labour the opportunity to discuss their decision again at all subsequent reviews, if they wish to do so. [2021]

1.2.9 Advise women to contact their midwife or maternity unit if they change their

mind before their next appointment, or as soon as possible if they have concerns about their baby (for example reduced or altered fetal movements). [2021]

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on induction of labour for pregnancy lasting longer than 41 weeks.

Full details of the evidence and the committee's discussion are in evidence review C: induction of labour for prevention of prolonged pregnancy.

## Preterm prelabour rupture of membranes

1.2.10 If a woman has preterm prelabour rupture of membranes, do not carry out induction of labour before 34+0 weeks unless there are additional obstetric indications (for example, infection or fetal compromise). Offer expectant management until 37+0 weeks. [2008, amended 2021]

1.2.11 If a woman has preterm prelabour rupture of membranes after 34+0 weeks, but before 37+0 weeks, discuss the options of expectant management until 37+0 weeks or induction of labour with her. When making a shared decision, take into consideration the following factors:

- risks to the woman (for example, sepsis, possible need for caesarean birth)
- risks to the baby (for example, sepsis, problems relating to preterm birth)
- local availability of neonatal intensive care facilities
- the woman's individual circumstances and her preferences [2008, amended 2021]

1.2.12 If a woman has preterm prelabour rupture of membranes after 34+0 weeks (but before 37+0 weeks), and has had a positive group B streptococcus test at any time in their current pregnancy, offer immediate induction of labour or caesarean birth. See the NICE guidelines on neonatal infection and preterm labour and birth. [2021]

## Prelabour rupture of membrane at term

1.2.13 Offer women with prelabour rupture of membranes at term (at or after 37+0

weeks) a choice of:

- expectant management for up to 24 hours, or
- induction of labour as soon as possible.

Discuss the benefits and risks of these options with the woman, and take into account her individual circumstances and preferences. [2008, amended 2021]

1.2.14 For women who choose expectant management after prelabour rupture of the membranes at term (at or after 37+0 weeks), offer induction of labour if labour has not started naturally after approximately 24 hours. See the NICE guideline on intrapartum care. [2008, amended 2021]

1.2.15 Respect the woman's decision if she chooses to wait for spontaneous onset of labour for over 24 hours after prelabour rupture of membranes at term. Discuss the woman's options for birth from this point onwards with her. [2021]

1.2.16 If a woman has prelabour rupture of membranes at term (at or after 37+0 weeks) and has had a positive group B streptococcus test at any time in their current pregnancy, offer immediate induction of labour or caesarean birth. See the NICE guideline on neonatal infection for advice on intrapartum antibiotics. [2021]

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on induction of labour for prelabour rupture of membranes.

## Previous caesarean birth

1.2.17 Advise women who have had a previous caesarean birth that:

- induction of labour could lead to an increased risk of emergency caesarean birth
- induction of labour could lead to an increased risk of uterine rupture
- the methods used for induction of labour will be guided by the need to reduce these risks (for example, by using mechanical methods). See the recommendations on methods for induction of labour

- some methods used for induction of labour may not be suitable (for example, both dinoprostone and misoprostol are contraindicated in women with a uterine scar). [2008, amended 2021]

1.2.18 If birth needs to be expedited, offer women who have had a previous caesarean birth a choice of:

- induction of labour, or
- planned caesarean birth.

Take into account the woman's circumstances and preferences and record the discussions and plan in the woman's notes. [2008, amended 2021]

1.2.19 Advise women that they can choose not to have induction of labour or caesarean birth, even when it may benefit their or their baby's health [2008, amended 2021]

## Maternal request

1.2.20 Consider requests for induction of labour only after discussing the benefits and risks with the woman, taking into account the woman's circumstances and preferences. [2008, amended 2021]

## Breech position

1.2.21 Induction of labour is not generally recommended if a woman's baby is in the breech position. [2008, amended 2021]

1.2.22 Consider induction of labour for babies in the breech position if:

- birth needs to be expedited, and
- external cephalic version is unsuccessful, declined or contraindicated, and
- the woman chooses not to have a planned caesarean birth.

Discuss the benefits and risks associated with induction of labour with the woman. [2008, amended 2021]

## Fetal growth restriction

1.2.23 Do not induce labour if there is fetal growth restriction with confirmed fetal compromise. Offer caesarean birth instead. [2008, amended 2021]

## Suspected fetal macrosomia

1.2.24 Using the information in appendix B, discuss with women without diabetes and with suspected fetal macrosomia that:

- the options for birth are expectant management, induction of labour or caesarean birth (see the NICE guideline on caesarean birth)
- there is uncertainty about the benefits and risks of induction of labour compared to expectant management, but:
  - with induction of labour the risk of shoulder dystocia reduced compared with expectant management
  - with induction of labour the risk of third- or fourth-degree perineal tears is increased compared with expectant management
  - there is evidence that the risk of perinatal death, brachial plexus injuries in the baby, or the need for emergency caesarean birth is the same between the 2 options
- they will also need to consider the impact of induction on their birth experience and on their baby (see recommendation 1.1.3).

Discuss the options for birth with the woman, taking into account her individual circumstances and her preferences, and respect her decision. Support recruitment into clinical trials, if available. [2021]

1.2.25 For guidance on suspected fetal macrosomia in women with pre-existing or gestational diabetes see the NICE guideline on diabetes in pregnancy. [2021]

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on induction of labour for suspected fetal macrosomia.

Full details of the evidence and the committee's discussion are in evidence review A: induction of labour for suspected fetal macrosomia.

## History of precipitate labour

1.2.26 Do not routinely offer induction of labour to women with a history of precipitate labour to avoid a birth unattended by healthcare professionals. [2008]

## Intrauterine fetal death – all women

1.2.27 In the event of an intrauterine fetal death, offer support to help women and their partners and family cope with the emotional and physical consequences of the death. Offer them information about specialist support. [2008]

1.2.28 In the event of an intrauterine fetal death, if the woman appears to be physically well, her membranes are intact and there is no evidence of infection or bleeding, discuss the options for birth (expectant management, induction of labour or caesarean birth) and respect the woman's decision. [2008, amended 2021]

1.2.29 In the event of an intrauterine fetal death, if there is evidence of ruptured membranes, infection or bleeding, offer immediate induction of labour or caesarean birth. [2008, amended 2021]

1.2.30 If a woman with an intrauterine fetal death chooses an induced labour, follow the recommendations on monitoring of uterine contractions (preferably using manual assessment) and provide one-to-one midwifery care of the woman during labour and birth. [2021]

### Intrauterine fetal death – women with a non-scarred uterus

1.2.31 If a woman with an intrauterine fetal death chooses an induced labour, offer:

- oral mifepristone 200 mg followed by vaginal dinoprostone or oral or vaginal misoprostol. Base the choice and dosage of drug used on clinical circumstances and national protocols, or
- a mechanical method of induction. [2008, amended 2021]

In November 2021, some uses of mifepristone, dinoprostone and misoprostol were off label. See NICE's information on prescribing medicines.

### Intrauterine fetal death – women who have had a previous caesarean birth

1.2.32 Advise women who have intrauterine fetal death, and who have had a previous lower segment caesarean birth, that:

- induction of labour could lead to an increased risk of uterine rupture
- the methods used for induction of labour will be guided by the need to reduce these risks (for example, by using mechanical methods). See the recommendations on methods for induction of labour.
- some methods used for induction of labour may not be suitable (for example, both dinoprostone and misoprostol are contraindicated in women with a uterine scar). [2021]

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on induction of labour for intrauterine fetal death after previous caesarean birth.

Full details of the evidence and the committee's discussion are in evidence review D: induction of labour for intrauterine fetal death after previous caesarean birth.

## 1.3 Methods for induction of labour

### Membrane sweeping

1.3.1 Explain to women:

- what a membrane sweep is

- that membrane sweeping might make it more likely that labour will start without the need for additional pharmacological or mechanical methods of induction
- that pain, discomfort and vaginal bleeding are possible from the procedure. [2008, amended 2021]

1.3.2 At antenatal visits after 39+0 weeks, discuss with women if they would like a vaginal examination for membrane sweeping, and if so obtain verbal consent from them before carrying out the membrane sweep. [2008, amended 2021]

1.3.3 Discuss with women whether they would like to have additional membrane sweeping if labour does not start spontaneously following the first sweep. [2008, amended 2021]

## Pharmacological and mechanical methods for inducing labour

1.3.4 Explain to women that a vaginal examination to assess the readiness of the cervix (recorded as the Bishop score) will help to decide which method of induction they will be offered first, and obtain consent to carry this out. [2021]

1.3.5 Discuss with women the risks and benefits of different methods to induce labour. Include that:

- both dinoprostone and misoprostol can cause hyperstimulation (see information on hyperstimulation rates in appendix C)
- when using pharmacological methods of induction, uterine activity and fetal condition must be monitored regularly
- if hyperstimulation does occur, the induction treatment will be stopped by giving no further medication, or by removal of vaginally administered products when possible
- there are differences in the ease with which different vaginal products can be removed (for example, dinoprostone controlled-release vaginal delivery systems can be more easily removed than gel or vaginal tablets)
- hyperstimulation can be treated with tocolysis, but hyperstimulation caused by misoprostol may be more difficult to reverse
- mechanical methods are less likely to cause hyperstimulation than pharmacological methods. [2021]

1.3.6 Follow the manufacturers' guidance on the use of dinoprostone and misoprostol preparations for the induction of labour, including when to remove dinoprostone controlled-release vaginal delivery systems. [2021]

1.3.7 For women with a Bishop score of 6 or less, offer induction of labour with dinoprostone as vaginal tablet, vaginal gel or controlled-release vaginal delivery system or with low dose (25 microgram) oral misoprostol tablets. [2021]

1.3.8 For women with a Bishop score of 6 or less, consider a mechanical method to induce labour (for example, a balloon catheter or osmotic cervical dilator) if:

- pharmacological methods are not suitable (for example, in women with a higher risk of, or from, hyperstimulation, or those who have had a previous caesarean birth), or
- the woman chooses to use a mechanical method.

See the NICE interventional procedures guidance on double balloon catheters for induction. [2021]

1.3.9 For women with a Bishop score of more than 6, offer induction of labour with amniotomy and an intravenous oxytocin infusion. [2021]

1.3.10 Advise women that they can have an amniotomy and can choose whether or not to have an oxytocin infusion, or can delay starting this, but that this may mean labour takes longer and there may be an increased risk of neonatal infection. [2021]

For a short explanation of why the committee made these recommendations and how they might affect practice, see the rationale and impact section on methods for induction of labour.

Full details of the evidence and the committee's discussion are in evidence review B: methods for induction of labour.

# 1.4 Methods that are not recommended for induction of labour

## Pharmacological methods

1.4.1 Be aware that the available evidence does not support the use of the following methods for induction of labour:

- oral dinoprostone
- intravenous dinoprostone
- extra-amniotic dinoprostone or $PGF_2$
- intracervical dinoprostone
- vaginal $PGF_2$
- intravenous oxytocin alone
- hyaluronidase
- corticosteroids
- oestrogen
- relaxin
- mifepristone (except in combination for intrauterine fetal death, see recommendation 1.2.31)
- vaginal nitric oxide donors. [2008, amended 2021]

## Non-pharmacological methods

1.4.2 Be aware that the available evidence does not support the following methods for induction of labour:

- herbal supplements
- acupuncture
- homeopathy

- castor oil
- hot baths
- enemas
- sexual intercourse. [2008]

# 1.5 Assessment before induction, monitoring and pain relief

## Assessment before induction

1.5.1 Ensure the position of the baby and the woman's condition are suitable for induction by:

- abdominally assessing the level and stability of the fetal head in the lower part of the uterus at or near the pelvic brim
- carrying out an ultrasound scan if there are any concerns about the position of the baby (for example, if it might be in the breech position)
- assessing and recording the Bishop score
- confirming a normal fetal heart rate pattern using antenatal cardiotocography interpretation
- confirming the absence of significant uterine contractions (not Braxton-Hicks) using cardiotocography. [2008, amended 2021]

1.5.2 Ensure facilities are available for cardiotocography wherever induction of labour is started. [2008, amended 2021]

## Monitoring

Note that the summaries of product characteristics for different preparations of dinoprostone contain different monitoring requirements. Always use the NICE guidance on dinoprostone in conjunction with the relevant summary of product characteristics.

1.5.3 When uterine contractions begin after administering dinoprostone or

misoprostol, assess fetal wellbeing and uterine contractions with intrapartum cardiotocography interpretation and:

- if the cardiotocogram is confirmed as normal, review the individual circumstances and, if considered low risk, use intermittent auscultation unless there are clear indications for further cardiotocography
- if the fetal heart rate is abnormal or there are excessive uterine contractions:
  - continue or restart continuous cardiotocography
  - do not administer any more doses, and
  - remove any vaginal pessaries or delivery systems if possible.

Follow the advice on monitoring during labour in the NICE guideline on intrapartum care. [2008, amended 2021]

1.5.4 Offer to reassess the wellbeing of the woman and baby and the Bishop score at appropriate intervals to monitor progress, depending on the method of induction being used, and the clinical condition of the woman. [2008, amended 2021]

1.5.5 Once active labour is established, carry out maternal and fetal monitoring as described in the NICE guideline on intrapartum care. [2008]

## Pain relief

1.5.6 Explain to women that induced labour may be more painful than spontaneous labour. [2008]

1.5.7 Discuss the available pain relief options in different settings with women. [2008]

1.5.8 During induction of labour, provide women with the pain relief appropriate for them and their pain as described in the NICE guideline on intrapartum care. This can include simple analgesia, labour in water and epidural analgesia. [2008, amended 2021]

# 1.6 Outpatient induction

Note that the summaries of product characteristics for different preparations of dinoprostone contain different monitoring requirements. Always use the NICE guidance on dinoprostone in conjunction with the relevant summary of product characteristics.

1.6.1 Consider outpatient induction of labour with vaginal dinoprostone preparations or mechanical methods in women who wish to return home, and who have no co-existing medical conditions or obstetric complications. Discuss with the woman the benefits and risks of returning home, and respect her decision. [2008, amended 2021]

1.6.2 Carry out a full clinical assessment of the woman and baby (see recommendations 1.5.1 and 1.5.2) and ensure safety and support procedures are in place. [2008, amended 2021]

1.6.3 For induction being undertaken on an outpatient basis, agree a review plan with the woman before she returns home. [2008, amended 2021]

1.6.4 Ask women to contact their midwife, maternity unit or obstetrician:

- when contractions begin, or
- if there are no contractions (in an agreed timeframe, depending on the method used), or
- if her membranes rupture, or
- if she develops bleeding, or
- if she has any other concerns, such as reduced or altered fetal movements, excessive pain or uterine contractions, side-effects or loss of the pessary. [2008, amended 2021]

# 1.7 Prevention and management of complications

## Uterine hyperstimulation

1.7.1 If uterine hyperstimulation occurs during induction of labour:

- carry out a fetal assessment
- do not administer any more doses of medicines to induce labour and remove any vaginal pessaries or delivery systems if possible
- consider tocolysis. [2008, amended 2021]

## Unsuccessful induction

1.7.2 If induction is unsuccessful, discuss this with the woman and provide support. Fully reassess the woman's condition and the pregnancy in general, and assess fetal wellbeing using antenatal cardiotocography interpretation. [2008, amended 2021]

1.7.3 If induction is unsuccessful, discuss and agree a plan for further management with the woman, including whether she would like further attempts at induction, taking into account the clinical circumstances and her preferences. [2008, amended 2021]

1.7.4 If induction is unsuccessful, the subsequent management options include:

- offering a rest period if clinically appropriate and then re-assessing the woman
- expectant management
- further attempts to induce labour
- caesarean birth. See the NICE guideline on caesarean birth. [2008, amended 2021]

## Cord prolapse

1.7.5 Take the following precautions to avoid the adverse effects of cord prolapse, which may occur if labour is induced:

- before induction, abdominally assess the level and stability of the fetal head in the lower part of the uterus at or near the pelvic brim (see the recommendations on assessment before induction)
- during the preliminary vaginal examination, obstetricians and midwives should palpate for umbilical cord presentation and avoid dislodging the baby's head

- carry out continuous cardiotocography during induction after the membranes have ruptured, if the presenting part is not stable and not well-applied to the cervix. In this situation, discuss the risks and benefits of induction of labour with the woman, and if necessary consider caesarean birth. If the presenting part stabilises and the cardiotocogram is normal, use intermittent auscultation unless there are clear indications for further cardiotocography. [2008, amended 2021]

## Placenta praevia, low-lying placenta or a previous history of antepartum haemorrhage

1.7.6 Check that there is no evidence of a low-lying placenta on previous scans before membrane sweeping and before induction of labour. [2008, amended 2021]

## Uterine rupture

1.7.7 If uterine rupture is suspected during induced labour, carry out an immediate category 1 caesarean birth. See the NICE guideline on caesarean birth. [2008, amended 2021]

# Terms used in this guideline

This section defines terms that have been used in a particular way for this guideline. For other definitions see the NICE glossary and the Think Local, Act Personal Care and Support Jargon Buster.

## Bishop score

The Bishop score is a numerical value obtained by doing a vaginal examination, and is based on the dilation, effacement (or length), position and consistency of the cervix and the station of the head with respect to the ischial spines of the pelvis. A score of 8 or more generally indicates that the cervix is ready to dilate, (previously the terms 'ripe' or 'favourable' were widely used) and when there is a high chance of spontaneous labour, or response to interventions made to induce labour. For the purposes of this guideline, a Bishop score of less than or equal to 6, or a score greater than 6, was used to help determine choice of pharmacological or mechanical methods to induce labour.

## Dinoprostone

Dinoprostone is the international non-proprietary name for prostaglandin E2. Previous versions of this guideline referred to prostaglandin E2, or PGE2, but in order to ensure uniformity with the naming

conventions in the BNF, this version refers to this medication as dinoprostone.

## Expectant management

A management approach, also called 'watch and wait', when no medical or surgical treatment is given. The aim is to allow labour to begin naturally.

## Hyperstimulation

This is overactivity of the uterus as a result of induction of labour. It is variously defined as uterine tachysystole (more than 5 contractions per 10 minutes for at least 20 minutes) and uterine hypersystole/hypertonicity (a contraction lasting at least 2 minutes). These may or may not be associated with changes in the fetal heart rate pattern (persistent decelerations, tachycardia or increased/decreased short term variability).

## Membrane sweeping

Membrane sweeping involves the examining finger passing through the cervix to rotate against the wall of the uterus, to separate the chorionic membrane from the decidua of the uterus. If the cervix will not admit a finger, massaging around the cervix in the vaginal fornices may achieve a similar effect.

## MBRRACE-UK

Mothers and babies: reducing risk through audits and confidential enquiries across the UK (MBRRACE-UK) is a series of audits carried out with the aim of identifying causes of maternal and perinatal death and morbidity and making recommendations to inform maternity care and so reduce these poor outcomes.

## Osmotic cervical dilator

A medical device used to dilate the uterine cervix by swelling as it absorbs fluid from surrounding tissue.

## Precipitate labour

A labour that is very quick and short, and the baby is born less than 3 hours after the start of uterine contractions.

## Suspected fetal macrosomia

A baby that is believed to be large for its gestational age, defined for the purposes of this guideline as an estimated fetal weight above the 95th percentile, at or after 36 weeks of pregnancy.

## Unsuccessful induction

Unsuccessful induction is defined as labour not starting after one cycle of treatment.

# Recommendations for research

The guideline committee has made the following recommendations for research.

## Key recommendations for research

### 1 Prevention of prolonged pregnancy

At what gestational age should induction of labour be offered in the subgroups of women who may be more likely to experience adverse outcomes if pregnancy continues? [2021]

For a short explanation of why the committee made the recommendation for research, see the rationale section on induction of labour for pregnancy lasting longer than 41 weeks.

Full details of the evidence and the committee's discussion are in evidence review C: induction of labour for prevention of prolonged pregnancy.

### 2 Prevention of prolonged pregnancy

Based on individual patient data meta-analysis, what is the optimal timing of induction of labour? [2021]

For a short explanation of why the committee made the recommendation for research, see the rationale section on induction of labour for pregnancy lasting longer than 41 weeks.

Full details of the evidence and the committee's discussion are in evidence review C: induction of labour for prevention of prolonged pregnancy.

### 3 Preterm prelabour rupture of membranes

What are the relative risks and benefits of induced labour versus expectant management in women whose membranes have ruptured spontaneously between 34 and 37 weeks? [2008]

## Why this is important

Intrauterine sepsis is more likely to develop in pregnancies that continue after the membranes have ruptured, putting both the woman and the baby at risk. In some such pregnancies, labour begins spontaneously at a variable interval after the membranes have ruptured, avoiding the need for induction. The value of antibiotic therapy and the administration of corticosteroids to the woman is unclear in this situation. A randomised study of active versus expectant management, taking account of time since membrane rupture, gestational age and maternal therapy, would be valuable.

## 4 Intrauterine fetal death after previous caesarean birth

How should labour be induced in women with intrauterine fetal death who have had a previous caesarean birth, and who choose to be induced? [2021]

For a short explanation of why the committee made the recommendation for research, see the rationale section on induction of labour for intrauterine fetal death after previous caesarean birth.

Full details of the evidence and the committee's discussion are in evidence review D: induction of labour for intrauterine fetal death after previous caesarean birth.

## 5 Membrane sweeping

What are the effectiveness and acceptability of, and maternal satisfaction with, the following:

- multiple versus once-only membrane sweeping, at varying gestational ages, depending on parity
- membrane sweeping versus cervical massage? [2008]

## Why this is important

Membrane sweeping is considered to be a relatively simple intervention that may positively influence the transition from maintenance of pregnancy to the onset of labour, reducing the need for formal induction of labour. However, there are disadvantages, such as possible vaginal bleeding and discomfort. Research into when and how frequently membrane sweeping should be carried out to maximise its effectiveness and acceptability would be of value.

## 6 Vaginal dinoprostone

What are the effectiveness, safety and maternal acceptability of:

- different regimens of vaginal dinoprostone, stratified by: clinical indications; cervical and membrane status; parity; and previous caesarean birth
- different management policies for unsuccessful induction of labour with vaginal dinoprostone (additional dinoprostone, oxytocin, elective caesarean birth or delay of induction, if appropriate). [2008]

## Why this is important

Despite extensive studies carried out over the past 30 years to determine the most effective ways of inducing labour with vaginal dinoprostone, uncertainties remain about how best to apply these agents in terms of their dosage and timing. It would be particularly useful to understand more clearly why vaginal dinoprostone is unsuccessful in inducing labour in some women.

## 7 Setting for induction of labour

Is it safe, effective and cost effective to carry out induction of labour in an outpatient setting? What are the advantages and disadvantages of such an approach, taking into account women's views?
[2008]

## Why this is important

In line with the way healthcare has developed in many areas of acute care, there is an increasing desire to reduce the time women spend in hospital. Several units are already exploring outpatient induction of labour policies and there is a need to study this approach in order to determine relative risks and benefits, as well as acceptability to women.

# Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice.

# Induction of labour for pregnancy lasting longer than 41 weeks

Recommendations 1.1.3 and 1.1.6, and recommendations 1.2.3 to 1.2.5, 1.2.8 and 1.2.9

## Why the committee made the recommendations

Based on their knowledge and experience the committee made recommendations on the advice that should be provided to all women in early pregnancy about mode of birth, the process of inducing labour, and the impact this may have on their place of birth, mode of birth and on their experience of birth. The committee also made recommendations about how these discussions may need to be revisited in later pregnancy, or if women decline induction.

There was evidence that caesarean birth, perinatal mortality and neonatal intensive care unit admission are reduced by earlier induction of labour (at 41+0 weeks) compared to later induction (at 42+0 weeks or after). However, there was not enough evidence, so the committee made a recommendation for research to identify the optimal timing of induction more precisely.

The committee were aware that data from the 2020 MBRRACE-UK report on perinatal mortality had shown that babies born to certain groups of women may be at higher risk of stillbirth and chose to highlight this in the guideline. As there was no evidence, the committee made a recommendation for research to identify the optimal timing of induction in groups of women who may be at higher risk of stillbirth.

## How the recommendations might affect practice

The recommendations decrease the gestational age at which induction of labour is discussed to prevent prolonged pregnancy, and may increase the number of women who undergo induction. The recommendations on monitoring may also increase the number of women who decline induction and then choose to have additional monitoring. Both these factors may increase resource use in the NHS.

Return to recommendations 1.1.3 and 1.1.6

Return to recommendations 1.2.3 to 1.2.5, 1.2.8 and 1.2.9

# Induction of labour for prelabour rupture of the membranes

Recommendations 1.2.12, 1.2.15 and 1.2.16

## Why the committee made the recommendations

The committee were aware of the recommendations in the NICE guideline on neonatal infection that advised immediate induction of labour or caesarean birth after preterm prelabour rupture of the membranes between 34+0 weeks and 37+0 weeks in women with a positive group B streptococcus test, and so added this recommendation to this section of the guideline.

Based on their knowledge and experience of the risks of group B streptococcal infection to the baby after rupture of the membranes, the committee agreed that with prelabour rupture of the membranes after 37+0 weeks in women with a positive group B streptococcus test, immediate induction of labour or caesarean birth would also be recommended.

In women who did not have a positive group B streptococcus test, but who had prelabour rupture of the membranes after 37+0 weeks, the committee were aware that expectant management for 24 hours was an option as the risk of infection to the baby was low. However, after that period, induction should be advised as the committee were aware that prolonged pregnancy at term after rupture of the membranes can increase risks to the baby, and they therefore advised that birth options should be discussed with women who choose not to have induction of labour after 24 hours.

## How the recommendations might affect practice

The recommendations will reinforce current practice.

Return to recommendations

# Induction of labour for suspected fetal macrosomia

Recommendations 1.2.24 and 1.2.25

 

## Why the committee made the recommendations

There was some evidence of both benefits and harms for induction of labour and for expectant management in women without diabetes with suspected fetal macrosomia, but there was uncertainty around this evidence, particularly relating to the risk of perineal tears. As there was not enough evidence to recommend one method over another, the committee recommended that women should be provided with information about different modes of birth so they can make an informed decision, and that recruitment into relevant clinical trials should be supported.

## How the recommendations might affect practice

Currently, there is variation in clinical practice and so the recommendations may mean an increase in consultation time to counsel women appropriately in some areas. This is not expected to lead to a substantial resource impact at national level.

Return to recommendations

# Induction of labour for intrauterine fetal death after previous caesarean birth

Recommendations 1.2.30 and 1.2.32

## Why the committee made the recommendations

In the absence of evidence, the committee made recommendations based on their knowledge and experience and also made a recommendation for research on intrauterine fetal death after previous caesarean birth. The committee agreed that the different options for birth should be discussed with women after intrauterine fetal death if they have had a previous caesarean birth, and their choice should be respected. They also agreed that women with IUFD should be cared for on a one-to-one basis and monitored.

The committee explained that, after intrauterine fetal death, women with a scarred uterus are at increased risk of uterine rupture. This should be taken into account when considering options for birth and if induction is carried out, uterine contractions should be carefully monitored.

The committee discussed that mifepristone 600 mg daily for 2 days is approved for the induction of labour following intrauterine fetal death when prostaglandin or oxytocin cannot be used, but that no evidence for its safety or efficacy in women with a previous caesarean birth had been identified and so they were

unable to recommend it. The committee discussed that in women with intrauterine fetal death and no previous caesarean birth a lower dose of mifepristone was used to sensitise the myometrium to prostaglandin-induced contractions, followed by a prostaglandin (dinoprostone or misoprostol). However, the committee were aware that both dinoprostone and misoprostol are contraindicated after previous caesarean birth and so made a recommendation to state this.

The committee recognised that mechanical methods of induction may be safe to use in women with a previous caesarean birth, and so they advised that these could be considered. This also brought the recommendations for induction after a previous caesarean birth for women with live babies or after intrauterine fetal death, in line with each other.

## How the recommendations might affect practice

Currently, there is variation in the management of women after an intrauterine fetal death who have had previous caesarean birth, so the recommendations may mean an increase in consultation time to counsel women appropriately in some areas, and an increase in monitoring to reduce the risk of uterine rupture. This is not expected to lead to a substantial resource impact at national level.

Return to recommendations

# Methods for induction of labour

Recommendations 1.3.4 to 1.3.10

## Why the committee made the recommendations

The committee agreed that, in their experience, women value being informed about the reason why certain treatments are offered, and that it should be made clear to women that the possible methods for induction of labour will depend primarily on the readiness of their cervix, which is assessed with a vaginal examination and recorded as the Bishop score.

There was good evidence that vaginal dinoprostone was effective at promoting vaginal birth within 24 hours for women with a Bishop score of 6 or less, without significantly increasing the risk of adverse outcomes for the woman or her baby. When the different preparations of vaginal dinoprostone were compared, there was little evidence to demonstrate that one preparation was superior to another. Therefore, the committee agreed that it was appropriate to offer a choice of preparation, depending on availability and the woman's preference. There was some evidence that dinoprostone preparations could lead to hyperstimulation with fetal heart rate changes.

Misoprostol was as effective as dinoprostone at promoting vaginal birth within 24 hours. There was evidence showing a risk of hyperstimulation with misoprostol, although this was predominantly with higher doses and vaginal preparations, and the committee took into consideration previous MHRA warnings relating to the misoprostol vaginal insert about this risk. The committee noted that, for the low dose oral preparations of misoprostol, the risk of hyperstimulation appeared to be the same or lower than with the dinoprostone vaginal preparations. Therefore, the committee agreed that misoprostol could be an alternative to dinoprostone for induction of labour, particularly for women who would prefer an oral preparation.

There was evidence that there was no increased risk of hyperstimulation when using mechanical methods for induction of labour (including osmotic cervical dilators and balloon catheters). Balloon catheters were also effective at promoting vaginal birth within 24 hours and did not appear to markedly increase the risk of other adverse outcomes. There was no evidence for the effectiveness of osmotic cervical dilators at promoting vaginal birth within 24 hours, but they too did not appear to markedly increase the risk of other adverse outcomes. Therefore, the committee agreed that these mechanical methods could be considered for induction of labour for women, particularly when there is a concern about hyperstimulation.

There was very little evidence for women with a Bishop score of more than 6. However, the committee noted that amniotomy and intravenous oxytocin was the most effective method to promote vaginal birth within 24 hours across the whole population. This was in keeping with their clinical experience, so they agreed that this should be the first choice for induction of labour for women in this group.

## How the recommendations might affect practice

Most hospitals use the recommended methods for induction of labour already, so these recommendations will not result in a significant change of practice. The advice specific to women with a Bishop score of more than 6 should provide more individualised care and standardise practice for this subgroup of women.

Return to recommendations

# Context

Induced labour may be recommended in circumstances when it appears that the benefits outweigh the risks for the mother and baby of continuing with the pregnancy, but with the aim of still enabling a vaginal birth. However, induction has an impact on the birth experience of women as it:

- removes the satisfaction of achieving the more natural birth that many woman hope for
- is generally more painful than spontaneous labour
- is more likely to lead to additional interventions such as assisted or operative birth, including caesarean birth, and
- is more likely to need epidural analgesia.

Induction of labour is a common procedure, with approximately a third of all women in the UK undergoing induction, and there are a variety of methods available using both pharmacological treatments and mechanical methods. The choice of method depends on the readiness of the woman's cervix (assessed using a vaginal examination, and categorised using the Bishop score), whether the membranes have ruptured, and the woman's preferences. The options available should be discussed and this discussion should include:

- an awareness of the efficacy and possible adverse effects for the woman and her baby associated with each method, and
- the likelihood that additional interventions (such as emergency caesarean birth) might be needed if the induction is not successful.

Women can choose not to have induction of labour, and appropriate care should then be offered to optimise the outcome of the pregnancy while respecting the woman's wishes.

The aim of this guideline is to give advice to healthcare professionals providing obstetric services, and to pregnant women, on the information and support women and their families and birth partners should be offered when making decisions about induction of labour. It also aims to define the circumstances when induction of labour may be appropriate, and identify the most effective way to induce labour, including choice of method, setting, timing, monitoring and pain relief.

# Finding more information and committee details

You can see everything NICE says on this topic in the NICE Pathway on induction of labour.

To find NICE guidance on related topics, including guidance in development, see the NICE webpage on intrapartum care.

For full details of the evidence and the guideline committee's discussions, see the evidence reviews. You can also find information about how the guideline was developed, including details of the committee.

NICE has produced tools and resources to help you put this guideline into practice. For general help and advice on putting our guidelines into practice, see resources to help you put NICE guidance into practice.

# Update information

November 2021: We have reviewed the evidence and made new recommendations on the induction of labour for prevention of prolonged pregnancy, induction of labour in suspected fetal macrosomia, induction of labour for intrauterine fetal death after previous caesarean birth and pharmacological and mechanical methods to induce labour. These recommendations are marked [2021].

We have also made some changes without an evidence review. These recommendations are marked [2008, amended 2021].

Recommendations marked [2008] last had an evidence review in 2008. In some cases minor changes have been made to the wording to bring the language and style up to date, without changing the meaning.

Changes to the 2008 recommendations, showing the original and updated wording for comparison, are listed in supplement 6.

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# Accreditation

# Baseline assessment tool for inducing labour (NICE clinical guideline NG207)

| | |
|---|---|
| **Number of relevant or partially relevant recommendations** | **0** |
| **Number of recommendations met** | **0** |
| **Number of recommendations partially met** | **0** |
| **Percentage of recommendations met** | |
| **Percentage of recommendations partially met** | |

*Date of regional endorsement: 27.01.2022*

| NICE recommendation | Guideline reference | Year of recommendation | Is the recommendation relevant? | Current activity/evidence | Recommendation met? | Actions needed to implement recommendation | Is there a risk associated with not implementing this recommendation? | Is there a cost or saving? | Deadline | Lead |
|---|---|---|---|---|---|---|---|---|---|---|
| **1.1 Information and decision making** | | | | | | | | | | |
| This section should be read in conjunction with the NICE guidelines on antenatal care, caesarean birth and intrapartum care. | | | | | | | | | | |
| Discuss preferences about mode of birth with women early on in their pregnancy. Take into account their individual circumstances, and discuss that options for birth can include:<br>•expectant management, **or**<br>•induction of labour, **or**<br>•planned caesarean birth (see the NICE guideline on caesarean birth).<br>Record these discussions and the woman's preferences in her notes. | 1.1.1 | 2008, amended 2021 | | | | | | | | |
| Confirm a woman's preferences for birth at antenatal visits towards the end of pregnancy, as these may have changed since earlier discussions. | 1.1.2 | 2008, amended 2021 | | | | | | | | |
| Explain to women that induction of labour is a medical intervention that will affect their birth options and their experience of the birth process. This could include that:<br>•vaginal examinations to assess the cervix are needed before and during induction, to determine the best method of induction and to monitor progress<br>•their choice of place of birth will be limited, as they may be recommended interventions (for example, oxytocin infusion, continuous fetal heart rate monitoring and epidurals) that are not available for home birth or in midwife-led birth units<br>•there may be limitations on the use of a birthing pool<br>•there may be a need for an assisted vaginal birth (using forceps or ventouse), with the associated increased risk of obstetric anal sphincter injury (for example, third- or fourth-degree perineal tears)<br>•pharmacological methods of induction can cause hyperstimulation – this is when the uterus contracts too frequently or contractions last too long, which can lead to changes in fetal heart rate and result in fetal compromise<br>•an induced labour may be more painful than a spontaneous labour<br>•their hospital stay may be longer than with a spontaneous labour. | 1.1.3 | 2021 | | | | | | | | |
| Discuss with women being offered induction of labour:<br>•the reasons for induction being offered<br>•when, where and how induction could be carried out<br>•the arrangements for support and pain relief (see also recommendations 1.5.7 and 1.5.8)<br>•the alternative options if the woman chooses not to have induction of labour, or decides at a later stage that she no longer wishes to proceed with the induction process<br>•the risks and benefits of induction of labour in specific circumstances, and the proposed induction methods<br>•that induction may not be successful, and how this would affect the woman's options (see the recommendations on unsuccessful induction). | 1.1.4 | 2008, amended 2021 | | | | | | | | |
| When offering induction of labour:<br>•give women time to discuss this information with others (for example, their partners, birthing companion or family) if they wish to do so before making a decision<br>•encourage women to look at other information (for example, by providing written information leaflets or encouraging them to look at information on the NHS website)<br>•ensure women have the opportunity to ask questions, and time to think about their options<br>•recognise that women can decide to proceed with, delay, decline or stop an induction.<br>Respect the woman's decision, even if healthcare professionals disagree with it, and do not allow personal views to influence the care they are given. Record the woman's decision in her notes. | 1.1.5 | 2008, amended 2021 | | | | | | | | |
| Provide information on induction of labour in line with the NICE guideline on patient experience in adult NHS services. | 1.1.6 | 2021 | | | | | | | | |
| **1.2 Induction of labour in specific circumstances** | | | | | | | | | | |
| **Pregnancy lasting longer than 41 weeks** | | | | | | | | | | |
| Give women with uncomplicated pregnancies every opportunity to go into spontaneous labour. | 1.2.1 | 2008 | | | | | | | | |
| Explain to women that labour usually starts naturally before 42+0 weeks, based on the gestational age estimated by their dating scan (see Table 1). | 1.2.2 | 2008, amended 2021 | | | | | | | | |
| Using the information in appendix A, explain to women that some risks associated with a pregnancy continuing beyond 41+0 weeks may increase over time and these include:<br>•increased likelihood of caesarean birth<br>•increased likelihood of the baby needing admission to a neonatal intensive care unit<br>•increased likelihood of stillbirth and neonatal death. | 1.2.3 | 2021 | | | | | | | | |
| Discuss with women that induction of labour from 41+0 weeks may reduce these risks, but that they will also need to consider the impact of induction on their birth experience (see recommendation 1.1.3) when making their decision. | 1.2.4 | 2021 | | | | | | | | |
| Be aware that, according to the 2020 MBRRACE-UK report on perinatal mortality, women from some minority ethnic backgrounds or who live in deprived areas have an increased risk of stillbirth and may benefit from closer monitoring and additional support. The report showed that across all births (not just those induced):<br>•compared with white babies (34/10,000), the stillbirth rate is<br>-more than twice as high in black babies (74/10,000)<br>-around 50% higher in Asian babies (53/10,000)<br>•the stillbirth rate increases according to the level of deprivation in the area the mother lives in, with almost twice as many stillbirths for women living in the most deprived areas (47/10,000) compared with the least deprived areas (26/10,000). | 1.2.5 | 2021 | | | | | | | | |
| If a woman chooses not to have induction of labour, discuss the woman's options from this point on with her (for example, expectant management or caesarean birth) and record the woman's decision in her notes. | 1.2.6 | 2008, amended 2021 | | | | | | | | |
| Discuss with women who choose not to have their labour induced if they wish to have additional fetal monitoring from 42 weeks. Advise women that:<br>•monitoring only gives a snapshot of the current situation, and cannot predict reliably any changes after monitoring ends, but provides information on how their baby is at the moment and so may help them make a decision on options for birth<br>•adverse effects on the baby (including stillbirth), and when these events might happen, cannot be predicted reliably or prevented even with monitoring<br>•fetal monitoring might consist of twice-weekly cardiotocography and ultrasound estimation of maximum amniotic pool depth. | 1.2.7 | 2008, amended 2021 | | | | | | | | |
| Offer women who choose to await the spontaneous onset of labour the opportunity to discuss their decision again at all subsequent reviews, if they wish to do so. | 1.2.8 | 2021 | | | | | | | | |

| NICE recommendation | Guideline reference | Year of recommendation | Is the recommendation relevant? | Current activity/evidence | Recommendation met? | Actions needed to implement recommendation | Is there a risk associated with not implementing this recommendation? | Is there a cost or saving? | Deadline | Lead |
|---|---|---|---|---|---|---|---|---|---|---|
| Advise women to contact their midwife or maternity unit if they change their mind before their next appointment, or as soon as possible if they have concerns about their baby (for example reduced or altered fetal movements). | 1.2.9 | 2021 | | | | | | | | |
| **Preterm prelabour rupture of membranes** | | | | | | | | | | |
| If a woman has preterm prelabour rupture of membranes, do not carry out induction of labour before 34+0 weeks unless there are additional obstetric indications (for example, infection or fetal compromise). Offer expectant management until 37+0 weeks. | 1.2.10 | 2008, amended 2021 | | | | | | | | |
| If a woman has preterm prelabour rupture of membranes after 34+0 weeks, but before 37+0 weeks, discuss the options of expectant management until 37+0 weeks or induction of labour with her. When making a shared decision, take into consideration the following factors:<br>•risks to the woman (for example, sepsis, possible need for caesarean birth)<br>•risks to the baby (for example, sepsis, problems relating to preterm birth)<br>•local availability of neonatal intensive care facilities<br>•the woman's individual circumstances and her preferences. | 1.2.11 | 2008, amended 2021 | | | | | | | | |
| **Additional information for recommendation 1.2.11**<br>Some preparations of vaginal dinoprostone are not approved for use before 37 weeks, are contraindicated for use with ruptured membranes, or should be used with caution with ruptured membranes. Refer to the individual summaries of product characteristics for each preparation of vaginal dinoprostone for further details. | 1.2.11 | | | | | | | | | |
| If a woman has preterm prelabour rupture of membranes after 34+0 weeks (but before 37+0 weeks), and has had a positive group B streptococcus test at any time in their current pregnancy, offer immediate induction of labour or caesarean birth. See the NICE guideline on neonatal infection and the NICE guideline on preterm labour and birth. | 1.2.12 | 2021 | | | | | | | | |
| **Prelabour rupture of membrane at term** | | | | | | | | | | |
| Offer women with prelabour rupture of membranes at term (at or after 37+0 weeks) a choice of:<br>•expectant management for up to 24 hours, or<br>induction of labour as soon as possible.Discuss the benefits and risks of these options with the woman, and take into account her individual circumstances and preferences. | 1.2.13 | 2008, amended 2021 | | | | | | | | |
| For women who choose expectant management after prelabour rupture of the membranes at term (at or over 37+0 weeks), offer induction of labour if labour has not started naturally after approximately 24 hours. See the NICE guideline on intrapartum care. | 1.2.14 | 2008, amended 2021 | | | | | | | | |
| Respect the woman's decision if she chooses to wait for spontaneous onset of labour for over 24 hours after prelabour rupture of membranes at term. Discuss the woman's options for birth from this point onwards with her. | 1.2.15 | 2021 | | | | | | | | |
| If a woman has prelabour rupture of membranes at term (at or over 37+0 weeks) and has had a positive group B streptococcus test at any time in their current pregnancy, offer immediate induction of labour or caesarean birth. See the NICE guideline on neonatal infection for advice on intrapartum antibiotics. | 1.2.16 | 2021 | | | | | | | | |
| **Previous caesarean birth** | | | | | | | | | | |
| Advise women who have had a previous caesarean birth that:<br>•induction of labour could lead to an increased risk of emergency caesarean birth<br>•induction of labour could lead to an increased risk of uterine rupture<br>•the methods used for induction of labour will be guided by the need to reduce these risks (for example, by using mechanical methods). See the recommendations on Methods for inducing labour<br>•some methods used for induction of labour may not be suitable (for example, both dinoprostone and misoprostol are contraindicated in women with a uterine scar). | 1.2.17 | 2008, amended 2021 | | | | | | | | |
| If birth needs to be expedited, offer women who have had a previous caesarean birth a choice of:<br>•induction of labour, **or**<br>•planned caesarean birth.<br>Take into account the woman's circumstances and preferences and record the discussions and plan in the woman's notes. | 1.2.18 | 2008, amended 2021 | | | | | | | | |
| Advise women that they can choose not to have induction of labour or caesarean birth, even when it may benefit their or their baby's health. | 1.2.19 | 2008, amended 2021 | | | | | | | | |
| **Maternal request** | | | | | | | | | | |
| Consider requests for induction of labour only after discussing the benefits and risks with the woman, taking into account the woman's circumstances and preferences. | 1.2.20 | 2008, amended 2021 | | | | | | | | |
| **Breech position** | | | | | | | | | | |
| Induction of labour is not generally recommended if a woman's baby is in the breech position. | 1.2.21 | 2008, amended 2021 | | | | | | | | |
| Consider induction of labour for babies in the breech position if:<br>•birth needs to be expedited, **and**<br>•external cephalic version is unsuccessful, declined or contraindicated, **and**<br>•the woman chooses not to have a planned caesarean birth.<br><br>Discuss the benefits and risks associated with induction of labour with the woman. | 1.2.22 | 2008, amended 2021 | | | | | | | | |
| **Fetal growth restriction** | | | | | | | | | | |
| Do not induce labour if there is fetal growth restriction with confirmed fetal compromise. Offer caesarean birth instead. | 1.2.23 | 2008, amended 2021 | | | | | | | | |
| **Suspected fetal macrosomia** | | | | | | | | | | |
| Using the information in appendix B, discuss with women without diabetes and with suspected fetal macrosomia that:<br>•the options for birth are expectant management, induction of labour or caesarean birth (see the NICE guideline on caesarean birth)<br>•there is uncertainty about the benefits and risks of induction of labour compared to expectant management, but:<br>-with induction of labour the risk of shoulder dystocia reduced compared with expectant management<br>-with induction of labour the risk of third- or fourth-degree perineal tears is increased compared with expectant management<br>-there is evidence that the risk of perinatal death, brachial plexus injuries in the baby, or the need for emergency caesarean birth is the same between the 2 options<br>•they will also need to consider the impact of induction on their birth experience and on their baby (see recommendation 1.1.3).<br>Discuss the options for birth with the woman, taking into account her individual circumstances and her preferences, and respect her decision. Support recruitment into clinical trials, if available. | 1.2.24 | 2021 | | | | | | | | |
| For guidance on suspected fetal macrosomia in women with pre-existing or gestational diabetes see the NICE guideline on diabetes in pregnancy. | 1.2.25 | 2021 | | | | | | | | |
| **History of precipitate labour** | | | | | | | | | | |
| Do not routinely offer induction of labour to women with a history of precipitate labour to avoid a birth unattended by healthcare professionals. | 1.2.26 | 2008 | | | | | | | | |
| **Intrauterine fetal death all women** | | | | | | | | | | |

| NICE recommendation | Guideline reference | Year of recommendation | Is the recommendation relevant? | Current activity/evidence | Recommendation met? | Actions needed to implement recommendation | Is there a risk associated with not implementing this recommendation? | Is there a cost or saving? | Deadline | Lead |
|---|---|---|---|---|---|---|---|---|---|---|
| In the event of an intrauterine fetal death, offer support to help women and their partners and family cope with the emotional and physical consequences of the death. Offer them information about specialist support. | 1.2.27 | 2008 | | | | | | | | |
| In the event of an intrauterine fetal death, if the woman appears to be physically well, her membranes are intact and there is no evidence of infection or bleeding, discuss the options for birth (expectant management, induction of labour or caesarean birth) and respect the woman's decision. | 1.2.28 | 2008, amended 2021 | | | | | | | | |
| In the event of an intrauterine fetal death, if there is evidence of ruptured membranes, infection or bleeding, offer immediate induction of labour or caesarean birth. | 1.2.29 | 2008, amended 2021 | | | | | | | | |
| If a woman with an intrauterine fetal death chooses an induced labour, follow the recommendations on monitoring of uterine contractions (preferably using manual assessment) and provide one-to-one midwifery care of the woman during labour and birth. | 1.2.30 | 2021 | | | | | | | | |
| **Intrauterine fetal death women with a non scarred uterus** | | | | | | | | | | |
| If a woman with an intrauterine fetal death chooses an induced labour, offer:<br>•oral mifepristone 200 mg followed by vaginal dinoprostone or oral or vaginal misoprostol. Base the choice and dosage of drug used on clinical circumstances and national protocols, **or**<br>•a mechanical method of induction.<br><br>In October 2021, some uses of mifepristone, dinoprostone and misoprostol were off label. See NICE's information on prescribing medicines. | 1.2.31 | 2008, amended 2021 | | | | | | | | |
| **Intrauterine fetal death women who have had a previous caesarean birth** | | | | | | | | | | |
| Advise women who have intrauterine fetal death, and who have had a previous lower segment caesarean birth, that:<br>• induction of labour could lead to an increased risk of uterine rupture<br>•the methods used for induction of labour will be guided by the need to reduce these risks (for example, by using mechanical methods). See the recommendations on Methods for inducing labour.<br>•some methods used for induction of labour may not be suitable (for example, both dinoprostone and misoprostol are contraindicated in women with a uterine scar). | 1.2.32 | 2021 | | | | | | | | |
| **1.3 Methods for induction of labour** | | | | | | | | | | |
| **Membrane sweeping** | | | | | | | | | | |
| Explain to women:<br>•what a membrane sweep is<br>•that membrane sweeping might make it more likely that labour will start without the need for additional pharmacological or mechanical methods of induction<br>•that pain, discomfort and vaginal bleeding are possible from the procedure. | 1.3.1 | 2008, amended 2021 | | | | | | | | |
| At antenatal visits after 39+0 weeks, discuss with women if they would like a vaginal examination for membrane sweeping, and if so obtain verbal consent from them before carrying out the membrane sweep. | 1.3.2 | 2008, amended 2021 | | | | | | | | |
| Discuss with women whether they would like to have additional membrane sweeping if labour does not start spontaneously following the first sweep. | 1.3.3 | 2008, amended 2021 | | | | | | | | |
| **Pharmacological and mechanical methods for inducing labour** | | | | | | | | | | |
| Explain to women that a vaginal examination to assess the readiness of the cervix (recorded as the Bishop score) will help to decide which method of induction they will be offered first, and obtain consent to carry this out. | 1.3.4 | 2021 | | | | | | | | |
| Discuss with women the risks and benefits of different methods to induce labour. Include that:<br>•both dinoprostone and misoprostol can cause hyperstimulation (see information on hyperstimulation rates in appendix C)<br>•when using pharmacological methods of induction, uterine activity and fetal condition must be monitored regularly<br>•if hyperstimulation does occur, the induction treatment will be stopped by giving no further medication, or by removal of vaginally administered products when possible<br>•there are differences in the ease with which different vaginal products can be removed (for example, dinoprostone controlled-release vaginal delivery systems can be more easily removed than gel or vaginal tablets)<br>•hyperstimulation can be treated with tocolysis, but hyperstimulation caused by misoprostol may be more difficult to reverse | 1.3.5 | 2021 | | | | | | | | |
| Follow the manufacturers' guidance on the use of dinoprostone and misoprostol preparations for the induction of labour, including when to remove dinoprostone controlled-release vaginal delivery systems. | 1.3.6 | 2021 | | | | | | | | |
| For women with a Bishop score of 6 or less, offer induction of labour with dinoprostone as vaginal tablet, vaginal gel or controlled-release vaginal delivery system or with low dose (25 microgram) oral misoprostol tablets. | 1.3.7 | 2021 | | | | | | | | |
| For women with a Bishop score of 6 or less, consider a mechanical method to induce labour (for example, a balloon catheter or osmotic cervical dilator) if:<br>•pharmacological methods are not suitable (for example, in women with a higher risk of, or from, hyperstimulation, or those who have had a previous caesarean birth), **or**<br>•the woman chooses to use a mechanical method.<br>See the NICE Interventional Procedure Guidance on double balloon catheters for | 1.3.8 | 2021 | | | | | | | | |
| For women with a Bishop score of more than 6, offer induction of labour with amniotomy and an intravenous oxytocin infusion. | 1.3.9 | 2021 | | | | | | | | |
| Advise women that they can have an amniotomy and can choose whether or not to have an oxytocin infusion, or can delay starting this, but that this may mean labour takes longer and there may be an increased risk of neonatal infection. | 1.3.10 | 2021 | | | | | | | | |
| **1.4 Methods that are not recommended for induction of labour** | | | | | | | | | | |
| **Pharmacological methods** | | | | | | | | | | |
| Be aware that the available evidence does not support the use of the following methods for induction of labour:<br>•oral dinoprostone<br>•intravenous dinoprostone<br>•extra-amniotic dinoprostone or $PGF_2$<br>•intracervical dinoprostone<br>•vaginal $PGF_2$<br>•intravenous oxytocin alone<br>•hyaluronidase<br>•corticosteroids<br>•oestrogen<br>•relaxin<br>•mifepristone (except in combination for intrauterine fetal death, see recommendation 1.2.31) | 1.4.1 | 2008, amended 2021 | | | | | | | | |
| **Non pharmacological methods** | | | | | | | | | | |

| NICE recommendation | Guideline reference | Year of recommendation | Is the recommendation relevant? | Current activity/evidence | Recommendation met? | Actions needed to implement recommendation | Is there a risk associated with not implementing this recommendation? | Is there a cost or saving? | Deadline | Lead |
|---|---|---|---|---|---|---|---|---|---|---|
| Be aware that the available evidence does not support the following methods for induction of labour:<br>•herbal supplements<br>•acupuncture<br>•homeopathy<br>•castor oil<br>•hot baths<br>•enemas<br>•sexual intercourse. | 1.4.2 | 2008 | | | | | | | | |
| **1.5 Assessment before induction, monitoring and pain relief** | | | | | | | | | | |
| **Assessment before induction** | | | | | | | | | | |
| Ensure the position of the baby and the woman's condition are suitable for induction by:<br>•abdominally assessing the level and stability of the fetal head in the lower part of the uterus at or near the pelvic brim<br>•carrying out an ultrasound scan if there are any concerns about the position of the baby (for example, if it might be in the breech position)<br>•assessing and recording the Bishop score<br>•confirming a normal fetal heart rate pattern using antenatal cardiotocography interpretation<br>•confirming the absence of significant uterine contractions (not Braxton-Hicks) using cardiotocography. | 1.5.1 | 2008, amended 2021 | | | | | | | | |
| Ensure facilities are available for cardiotocography wherever induction of labour is started. | 1.5.2 | 2008, amended 2021 | | | | | | | | |
| **Monitoring** | | | | | | | | | | |
| Note that the summaries of product characteristics for different preparations of dinoprostone contain different monitoring requirements. Always use the NICE guidance on dinoprostone in conjunction with the relevant summary of product characteristics. | | | | | | | | | | |
| When uterine contractions begin after administering dinoprostone or misoprostol, assess fetal wellbeing and uterine contractions with intrapartum cardiotocography interpretation and:<br>•if the cardiotocogram is confirmed as normal, review the individual circumstances and, if considered low risk, use intermittent auscultation unless there are clear indications for further cardiotocography<br>•if the fetal heart rate is abnormal or there are excessive uterine contractions:<br>-continue or restart continuous cardiotocography<br>-do not administer any more doses, and<br>-remove any vaginal pessaries or delivery systems if possible.<br>Follow the [illegible] in the NICE guideline on [illegible] | 1.5.3 | 2008, amended 2021 | | | | | | | | |
| Offer to reassess the wellbeing of the woman and baby and the Bishop score at appropriate intervals to monitor progress, depending on the method of induction being used, and the clinical condition of the woman. | 1.5.4 | 2008, amended 2021 | | | | | | | | |
| Once active labour is established, carry out maternal and fetal monitoring as described in the NICE guideline on intrapartum care. | 1.5.5 | 2008 | | | | | | | | |
| **Pain relief** | | | | | | | | | | |
| Explain to women that induced labour may be more painful than spontaneous labour. | 1.5.6 | 2008 | | | | | | | | |
| Discuss the available pain relief options in different settings with women. | 1.5.7 | 2008 | | | | | | | | |
| During induction of labour, provide women with the pain relief appropriate for them and their pain as described in the NICE guideline on intrapartum care. This can include simple analgesia, labour in water and epidural analgesia. | 1.5.8 | 2008, amended 2021 | | | | | | | | |
| **1.6 Outpatient induction** | | | | | | | | | | |
| Note that the summaries of product characteristics for different preparations of dinoprostone contain different monitoring requirements. Always use the NICE guidance on dinoprostone in conjunction with the relevant summary of product characteristics. | | | | | | | | | | |
| Consider outpatient induction of labour with vaginal dinoprostone preparations or mechanical methods in women who wish to return home, and who have no co-existing medical conditions or obstetric complications. Discuss with the woman the benefits and risks of returning home, and respect her decision. | 1.6.1 | 2008, amended 2021 | | | | | | | | |
| Carry out a full clinical assessment of the woman and baby (see recommendation 1.5.1 and 1.5.2) and ensure safety and support procedures are in place. | 1.6.2 | 2008, amended 2021 | | | | | | | | |
| For induction being undertaken on an outpatient basis, agree a review plan with the woman before she returns home. | 1.6.3 | 2008, amended 2021 | | | | | | | | |
| Ask women to contact their midwife, maternity unit or obstetrician:<br>•when contractions begin, **or**<br>•if there are no contractions (in an agreed timeframe, depending on the method used), **or**<br>•if her membranes rupture, **or**<br>•if she develops bleeding, **or**<br>•if she has any other concerns, such as reduced or altered fetal movements, excessive pain or uterine contractions, side-effects or loss of the pessary. | 1.6.4 | 2008, amended 2021 | | | | | | | | |
| **1.7 Prevention and management of complications** | | | | | | | | | | |
| **Uterine hyperstimulation** | | | | | | | | | | |
| If uterine hyperstimulation occurs during induction of labour:<br>•carry out a fetal assessment<br>•do not administer any more doses of medicines to induce labour and remove any vaginal pessaries or delivery systems if possible<br>•consider tocolysis. | 1.7.1 | 2008, amended 2021 | | | | | | | | |
| **Unsuccessful induction** | | | | | | | | | | |
| If induction is unsuccessful, discuss this with the woman and provide support. Fully reassess the woman's condition and the pregnancy in general, and assess fetal wellbeing using antenatal cardiotocography interpretation. | 1.7.2 | 2008, amended 2021 | | | | | | | | |
| If induction is unsuccessful, discuss and agree a plan for further management with the woman, including whether she would like further attempts at induction, taking into account the clinical circumstances and her preferences. | 1.7.3 | 2008, amended 2021 | | | | | | | | |
| If induction is unsuccessful, the subsequent management options include:<br>•offering a rest period if clinically appropriate and then re-assessing the woman<br>•expectant management<br>•further attempts to induce labour<br>•caesarean birth. See the NICE guideline on caesarean birth. | 1.7.4 | 2008, amended 2021 | | | | | | | | |
| **Cord prolapse** | | | | | | | | | | |

| NICE recommendation | Guideline reference | Year of recommendation | Is the recommendation relevant? | Current activity/evidence | Recommendation met? | Actions needed to implement recommendation | Is there a risk associated with not implementing this recommendation? | Is there a cost or saving? | Deadline | Lead |
|---|---|---|---|---|---|---|---|---|---|---|
| Take the following precautions to avoid the adverse effects of cord prolapse, which may occur if labour is induced:<br>•before induction, abdominally assess the level and stability of the fetal head in the lower part of the uterus at or near the pelvic brim (see the recommendations on assessment before induction)<br>•during the preliminary vaginal examination, obstetricians and midwives should palpate for umbilical cord presentation and avoid dislodging the baby's head<br>•carry out continuous cardiotocography during induction after the membranes have ruptured, if the presenting part is not stable and not well-applied to the cervix. In this situation, discuss the risks and benefits of induction of labour with the woman, and if necessary consider caesarean birth. If the presenting part stabilises and the cardiotocogram is normal, use intermittent auscultation unless there are clear indications for further cardiotocography. | 1.7.5 | 2008, amended 2021 | | | | | | | | |
| **Placenta praevia, low lying placenta or a previous history of antepartum haemorrhage** | | | | | | | | | | |
| Check that there is no evidence of a low-lying placenta on previous scans before membrane sweeping and before induction of labour. | 1.7.6 | 2008, amended 2021 | | | | | | | | |
| **Uterine rupture** | | | | | | | | | | |
| If uterine rupture is suspected during induced labour, carry out an immediate category 1 caesarean birth. See the NICE guideline on caesarean birth. | 1.7.7 | 2008, amended 2021 | | | | | | | | |

**Table 1. Gestational age at which labour started, as a proportion of labours which started spontaneously**

| Gestational age (weeks) | Proportion of spontaneous labours that started at this gestational age | Cumulative proportion of spontaneous labours that started by this gestational age |
|---|---|---|
| 31 weeks and under | 2.40% | 2.40% |
| 32+0 to 36+6 weeks | 5.30% | 7.70% |
| 37+0 to 37+6 weeks | 5.10% | 12.80% |
| 38+0 to 38+6 weeks | 12.10% | 24.90% |
| 39+0 to 39+6 weeks | 25.40% | 50.30% |
| 40+0 to 40+6 weeks | 32.50% | 82.80% |
| 41+0 to 41+6 weeks | 16.20% | 99.00% |
| 42+0 weeks and over | 0.90% | 100% |

Data from NHS Hospital Episode Statistics/Maternity Services Data set 2019-20.

NICE National Institute for Health and Care Excellence

NICE guidance

# Sodium zirconium cyclosilicate for treating hyperkalaemia

Technology appraisal guidance
Published: 4 September 2019
www.nice.org.uk/guidance/ta599

# Your responsibility

The recommendations in this guidance represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, health professionals are expected to take this guidance fully into account, alongside the individual needs, preferences and values of their patients. The application of the recommendations in this guidance are at the discretion of health professionals and their individual patients and do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Commissioners and/or providers have a responsibility to provide the funding required to enable the guidance to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

# Contents

# 1 Recommendations

1.1 Sodium zirconium cyclosilicate is recommended as an option for treating hyperkalaemia in adults only if used:

- in emergency care for acute life-threatening hyperkalaemia alongside standard care or
- for people with persistent hyperkalaemia and chronic kidney disease stage 3b to 5 or heart failure, if they:
  - have a confirmed serum potassium level of at least 6.0 mmol/litre and
  - because of hyperkalaemia, are not taking an optimised dosage of renin-angiotensin-aldosterone system (RAAS) inhibitor and
  - are not on dialysis. [amended 2022]

1.2 Stop sodium zirconium cyclosilicate if RAAS inhibitors are no longer suitable. [amended 2022]

1.3 This recommendation is not intended to affect treatment with sodium zirconium cyclosilicate that was started in the NHS before this guidance was published. People having treatment outside this recommendation may continue without change to the funding arrangements in place for them before this guidance was published, until they and their NHS clinician consider it appropriate to stop.

Why the committee made these recommendations

Sodium zirconium cyclosilicate is a treatment for people with high blood potassium levels (hyperkalaemia). It may benefit adults with chronic kidney disease or heart failure, either:

- in emergency care for life-threatening hyperkalaemia or
- for persistent hyperkalaemia that prevents people from having an optimised dose of RAAS inhibitors.

Treating acute life-threatening hyperkalaemia in emergency care is established clinical practice. Evidence from people with hyperkalaemia having treatment in outpatient care suggests that

sodium zirconium cyclosilicate could be a useful addition to emergency care. Other potassium-lowering treatments are rarely used in this setting because they are poorly tolerated.

The cost-effectiveness estimates for sodium zirconium cyclosilicate suggest that it is a good use of NHS resources for treating acute life-threatening hyperkalaemia in emergency care. Therefore, it is recommended.

Clinical trials show that sodium zirconium cyclosilicate lowers serum potassium when used in outpatient care. But there is no clinical evidence that it extends life or improves quality of life. Sodium zirconium cyclosilicate may allow people to stay on RAAS inhibitors (drugs used to treat heart failure and kidney disease) for longer. Staying on these drugs may extend life and improve quality of life.

Considering the benefit from more people being able to stay on RAAS inhibitors, the cost-effectiveness estimates for sodium zirconium cyclosilicate suggest that it is a good use of NHS resources. Therefore, it is recommended for treating confirmed persistent hyperkalaemia when started in specialist care, for people who are not taking an optimised dose of RAAS inhibitors because of hyperkalaemia.

# 2 Information about sodium zirconium cyclosilicate

Information about sodium zirconium cyclosilicate

| | |
|---|---|
| Marketing authorisation indication | Sodium zirconium cyclosilicate (Lokelma, AstraZeneca) has a marketing authorisation 'for the treatment of hyperkalaemia in adult patients'. |
| Dosage in the marketing authorisation | Correction phase:<br>The recommended starting dose of sodium zirconium cyclosilicate is 10 g, administered 3 times a day orally as a suspension in water. When normal serum potassium levels are reached, the maintenance regimen should be followed. If normal serum potassium levels are not reached after 72 hours of treatment, sodium zirconium cyclosilicate should be stopped.<br>Maintenance phase:<br>For people with normal serum potassium levels after the correction phase, the minimal effective dose of sodium zirconium cyclosilicate to prevent recurrence of hyperkalaemia should be established. A starting dose of 5 g once daily is recommended, with possible titration up to a maximum of 10 g once daily or down to 5 g once every other day as needed to maintain a normal serum potassium level. |
| Price | The list price of sodium zirconium cyclosilicate is £10.40 per 10-g sachet or £5.20 per 5-g sachet (company information, November 2021).<br>Costs may vary in different settings because of negotiated procurement discounts. |

# 3 Committee discussion

The appraisal committee (section 6) considered evidence submitted by AstraZeneca and a review of this submission by the evidence review group (ERG). See the committee papers for full details of the evidence.

## Treating hyperkalaemia

### Patients in the NHS with serum potassium levels above the normal range do not always need treatment to lower potassium

3.1 Hyperkalaemia is a high level of potassium in the blood. The European Resuscitation Council classifies hyperkalaemia as mild (serum potassium level of 5.5 mmol/litre to 5.9 mmol/litre), moderate (6.0 mmol/litre to 6.4 mmol/litre) or severe (6.5 mmol/litre and above). The company's clinical trials recruited people with serum (blood) potassium levels above 5.0 mmol/litre. The committee understood that serum potassium tests may incorrectly identify hyperkalaemia, and potassium levels often need to be confirmed. It concluded that any use of sodium zirconium cyclosilicate would be limited to confirmed hyperkalaemia. Hyperkalaemia occurs most commonly in people with chronic kidney disease (stages 4 and 5), and in heart failure. It can also occur after starting treatments for high blood pressure, chronic kidney disease, proteinuria and heart failure, which include potassium-sparing diuretics or renin-angiotensin-aldosterone system (RAAS) inhibitors. RAAS inhibitors include angiotensin-converting enzyme (ACE) inhibitors, angiotensin II receptor blockers (ARBs) and aldosterone receptor antagonists. Clinicians routinely monitor serum potassium in people with chronic kidney disease and in people having RAAS inhibitors. The clinical experts at the second committee meeting explained they would consider drug treatment for hyperkalaemia, if a well-tolerated treatment were available, mainly to optimise the use of RAAS inhibitors. They would consider drug treatment for:

- people with chronic kidney disease and serum potassium levels above 6.0 mmol/litre and

- some people with heart failure and serum potassium levels above 5.5 mmol/litre.

The committee understood that many people have both heart failure and chronic kidney disease, so it may be appropriate to start drug treatment at the same serum potassium level for both diseases. The committee was not presented with evidence for a differential effect of sodium zirconium cyclosilicate between people with chronic kidney disease and heart failure (see section 3.10). Once the diagnosis of hyperkalaemia is confirmed, the decision to use a treatment that actively lowers serum potassium takes into account whether the hyperkalaemia is life threatening. This is based on whether the rise in serum potassium is acute and whether there are characteristic electrocardiogram (ECG) changes. The committee concluded that most of the people in the company's clinical trials, which recruited people with serum potassium levels above 5.0 mmol/litre, would not have treatment for hyperkalaemia in the NHS.

## Treating life-threatening acute hyperkalaemia and chronic hyperkalaemia is different

3.2 The need for, and type of, treatment for hyperkalaemia depends on its severity. Life-threatening acute hyperkalaemia needs emergency treatment in hospital. NICE-accredited clinical practice guidelines for treating acute hyperkalaemia from the UK Renal Association state that the risk of cardiac arrhythmias increases with serum potassium levels above 6.5 mmol/litre. Small rises in serum potassium above this can cause ECG changes. To lower the risk of cardiac arrest, clinicians use active potassium-lowering treatments, then identify and remove the cause of hyperkalaemia. The guidelines include the following treatments:

- Calcium chloride or calcium gluconate intravenously to protect the heart if there is ECG evidence of hyperkalaemia.
- Insulin and glucose intravenously to move potassium from the blood into cells.
- Nebulised salbutamol as an adjunctive therapy to insulin and glucose for serum potassium levels of 6.5 mmol/litre and above to move potassium from the blood into cells.
- After severe hyperkalaemia has resolved, potassium-binding agents may be offered for 3 or more days (namely, calcium resonium given orally) to remove potassium from the body.

- Stopping or reducing RAAS inhibitors, which can increase serum potassium levels.

The aim of treatment of chronic hyperkalaemia is to lower potassium levels to prevent acute life-threatening hyperkalaemia. Treatment includes:

- Advising people with chronic kidney disease to avoid foods high in potassium.
- Stopping or reducing RAAS inhibitors and potassium-sparing diuretics.
- Avoiding non-steroidal anti-inflammatory drugs and trimethoprim.

The clinical expert at the first committee meeting explained that people who have normal serum potassium levels after emergency treatment do not have long-term (maintenance) treatment with a potassium-lowering drug in current clinical practice. He also noted that calcium resonium is poorly tolerated by patients. The committee concluded that managing acute life-threatening hyperkalaemia differs from managing persistent but non-life-threatening hyperkalaemia, which justified the separate analyses for sodium zirconium cyclosilicate in these populations.

## People with chronic hyperkalaemia would welcome an alternative to stopping RAAS inhibitors

3.3 The company proposed that people with chronic hyperkalaemia who have sodium zirconium cyclosilicate would be less likely to stop RAAS inhibitors. Therefore, they would live longer and have a lower risk of worsening kidney disease or heart failure and death. However, it did not provide any clinical evidence for this (see section 3.10). NICE's guideline on chronic kidney disease: assessment and management states that RAAS inhibitors should not be routinely started in people with serum potassium levels of 5.0 mmol/litre and above, and should be stopped in people with levels of 6.0 mmol/litre and above. NICE's guideline on chronic heart failure in adults: diagnosis and management states that serum potassium levels should be monitored before and after starting a RAAS inhibitor or changing RAAS inhibitor dose, but does not specify the serum potassium levels at which RAAS inhibitors should be avoided or stopped. The committee and the clinical experts at the committee meetings agreed that RAAS inhibitors would be used in the NHS for many people with serum potassium levels 5.0 mmol/litre and above, and would be stopped when serum potassium levels are 6.0 mmol/litre and above. At levels of serum potassium below 6.0 mmol/litre, clinicians would likely recommend reducing, rather than stopping, the RAAS inhibitor. This is because the perceived benefits

of being on treatment outweigh the risks of having a serum potassium level between 5.0 mmol/litre and 6.0 mmol/litre. The committee noted that some people stop RAAS inhibitors for reasons other than hyperkalaemia. It concluded that patients and clinicians are keen for new treatments that would allow them to continue RAAS inhibitors.

## The long-term benefit of continuing RAAS inhibitors on quality of life and survival in people with hyperkalaemia may vary

3.4 The clinical expert at the first committee meeting explained that the benefit, or potential harm, of being on RAAS inhibitor treatment depended on:

- the underlying condition
- the class of RAAS inhibitor (ACE inhibitors, ARBs, aldosterone receptor antagonists) and
- outcome (for example, cardiovascular disease, worsening of kidney disease, death).

The British Society for Heart Failure's response to consultation and a clinical expert present at the second meeting noted that RAAS inhibitors benefit people with heart failure with reduced ejection fraction, but not people with preserved ejection fraction. The committee concluded that the harms and benefits of stopping RAAS inhibitors because of hyperkalaemia compared with standard care could be affected by the:

- underlying condition
- type of RAAS inhibitor
- dose of RAAS inhibitor
- number of RAAS inhibitors
- reason for stopping a RAAS inhibitor.

The committee also concluded that the long-term benefit of continuing RAAS inhibitors on quality of life and survival in people with hyperkalaemia may vary and that it would consider the balance of benefits and harms in its decision making.

## Sodium zirconium cyclosilicate is unlikely to replace a low-potassium diet

3.5 The patient experts noted that maintaining a low-potassium diet is challenging because so many foods contain potassium. The clinical experts explained that they consider the diet worth trying; NICE recommends it for people with chronic kidney disease, and it lowers serum potassium compared with an unrestricted diet. They added that a new treatment option would not replace dietary advice but complement it, and may mean that the diet need not be so strict. The committee concluded that sodium zirconium cyclosilicate is unlikely to replace a low-potassium diet.

# Company positioning of sodium zirconium cyclosilicate

## The company proposes sodium zirconium cyclosilicate for a population narrower than that covered by the marketing authorisation

3.6 The marketing authorisation indication for sodium zirconium cyclosilicate specifies 'treatment for hyperkalaemia'. It was based on the company's trials in which people with serum potassium levels above 5.0 mmol/litre were recruited and had treatment (see section 3.8). The company focused its submission on people with chronic kidney disease (stages 3b to 5, excluding those on dialysis) or heart failure (who may also have chronic kidney disease, including stage 3a). The committee noted that the population in the company's submission was narrower than that covered by the marketing authorisation because the marketing authorisation includes people with other conditions (see section 2). At the third committee meeting, the company proposed that people with confirmed serum potassium levels of 6.0 mmol/litre and above would have treatment. The committee recalled that:

- starting treatment at the same serum potassium level for chronic kidney disease and heart failure may be appropriate (see section 3.1)
- it had not seen evidence justifying different starting levels between chronic kidney disease and heart failure

- 6.0 mmol/litre was the same serum potassium level as that for stopping RAAS inhibitors (see section 3.3).

  Therefore, the committee concluded that it would appraise sodium zirconium cyclosilicate for the population and the starting serum potassium level, 6.0 mmol/litre, the company proposed, which was narrower than that covered by the marketing authorisation.

## The company proposes that sodium zirconium cyclosilicate will be used alongside standard care for acute hyperkalaemia and started in specialist care for chronic hyperkalaemia

3.7 The marketing authorisation for sodium zirconium cyclosilicate covers using it as a corrective treatment for lowering serum potassium levels followed by maintenance treatment (at a lower dose) for people whose serum potassium levels return to normal after corrective treatment. The maintenance dose aims to avoid repeat hyperkalaemia. The committee noted that the marketing authorisation does not specify whether sodium zirconium cyclosilicate should be used to treat life-threatening hyperkalaemia needing emergency treatment, or persistent hyperkalaemia in outpatient care. The company proposed that sodium zirconium cyclosilicate would be used:

- In emergency care, as an alternative to calcium resonium and permanently stopping RAAS inhibitors, in people with high levels of serum potassium who need immediate hospital treatment. It explained that sodium zirconium cyclosilicate would complement rather than replace the use of insulin and glucose in patients with life-threatening hyperkalaemia.

- As an alternative to stopping RAAS inhibitors to manage chronic hyperkalaemia and to prevent life-threatening hyperkalaemia, in people with hyperkalaemia identified through routine monitoring. It explained that sodium zirconium cyclosilicate would complement rather than replace a low-potassium diet and may allow such a diet to be less strict (see section 3.5). It also explained that sodium zirconium cyclosilicate would be started in specialist care rather than in general practice.

  The committee concluded that it would appraise sodium zirconium cyclosilicate in the settings the company proposed, and that the comparators were both calcium resonium and managing RAAS inhibitors after emergency treatment, and managing RAAS inhibitors for chronic hyperkalaemia.

# Clinical effectiveness

## Trial evidence does not show whether sodium zirconium cyclosilicate is more clinically effective than NHS standard care

3.8 The clinical effectiveness evidence for sodium zirconium cyclosilicate came from the ZS004 and ZS005 trials. The trials were done in outpatient care. They included people who had lower serum potassium levels than would be treated in the NHS. In its consultation response, the company presented results for 8 patients in ZS004 with serum potassium levels of 6.5 mmol/litre and above, arguing that these patients would have emergency treatment in the NHS. However, the committee noted that these patients also had treatment as outpatients, so did not reflect patients who would have treatment in emergency care in the NHS. Both trials had 2 phases. The first 'correction' phase was single arm (everyone had treatment to lower serum potassium; there was no control group) in patients with serum potassium levels of 5.1 mmol/litre and above. The committee recognised that some of the response may have been related to regression to the mean. In response to the first consultation, the company presented data from a third trial, ZS003, which included a placebo-control arm in the 2-day correction phase. The second phase of all 3 trials measured how well sodium zirconium cyclosilicate maintained serum potassium levels in people whose serum potassium levels had responded in the correction phase and were between 3.5 mmol/litre and 5.0 mmol/litre. In ZS004, people whose serum potassium levels had responded were randomised to placebo or to continue sodium zirconium cyclosilicate for 28 days. In ZS005, all people whose serum potassium levels had responded had sodium zirconium cyclosilicate for 52 weeks. The committee appreciated that the primary outcome measure in all the trials was mean serum potassium level. The trials all showed that sodium zirconium cyclosilicate treatment reduced serum potassium level from baseline. The single-arm maintenance part of ZS005 measured changing use of RAAS inhibitors as an exploratory end point. However, the single-arm design of this trial meant that there were no data on whether sodium zirconium cyclosilicate, compared with standard care, allowed more patients to continue on RAAS inhibitors, a key potential benefit suggested by the company (see section 3.3). The committee concluded that the company had not provided any data comparing sodium zirconium cyclosilicate with current NHS treatments to correct hyperkalaemia and maintain normal serum potassium levels in outpatient care (that is, management of RAAS inhibitors). Without these data, it

could not determine whether sodium zirconium cyclosilicate is more clinically effective than current standard care in the NHS for treating chronic hyperkalaemia.

## Sodium zirconium cyclosilicate could be beneficial in treating acute life-threatening hyperkalaemia

3.9 The committee noted that acute hyperkalaemia can be fatal and treating acute life-threatening hyperkalaemia in hospital is established clinical practice. It agreed that lowering potassium levels for patients needing emergency care was a life-saving intervention. The committee therefore concluded that randomised evidence was not needed to show that treating life-threatening hyperkalaemia in emergency care prolonged life. As such, the uncontrolled evidence showing that sodium zirconium cyclosilicate reduces serum potassium (see section 3.8) was sufficient for the committee to conclude that it could be useful for people with hyperkalaemia needing treatment in emergency care.

## There is no direct evidence that sodium zirconium cyclosilicate increases length or quality of life for people having treatment for chronic hyperkalaemia

3.10 The company did a post-hoc analysis of the subgroups of patients in ZS004 and ZS005 who had baseline serum potassium levels of 6.0 mmol/litre and above. This is the threshold at which RAAS inhibitors are likely to be stopped and at which the company proposed sodium zirconium cyclosilicate would be used (see section 3.6). Most patients having sodium zirconium cyclosilicate had a serum potassium value of between 4.0 mmol/litre and 6.0 mmol/litre after the correction phase. For most of these patients, their serum potassium remained within these levels during the maintenance phase. The company also provided data from ZS003, which showed that patients having sodium zirconium cyclosilicate had stable serum potassium levels during the 12-day maintenance period compared with small increases for patients on placebo. The committee noted:

- The placebo in ZS003 did not reflect NHS practice (for example stopping RAAS inhibitors).

- In ZS003 patients with serum potassium levels of above 5.0 mmol/litre started treatment. Clinicians in the NHS would not typically offer treatment at this level (see section 3.1).

- Symptoms of hyperkalaemia may be similar to symptoms of the underlying condition, for example, heart failure. So, treating hyperkalaemia may not result in a noticeable effect on symptoms.

- ZS005 was the longest trial, with follow up of 52 weeks. The company provided no evidence for the effectiveness of sodium zirconium cyclosilicate beyond 52 weeks. In its updated base case, the company assumed that patients would have the drug indefinitely (see section 3.14), an assumption 1 clinical expert supported.

- The company did not present any statistical tests for interaction by subgroup, so it was unknown whether patients with chronic kidney disease or heart failure derived greater benefit from sodium zirconium cyclosilicate.

  The committee was also aware that the company claimed that treatment with sodium zirconium cyclosilicate would prolong life and improve quality of life, but none of the trials showed this. The ERG and the consultation responses noted that the company could resolve this uncertainty with a clinical trial designed to report on outcomes such as mortality, disease progression and patterns of RAAS inhibitor use. The company indicated that it was not planning such a trial. The committee concluded that, although the trial results showed that continuing sodium zirconium cyclosilicate was associated with lower serum potassium than stopping the drug, there was no direct evidence that sodium zirconium cyclosilicate improves survival or quality of life over other treatments for people with chronic hyperkalaemia.

## Sodium zirconium cyclosilicate is associated with adverse effects

3.11 The company presented data showing that treatment with sodium zirconium cyclosilicate was associated with hypokalaemia, that is low serum potassium. Hypokalaemia, like hyperkalaemia, is associated with life-threatening arrhythmias. The company explained that treating hyperkalaemia at 6.0 mmol/ litre and above was less likely to cause hypokalaemia than when treating it at lower levels. The committee concluded that sodium zirconium cyclosilicate is associated with adverse effects.

## Stopping RAAS inhibitors likely increases the risk of death,

## hospitalisation and disease progression

3.12 Data were not collected in ZS003, ZS004 and ZS005 on the effect of sodium zirconium cyclosilicate on long-term outcomes such as progression of chronic kidney disease or mortality. However, the company proposed in its model that people with hyperkalaemia who have sodium zirconium cyclosilicate live longer and have a better quality of life than people who do not. This was because treatment with sodium zirconium cyclosilicate would allow them to maintain or restart treatment with RAAS inhibitors. The committee noted that the company provided only exploratory data from a single-arm trial (ZS005) of sodium zirconium cyclosilicate. This showed that most people on RAAS inhibitors continued to have the same dose and some people not on them at the start of the trial had started them by the end of the trial follow up. The committee recalled that there was no evidence showing that RAAS inhibitor dosing was different for people having sodium zirconium cyclosilicate than for people who didn't (see section 3.8). Independent of this, based on targeted reviews for chronic kidney disease and heart failure, the company presented data from a network meta-analysis of randomised controlled trials and several observational studies. The company assumed that, because these studies showed that starting a RAAS inhibitor is associated with living longer, people who stop a RAAS inhibitor would have shortened lives. The company also presented evidence that RAAS inhibitors are associated with delayed disease progression, and therefore improved quality of life. The committee recognised that the company's evidence addressed the decision problem indirectly. It noted that the trials in the company's literature search compared starting RAAS inhibitors with not starting them, rather than the question relevant to this appraisal, that is, reducing or stopping RAAS inhibitors compared with continuing them. In addition, sodium zirconium cyclosilicate may allow more people to remain on RAAS inhibitors. However, the reason for some people having high potassium levels may be a worsening of the underlying disease, and it is unclear whether the clinical benefit seen in the trials would translate fully. For example, the committee understood from the clinical expert and consultation responses that the benefits of RAAS inhibitors were well established for certain people, but their benefits were uncertain for others, for example, people close to needing kidney dialysis. It concluded that, in the population being considered, stopping RAAS inhibitors would generally be associated with an increased risk of adverse outcomes and disease progression. The committee was not satisfied that the company had presented robust data

on how sodium zirconium cyclosilicate alters dosing of RAAS inhibitors compared with standard care, or the extent to which such alterations improved length and quality of life. However, the committee was also aware of NICE guidance recommending stopping RAAS inhibitors at serum potassium levels of 6.0 mmol/litre and above (see section 3.3). It concluded that starting RAAS inhibitors prolongs life for many people, so stopping them for people who benefit from them would likely shorten life.

## There is insufficient evidence to prove that lowering serum potassium levels improves long-term outcomes

3.13 The company also proposed in its model that lowering serum potassium with sodium zirconium cyclosilicate causes people to live longer. It based this on a review of evidence on the association between serum potassium and adverse outcomes for people with chronic kidney disease or heart failure. This evidence, from observational cohort studies, showed that a higher risk of death, hospitalisation and major adverse cardiovascular events was associated with high, but also with lower than normal, serum potassium levels. Using these data, the company assumed that, because people with higher than normal serum potassium have a higher risk of death, sodium zirconium cyclosilicate prolongs life because it lowers serum potassium. The committee noted that the observational data did not guarantee an independent causal effect between high serum potassium levels and death. Importantly, even if it did, the committee noted that the observational data did not provide evidence that lowering serum potassium extends life. The committee was aware that these studies could adjust only for known, measured confounders. It also noted that the authors of a company-supported observational study used in the model cautioned against assuming a causal effect, and acknowledged the possibility of residual confounding. At the third committee meeting, the company agreed that these observational data did not prove causality. The committee agreed that a relationship between lowering serum potassium to a normal range and fewer adverse outcomes was biologically plausible in certain clinical situations. The company did not provide interventional randomised evidence that lowering serum potassium prolongs life in chronic hyperkalaemia. The committee was aware that any association between serum potassium levels and mortality may have been influenced by time-dependent confounding. Specifically, patients with hyperkalaemia may have stopped having RAAS inhibitors, increasing the risk of death. The committee concluded that there was insufficient evidence to

prove that lowering serum potassium levels for people in outpatient care improves outcomes.

# Cost-effectiveness modelling

## A patient-level simulation model is appropriate

3.14 The company modelled the cost effectiveness of sodium zirconium cyclosilicate using a patient-level simulation model. The model generated a serum potassium trajectory for each patient over time. The proportion of patients who entered the model on RAAS inhibitors was based on ZS005 (36% of people with chronic kidney disease and 70% of people with heart failure). Thereafter, RAAS inhibitor use was determined by the patient's serum potassium trajectory (as below). The company chose to model sodium zirconium cyclosilicate as prolonging life in 2 ways: by level of serum potassium (in which treatment led to the full theoretical benefit seen in epidemiological studies) and by whether the patient was on a RAAS inhibitor (see section 3.12 and section 3.13). The company modelled 2 settings:

- Emergency care: patients had sodium zirconium cyclosilicate after insulin–glucose for up to 28 days. The company chose 28 days based on the length of ZS004. The time horizon was 52 weeks.
- Outpatient care: patients had sodium zirconium cyclosilicate for 28 days if it was the first episode of hyperkalaemia or for a lifetime, if otherwise. The committee understood the company chose a lifetime duration of treatment because clinical experts stated that treatment would continue as long as there was evidence of clinical benefit (see section 3.10).

  The clinical experts noted that they may offer people sodium zirconium cyclosilicate only for a few days in emergency care, rather than 28 days.

  The committee noted that the company's updated base case incorporated some, but not all, of its preferred assumptions, including:

- starting treatment with sodium zirconium cyclosilicate at serum potassium values of 6.0 mmol/litre and above for both chronic kidney disease and heart failure

- comparative data for standard care during the correction phase (from ZS003, see section 3.8)
- modelling a reduction in serum potassium level when patients stop or reduce their dose of RAAS inhibitors
- 80% of patients with a serum potassium level between 5.5 mmol/litre and 6.0 mmol/litre reduce their dose of RAAS inhibitors and 20% stop them
- all patients with a serum potassium level above 6.0 mmol/litre stop RAAS inhibitors for 12 weeks, after which around 50% of people restart them.

The committee concluded that a patient-simulation model was appropriate for decision making.

## The company's approach to modelling the association between RAAS inhibitor use and outcomes is appropriate, but the data are inadequate

3.15 The company modelled an association between use of RAAS inhibitors and the risks of mortality, hospitalisation and major adverse cardiovascular events. This was based on odds ratios from a network meta-analysis of clinical trials of starting RAAS inhibitors (Xie et al. 2016). The committee recalled and accepted evidence from the clinical and patient experts that maintaining RAAS inhibitor therapy is likely to be beneficial for certain patients (see section 3.12). It noted that the company did scenario analyses using alternative data sources and assuming that RAAS inhibitor use had no effect on outcomes. The committee did not see robust evidence of the effect of sodium zirconium cyclosilicate on RAAS inhibitor use. However, it was aware that clinicians are encouraged to stop RAAS inhibitor treatment in people with serum potassium levels of 6.0 mmol/litre and above. The committee concluded that the company's approach to modelling the association between RAAS inhibitor use and outcomes was appropriate.

## It is appropriate to consider the company's scenario removing the association between serum potassium levels and outcomes

3.16 In its base case, the company modelled an association between serum potassium levels and the risks of mortality, hospitalisation and major adverse

cardiovascular events using observational studies. The committee recalled that the observational studies supporting this assumption did not establish that lowering serum potassium improved outcomes. Also, it was aware that the underlying causes of hyperkalaemia may have led to poor outcomes rather than the hyperkalaemia itself. Importantly, it had not been presented with evidence that lowering serum potassium in chronic hyperkalaemia prolongs life. The committee concluded that it was not appropriate to assume that lowering serum potassium prolongs life in people with chronic hyperkalaemia, based only on observational studies relating a surrogate end point to adverse outcomes. The committee also noted that any association between serum potassium level and mortality may have been partially captured in the model. This is because patients in the model with a lower serum potassium level are more likely to be having RAAS inhibitors, and therefore have a decreased risk of death (see section 3.15). The company provided additional scenario analyses reducing the strength of the association from the observational evidence or removing it entirely. The committee concluded that it was appropriate to use the scenario analysis removing the association between serum potassium and adverse outcomes in its decision making.

# Cost-effectiveness estimates

## Sodium zirconium cyclosilicate alongside standard care is recommended as an option for people who need emergency treatment of hyperkalaemia

3.17 The committee considered the cost-effectiveness results in emergency care. It recalled that it did not need randomised evidence to show that treating hyperkalaemia in emergency care prolonged life, and that such treatment was standard clinical practice (see section 3.9). The committee was aware that acute hyperkalaemia can be fatal. It agreed that sodium zirconium cyclosilicate reduced serum potassium levels quickly so was a suitable treatment option in emergency care after standard treatments including insulin and glucose (see section 3.2). It recalled that the company had positioned sodium zirconium cyclosilicate to be used alongside standard care for the treatment of life-threatening acute hyperkalaemia (see section 3.7). The committee noted that the drug was associated with lower costs and improved quality of life in both the company's and ERG's base cases and all scenario analyses. It recalled that there was some uncertainty about the results because there was limited clinical

evidence of sodium zirconium cyclosilicate's use in emergency care (see section 3.8). Also, the gain in quality-adjusted life years (QALYs) was very small. It also recalled that the model used a short time horizon for this analysis so any long-term benefits of sodium zirconium cyclosilicate (such as enabling patients to restart RAAS inhibitors) may have been underestimated. The committee agreed that people with life-threatening hyperkalaemia would value the option of another treatment to lower serum potassium levels that was better tolerated than calcium resonium (see section 3.2). It therefore concluded that it could recommend sodium zirconium cyclosilicate alongside standard care as an option for people needing treatment for acute hyperkalaemia in emergency care.

## Sodium zirconium cyclosilicate is recommended as a treatment option for chronic hyperkalaemia

3.18 The committee then considered the cost-effectiveness results for chronic hyperkalaemia. The company's revised base-case incremental cost-effectiveness ratios (ICERs) were less than £20,000 per QALY gained compared with standard care for people with hyperkalaemia who have either chronic kidney disease or heart failure. The exact ICERs cannot be reported here because they are considered confidential by the company. The committee noted that the company's base case included an association between serum potassium levels and mortality, which the committee did not accept (see section 3.16). However, in the scenario removing this association, the ICERs were also below £20,000 per QALY gained. Therefore, the committee concluded that sodium zirconium cyclosilicate was a cost-effective use of NHS resources for treating chronic hyperkalaemia. The committee noted that, in this scenario, most of the benefits arise because more people are able to have RAAS inhibitors with sodium zirconium cyclosilicate. However, it recalled that some people do not benefit from RAAS inhibitors (see section 3.4), and so concluded that it would not be appropriate for these people to start sodium zirconium cyclosilicate. It further concluded that some people may have to stop RAAS inhibitors for reasons other than hyperkalaemia. The committee concluded that, in these situations, people should also stop having sodium zirconium cyclosilicate. It emphasised that uncertainties remained around the clinical benefit of sodium zirconium cyclosilicate and that these could be addressed by clinical trials (see section 5.1).

# Innovation

## The company did not show that sodium zirconium cyclosilicate is innovative

3.19 The company proposed several benefits of sodium zirconium cyclosilicate, including preventing the need to modify RAAS inhibitor treatment and avoiding a restrictive low-potassium diet, but did not show evidence of these benefits. The committee was aware that other gastrointestinal potassium binders exist, and, although these are not well tolerated, sodium zirconium cyclosilicate does not represent a step-change in treatment. The committee concluded that sodium zirconium cyclosilicate could not be considered innovative.

# 4 Implementation

4.1 Section 7(6) of the National Institute for Health and Care Excellence (Constitution and Functions) and the Health and Social Care Information Centre (Functions) Regulations 2013 requires clinical commissioning groups, NHS England and, with respect to their public health functions, local authorities to comply with the recommendations in this appraisal within 3 months of its date of publication.

4.2 The Welsh ministers have issued directions to the NHS in Wales on implementing NICE technology appraisal guidance. When a NICE technology appraisal recommends the use of a drug or treatment, or other technology, the NHS in Wales must usually provide funding and resources for it within 2 months of the first publication of the final appraisal document.

4.3 When NICE recommends a treatment 'as an option', the NHS must make sure it is available within the period set out in the paragraphs above. This means that, if a patient has hyperkalaemia and the doctor responsible for their care thinks that sodium zirconium cyclosilicate is the right treatment, it should be available for use, in line with NICE's recommendations.

# 5 Recommendations for research

5.1 The committee noted that there was no clinical evidence showing that having sodium zirconium cyclosilicate improved length or quality of life or allowed patients to stay on optimal doses of renin-angiotensin-aldosterone system (RAAS) inhibitors. It therefore considered that it would be valuable to have studies comparing sodium zirconium cyclosilicate plus standard care with standard care alone in people with confirmed hyperkalaemia of 6.0 mmol/litre and above, and that these should investigate:

- mortality
- disease progression
- patterns of RAAS inhibitor use
- healthcare utilisation, and
- health-related quality of life.

# 6 Appraisal committee members and NICE project team

## Appraisal committee members

The 4 technology appraisal committees are standing advisory committees of NICE. This topic was considered by committee B.

Committee members are asked to declare any interests in the technology to be appraised. If it is considered there is a conflict of interest, the member is excluded from participating further in that appraisal.

The minutes of each appraisal committee meeting, which include the names of the members who attended and their declarations of interests, are posted on the NICE website.

## NICE project team

Each technology appraisal is assigned to a team consisting of 1 or more health technology analysts (who act as technical leads for the appraisal), a technical adviser and a project manager.

Mary Hughes and Alan Lamb
Technical leads

Ross Dent
Technical adviser

Jeremy Powell
Project manager

# Update information

January 2022: Changes were made to recommendations 1.1 and 1.2 because sodium zirconium cyclosilicate is now available in both primary and secondary care.

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# Accreditation

NICE National Institute for Health and Care Excellence

NICE guideline

# Glaucoma: diagnosis and management

NICE guideline

Published: 1 November 2017

www.nice.org.uk/guidance/ng81

# Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

# Contents

This guideline replaces CG85.

This guideline is the basis of QS180.

# Overview

This guideline covers diagnosing and managing glaucoma in people aged 18 and over. It includes recommendations on testing and referral (case-finding) for chronic open-angle glaucoma and ocular hypertension and on effective diagnosis, treatment and reassessment to stop these conditions progressing.

We have produced a large print version of this guideline, which is available to download in tools and resources.

# Who is it for?

- Healthcare professionals
- People involved in clinical governance in both primary and secondary care
- People with suspected cancer and their families and/or carers

# Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in NICE's information on making decisions about your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

## 1.1 Case-finding

The recommendations on case-finding are for primary eye care professionals before referral for diagnosis of chronic open angle glaucoma (COAG) and related conditions and are separate from a sight test.

1.1.1 Before referral for further investigation and diagnosis of COAG and related conditions, offer all of the following tests:

- central visual field assessment using standard automated perimetry (full threshold or supra-threshold)
- optic nerve assessment and fundus examination using stereoscopic slit lamp biomicroscopy (with pupil dilatation if necessary), and optical coherence tomography (OCT) or optic nerve head image if available
- intraocular pressure (IOP) measurement using Goldmann-type applanation tonometry
- peripheral anterior chamber configuration and depth assessments using gonioscopy or, if not available or the person prefers, the van Herick test or OCT. [2017]

1.1.2 Do not base a decision to refer solely on IOP measurement using non-contact tonometry. [2017]

1.1.3 Do not refer people who have previously been discharged from hospital eye services after assessment for COAG and related conditions unless clinical circumstances have changed and a new referral is needed. [2017]