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

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

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

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

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

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

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

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

2.7.2 DNAs – Review Outpatient

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

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

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

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

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

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

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

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

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

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

2.7.3 CNAs – Patient Initiated Cancellations of Outpatient Appointments

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

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

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

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

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

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

2.8 CNAs – HOSPITAL INITIATED CANCELLATIONS

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

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

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

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

2.9 CLINIC OUTCOME MANAGEMENT

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

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

2.10 CLINIC TEMPLATE CHANGES

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

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

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

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

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

2.11 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

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

2.12 OPEN REGISTRATIONS

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

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

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

- added to a review waiting list.

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

2.13 TIME CRITICAL CONDITIONS

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

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

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

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

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

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

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

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

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

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

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

2.14 TECHNICAL GUIDANCE

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

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

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

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

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 3

GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

3.1 INTRODUCTION

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

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

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

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

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

3.2 KEY PRINCIPLES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.3 NEW DIAGNOSTIC REQUESTS

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

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

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

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

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

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

3.4 CALCULATION OF THE WAITING TIME – STARTING TIME

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

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

3.5 REASONABLE OFFERS

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

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

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

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

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

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

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

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

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

3.6 FOLLOW UP APPOINTMENTS

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

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

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

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

3.7 PLANNED PATIENTS

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

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

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

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

3.8 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

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

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

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

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

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

3.9.1 DNAs – Diagnostic Appointment

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

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

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

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

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

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

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

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

3.9.2 DNAs – Follow up Diagnostic Appointment

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

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

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

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

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

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

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

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

3.9.3 CNAs – Patient Initiated Cancellations of Diagnostic Appointment

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

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

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

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

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

3.10 CNAs - HOSPITAL INITIATED CANCELLATIONS

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

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

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

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

3.11 SESSION OUTCOME MANAGEMENT

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

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

3.12 SESSION TEMPLATE CHANGES

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

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

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

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

3.13 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

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

3.14 TECHNICAL GUIDANCE

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

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

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 4

GUIDANCE FOR MANAGEMENT OF ELECTIVE ADMISSIONS

4.1 INTRODUCTION

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

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

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

4.2 KEY PRINCIPLES

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

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

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

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

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

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

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

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

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

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

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

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

4.3 PRE-ASSESSMENT

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

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

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

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

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

4.4 CALCULATION OF THE WAITING TIME

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

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

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

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

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

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

4.5.3 A reasonable offer is defined as:

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

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

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

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

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

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

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

4.6 INPATIENT AND DAYCASE ACTIVE WAITING LISTS

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

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

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

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

4.7 SUSPENDED PATIENTS

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

4.7.2 A period of suspension is defined as:

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

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

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

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

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

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

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

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

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

4.8 PLANNED PATIENTS

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

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

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

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

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

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

4.9 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

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

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

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

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

DNAs – Inpatient/Daycase

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

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

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

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

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

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

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

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

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

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

4.10.2 CNAs – Patient Initiated Cancellations of inpatient/daycase admission

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

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

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

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

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

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

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

4.11. CNAs - HOSPITAL INITIATED CANCELLATIONS

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

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

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

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

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

4.12 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

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

4.13 TECHNICAL GUIDANCE

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

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

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 5

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

5.1 INTRODUCTION

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

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

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

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

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

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

5.1.7 Fixed appointments should only be used in exceptional circumstances.

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

5.2 KEY PRINCIPLES

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

1. urgent and
2. routine.

No other clinical priorities should be used for AHP services.

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

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

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

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

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

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

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

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

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

5.3 NEW REFERRALS

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

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

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

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

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

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

5.4 CALCULATION OF THE WAITING TIME

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

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

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

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

5.5 REASONABLE OFFERS

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

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

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

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

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

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

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

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

5.6 REVIEW APPOINTMENTS

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

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

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

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

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

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

5.7.1 DNAs – New AHP Appointments

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

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

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

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

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

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

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

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

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

5.7.2 DNAs – Review Appointments

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.8 CNAs – SERVICE INITIATED CANCELLATIONS

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

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

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

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

5.9 CLINIC OUTCOME MANAGEMENT

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

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

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

5.10 CLINIC TEMPLATE CHANGES

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

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

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

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

5.11 TRANSFERS BETWEEN TRUSTS or to INDEPENDENT SECTOR

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

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

5.12 TECHNICAL GUIDANCE

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

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

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

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

SPC tool

NHS Improvement

Instructions

Set-up

1) Save your file using the **save as** function under the file tab on your computer.
2) Enter your organisation's name.
3) Enter your team's or unit's name.
4) Enter what you are measuring (patients, falls, etc).
5) Enter a maximum theoretical value (as an error check- optional).
6) Enter the start date.
7) Choose days, weeks or months for your data frequency
8) Choose the duration of your projectin days weeks or months.
9) You can change the date format of the horizontal axis from dd/mm/yy to mm yy .
   Choose from the drop down list, then click the **'change axis'** button.
10) You can change the vertical axis units and format. Enter the highest and lowest values you want to display, and the type of axis you want to use (integer, decimal or percentage) and click the **'change axis'** button
11) If you are using a baseline, specify the period (between 12 and 20).
    You can also do this by selecting an intervention date at the end of your baseline period.

Daily use

1) Enter your data against the correct date in the yellow and green cells.
2) Save your data each day by clicking the red **SAVE** button.

Statistical process control

An SPC chart is a plot of data over time. It allows you to distinguish between common and special cause variation. It includes a mean and two process limits which are both used in the statistical interpretation of data.

To help you interpret the data a number of rules can be applied.

The rules

1) Any single point outside the process limits.
2) A run of 7 points above or below the mean (a shift), or a run of 7 points all consecutively ascending or descending (a trend).
3) 2 out of 3 points within 1 sigam of the upper or lower control limit
4) A large change in the moving range (greater that 3.27 * av moving range)

All these rules are aids to interpretation but still require intelligent examination of the data.
This tool highlights when a rule has been broken and highlights whether this is improvement or deterioration

If you change in your process and observe a persistent shift in your data, it may be appropriate to change the process limits. A process limit change can be added if the observed change is sustained for a longer period not just 7 points. You should try and find out the cause of the process change before recalculating the limits and annotate this on the chart. Be very cautions if you do not know what changed the process.

Statistical Process Control (XmR) tool

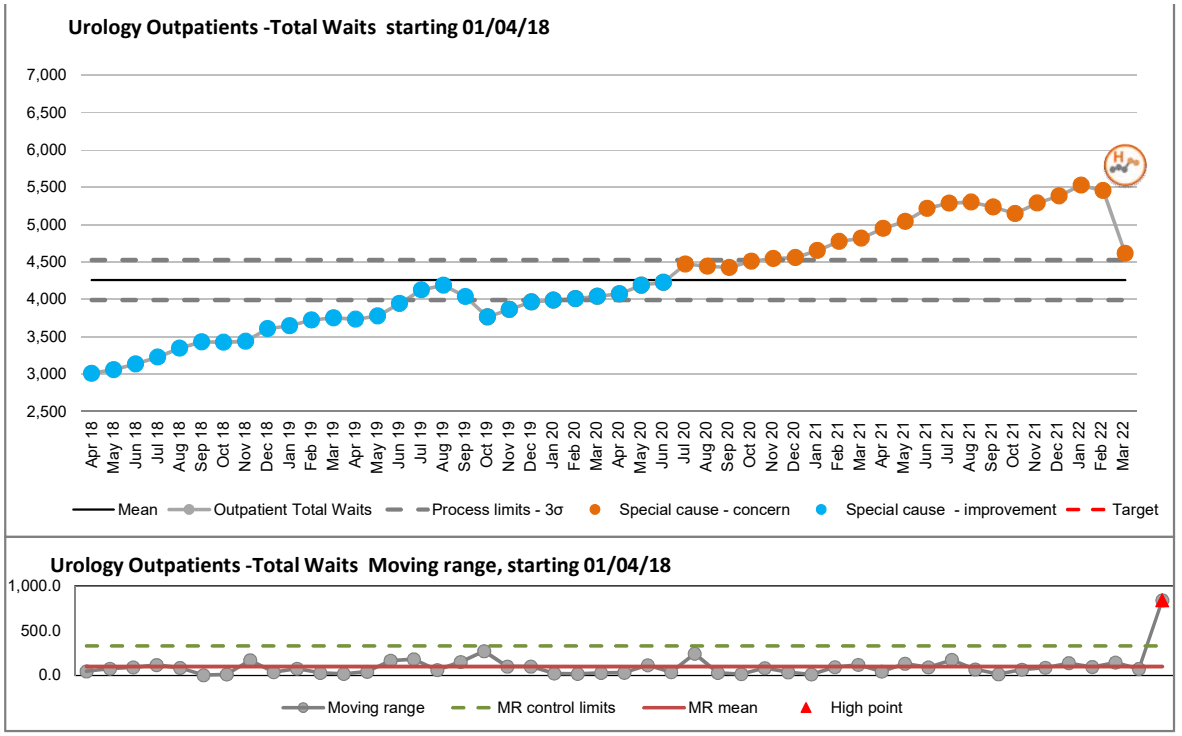
Chart title: Urology Outpatients

Low is good

01/04/18 please select date <= 28th

Set baseline

Date	Outpatient Total Waits	Date	Outpatient Total Waits	Date	Outpatient Total Waits	Date	Outpatient Total Waits
Apr 18							
May 18							
Jun 18							
Jul 18							
Aug 18							
Sep 18							
Oct 18							



Summary statistics

Mean observation - $\bar{x}$	4259.0
Average moving range - $\overline{mR}$	100.6
Three sigma - 3σ	267.6
Upper/lower process limit (% epressed as decimals)	3991.38/ 4526.66
Upper moving range Limit	329.0

Data observations

This type of chart (SPC) allows you to identify statistically significant changes in data. The dotted lines (process limits) represent the expected range for data points if variation is within expected limits - that is, normal. You can aply a number of rules to identify when the process is not in control - that is, special variation.

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 17 data points which are above the line. There are 19 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Trend	When there is a run of 7 increasing or decreasing sequential points this may indicate a sigificant change in the process. This process is not in control. In this data set there is a run of rising points.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

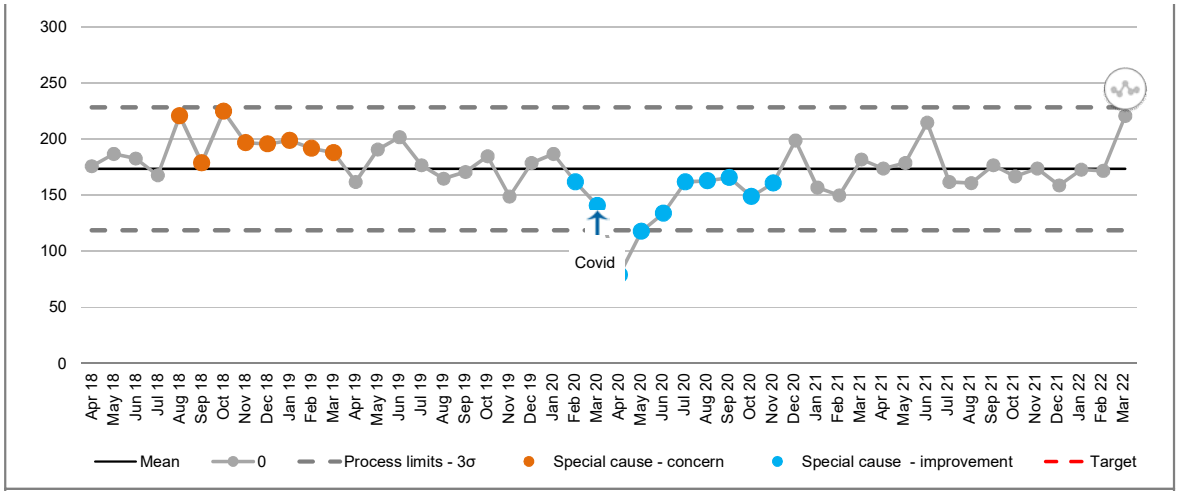
Statistical Process Control (XmR) tool

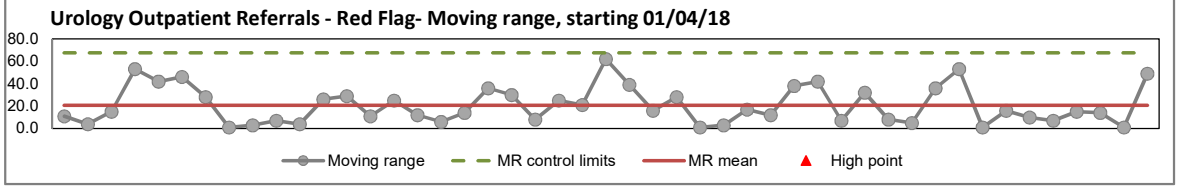
Chart title: Urology Outpatient Referrals - Red Flag

01/04/18 please select date <= 28th

Set baseline

Date	0	Date	0	Date	0	Date	0
Apr 18	176.0	Aug 20	163.0				
May 18	187.0	Sep 20	166.0				
Jun 18	183.0	Oct 20	149.0				
Jul 18	168.0	Nov 20	161.0				
Aug 18	221.0	Dec 20	199.0				
Sep 18	179.0	Jan 21	157.0				
Oct 18	225.0	Feb 21	150.0				
Nov 18	197.0	Mar 21	182.0				
Dec 18	196.0	Apr 21	174.0				
Jan 19	199.0	May 21	179.0				
Feb 19	192.0	Jun 21	215.0				
Mar 19	188.0	Jul 21	162.0				
Apr 19	162.0	Aug 21	161.0				
May 19	191.0	Sep 21	177.0				
Jun 19	202.0	Oct 21	167.0				
Jul 19	177.0	Nov 21	174.0				
Aug 19	165.0	Dec 21	159.0				
Sep 19	171.0	Jan 22	173.0				
Oct 19	185.0	Feb 22	172.0				
Nov 19	149.0	Mar 22	221.0				
Dec 19	179.0						
Jan 20	187.0						
Feb 20	162.0						
Mar 20	141.0						
Apr 20	79.0						
May 20	118.0						
Jun 20	134.0						
Jul 20	162.0						





Summary statistics

Mean observation - $\bar{X}$	173.7
Average moving range - $\overline{mR}$	20.6
Three sigma - 3σ	54.8
Upper/lower process limit (% epressed as decimals)	118.83/ 228.51
Upper moving range Limit	67.4

Data observations

This type of chart (SPC) allows you to identify statistically significant changes in data. The dotted lines (process limits) represent the expected range for data points if variation is within expected limits - that is, normal. You can aply a number of rules to identify when the process is not in control - that is, special variation.

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

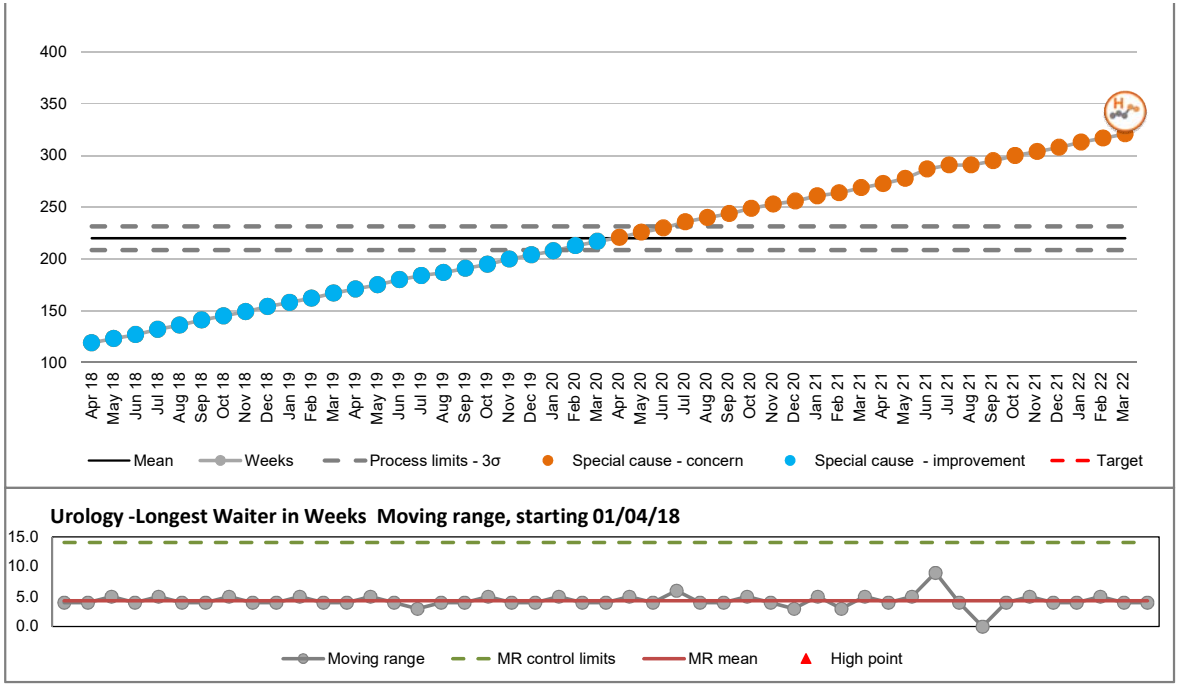
Statistical Process Control (XmR) tool

Chart title: Urology

01/04/18 please select date <= 28th

Set baseline

Apr 18							
May 18							
Jun 18							
Jul 18							
Aug 18							
Sep 18							
Oct 18							



Summary statistics

Mean observation - $\bar{X}$	220.1
Average moving range - $\overline{mR}$	4.3
Three sigma - 3σ	11.4
Upper/lower process limit (% epressed as decimals)	208.67/ 231.54
Upper moving range Limit	14.1

Data observations

This type of chart (SPC) allows you to identify statistically significant changes in data. The dotted lines (process limits) represent the expected range for data points if variation is within expected limits - that is, normal. You can aply a number of rules to identify when the process is not in control - that is, special variation.

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 21 data points which are above the line. There are 22 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Trend	When there is a run of 7 increasing or decreasing sequential points this may indicate a sigificant change in the process. This process is not in control. In this data set there is a run of rising points.

Statistical Process Control (XmR) tool

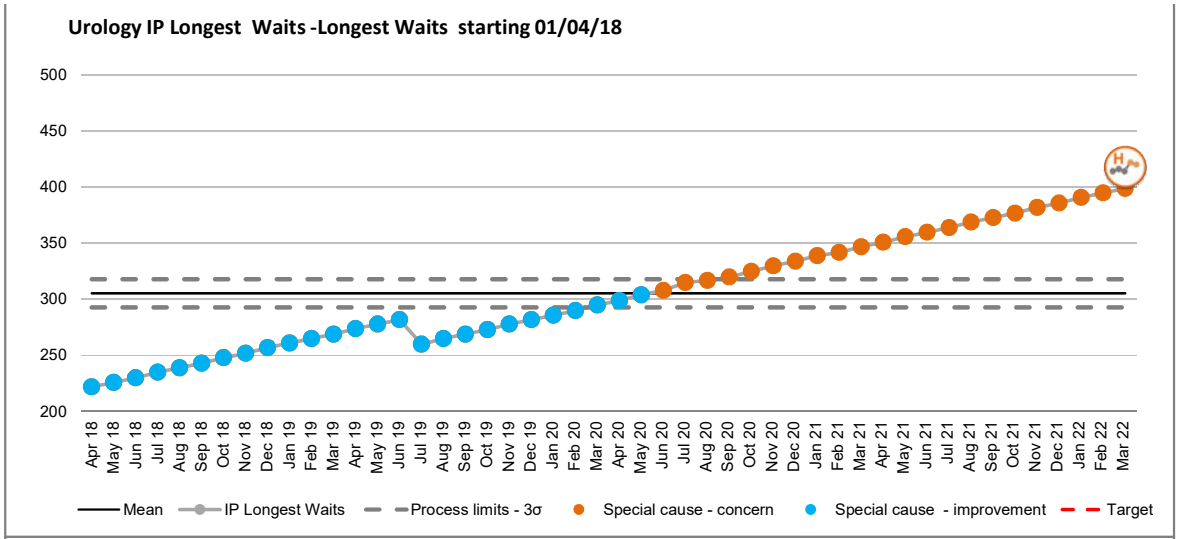
Chart title: Urology IP Longest Waits

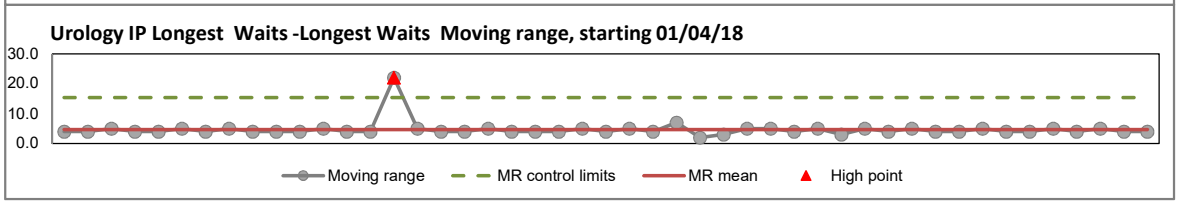
Low is good

01/04/18 please select date <= 28th

Set baseline

Date	IP Longest Waits	Date	IP Longest Waits	Date	IP Longest Waits	Date	IP Longest Waits
Apr 18	222.0	Aug 20	317.0				
May 18	226.0	Sep 20	320.0				
Jun 18	230.0	Oct 20	325.0				
Jul 18	235.0	Nov 20	330.0				
Aug 18	239.0	Dec 20	334.0				
Sep 18	243.0	Jan 21	339.0				
Oct 18	248.0	Feb 21	342.0				
Nov 18	252.0	Mar 21	347.0				
Dec 18	257.0	Apr 21	351.0				
Jan 19	261.0	May 21	356.0				
Feb 19	265.0	Jun 21	360.0				
Mar 19	269.0	Jul 21	364.0				
Apr 19	274.0	Aug 21	369.0				
May 19	278.0	Sep 21	373.0				
Jun 19	282.0	Oct 21	377.0				
Jul 19	260.0	Nov 21	382.0				
Aug 19	265.0	Dec 21	386.0				
Sep 19	269.0	Jan 22	391.0				
Oct 19	273.0	Feb 22	395.0				
Nov 19	278.0	Mar 22	399.0				
Dec 19	282.0						
Jan 20	286.0						
Feb 20	290.0						
Mar 20	295.0						
Apr 20	299.0						
May 20	304.0						
Jun 20	308.0						
Jul 20	315.0						





Summary statistics

Mean observation - $\bar{X}$	305.5
Average moving range - $\overline{mR}$	4.7
Three sigma - 3σ	12.5
Upper/lower process limit (% epressed as decimals)	292.95/ 317.97
Upper moving range Limit	15.4

Data observations

This type of chart (SPC) allows you to identify statistically significant changes in data. The dotted lines (process limits) represent the expected range for data points if variation is within expected limits - that is, normal. You can aply a number of rules to identify when the process is not in control - that is, special variation.

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 19 data points which are above the line. There are 23 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Trend	When there is a run of 7 increasing or decreasing sequential points this may indicate a sigificant change in the process. This process is not in control. In this data set there is a run of rising points.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing
mR	On the moving range chart points which fall above the moving range process limit - grey dotted line - are unusual and suggest that the system is out of control. This should be investigated. There is 1 data point which is above the line.

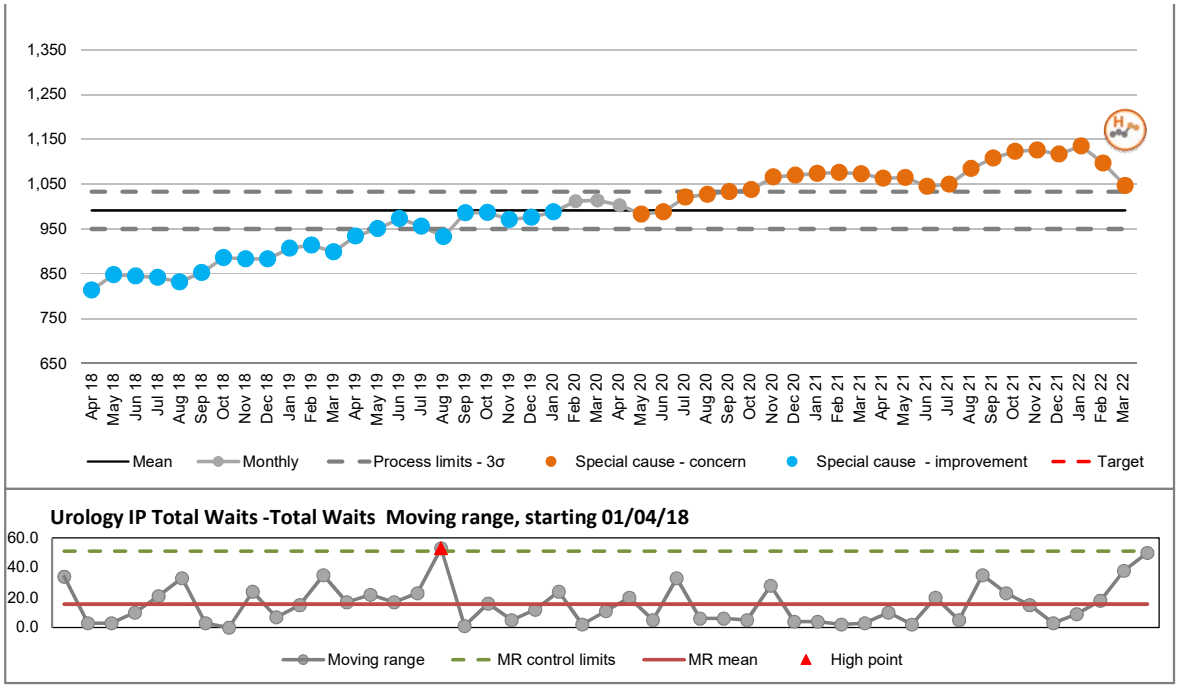
Statistical Process Control (XmR) tool

Chart title: Urology IP Total Waits

01/04/18 please select date <= 28th

Set baseline

Apr 18							
May 18							
Jun 18							
Jul 18							
Aug 18							
Sep 18							
Oct 18							



Summary statistics

Mean observation - $\bar{X}$	991.7
Average moving range - $\overline{mR}$	15.6
Three sigma - 3σ	41.6
Upper/lower process limit (% epressed as decimals)	950.07/ 1033.26
Upper moving range Limit	51.1

Data observations

This type of chart (SPC) allows you to identify statistically significant changes in data. The dotted lines (process limits) represent the expected range for data points if variation is within expected limits - that is, normal. You can aply a number of rules to identify when the process is not in control - that is, special variation.

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 18 data points which are above the line. There are 14 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Trend	When there is a run of 7 increasing or decreasing sequential points this may indicate a sigificant change in the process. This process is not in control. In this data set there is a run of rising points.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Statistical Process Control (XmR) tool

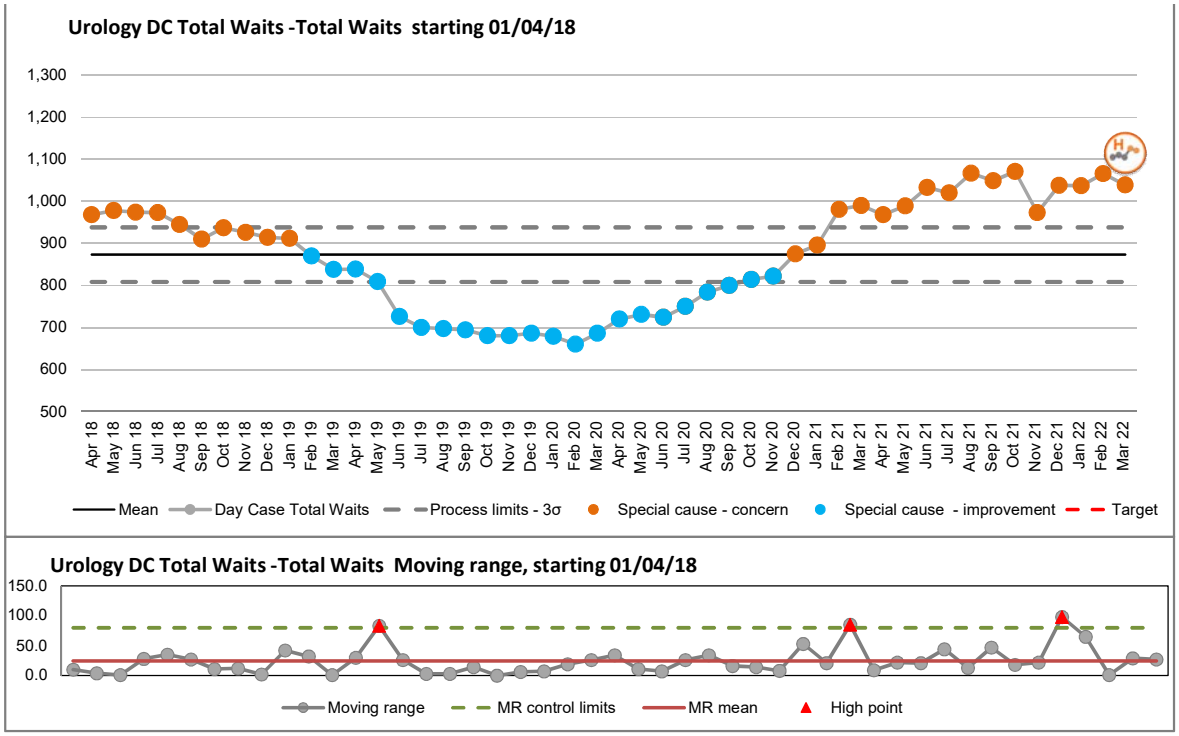
Chart title: Urology DC Total Waits

Low is good

01/04/18 please select date <= 28th

Set baseline

Date	Day Case Total Waits	Date	Day Case Total Waits	Date	Day Case Total Waits	Date	Day Case Total Waits
Apr 18							
May 18							
Jun 18							
Jul 18							
Aug 18							
Sep 18							
Oct 18							



Summary statistics

Mean observation - $\bar{X}$	873.3
Average moving range - $\overline{mR}$	24.4
Three sigma - 3σ	64.9
Upper/lower process limit (% epressed as decimals)	808.38/ 938.21
Upper moving range Limit	79.8

Data observations

This type of chart (SPC) allows you to identify statistically significant changes in data. The dotted lines (process limits) represent the expected range for data points if variation is within expected limits - that is, normal. You can aply a number of rules to identify when the process is not in control - that is, special variation.

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 19 data points which are above the line. There are 16 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Trend	When there is a run of 7 increasing or decreasing sequential points this may indicate a sigificant change in the process. This process is not in control. In this data set there is a run of rising and falling points.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Statistical Process Control (XmR) tool

WIT-47303

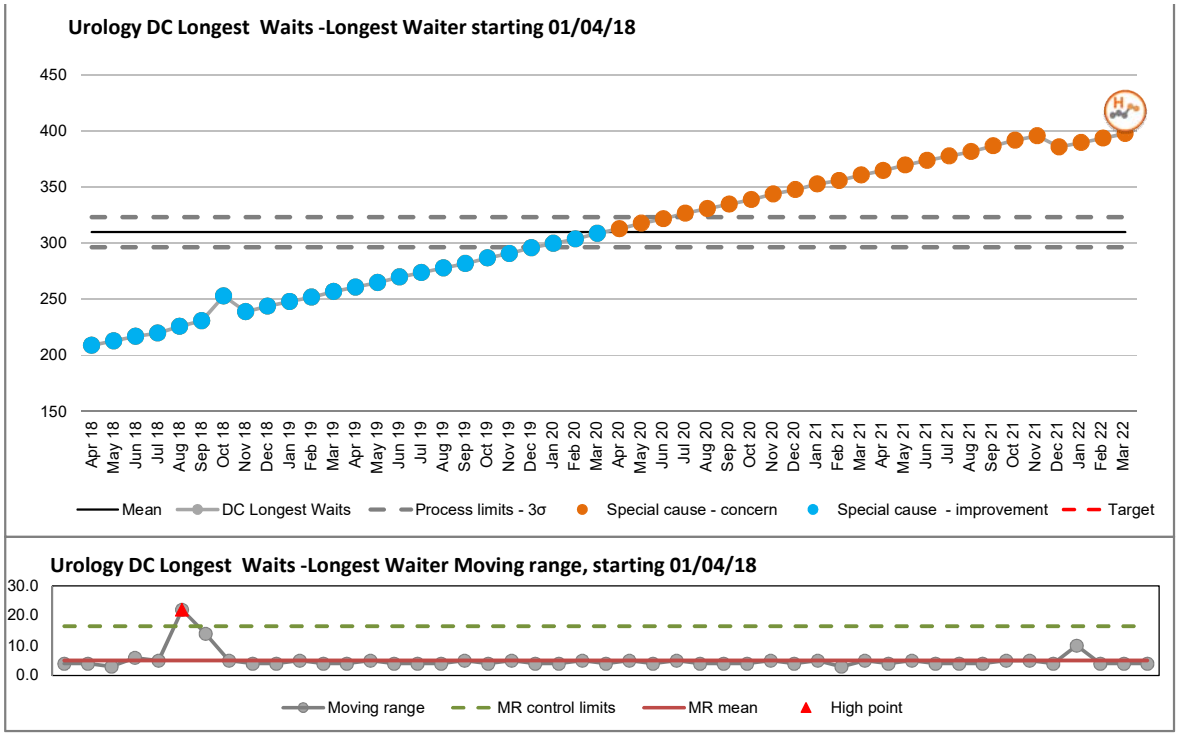
Chart title: Urology DC Longest Waits

Low is good

01/04/18 please select date <= 28th

Set baseline

Date	DC Longest Waits	Date	DC Longest Waits	Date	DC Longest Waits	Date	DC Longest Waits
Apr 18	209.0	Aug 20	331.0				
May 18	213.0	Sep 20	335.0				
Jun 18	217.0	Oct 20	339.0				
Jul 18	220.0	Nov 20	344.0				
Aug 18	226.0	Dec 20	348.0				
Sep 18	231.0	Jan 21	353.0				
Oct 18	253.0	Feb 21	356.0				
Nov 18	239.0	Mar 21	361.0				
Dec 18	244.0	Apr 21	365.0				
Jan 19	248.0	May 21	370.0				
Feb 19	252.0	Jun 21	374.0				
Mar 19	257.0	Jul 21	378.0				
Apr 19	261.0	Aug 21	382.0				
May 19	265.0	Sep 21	387.0				
Jun 19	270.0	Oct 21	392.0				
Jul 19	274.0	Nov 21	396.0				
Aug 19	278.0	Dec 21	386.0				
Sep 19	282.0	Jan 22	390.0				
Oct 19	287.0	Feb 22	394.0				
Nov 19	291.0	Mar 22	398.0				
Dec 19	296.0						
Jan 20	300.0						
Feb 20	304.0						
Mar 20	309.0						
Apr 20	313.0						
May 20	318.0						
Jun 20	322.0						
Jul 20	327.0						



Summary statistics

Mean observation - $\bar{X}$	310.1
Average moving range - $\overline{mR}$	5.0
Three sigma - 3σ	13.4
Upper/lower process limit (% epressed as decimals)	296.69/ 323.52
Upper moving range Limit	16.5

Data observations

This type of chart (SPC) allows you to identify statistically significant changes in data. The dotted lines (process limits) represent the expected range for data points if variation is within expected limits - that is, normal. You can aply a number of rules to identify when the process is not in control - that is, special variation.

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 21 data points which are above the line. There are 21 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Trend	When there is a run of 7 increasing or decreasing sequential points this may indicate a sigificant change in the process. This process is not in control. In this data set there is a run of rising points.
mR	On the moving range chart points which fall above the moving range process limit - grey dotted line - are unusual and suggest that the system is out of control. This should be investigated. There is 1 data point which is above the line.

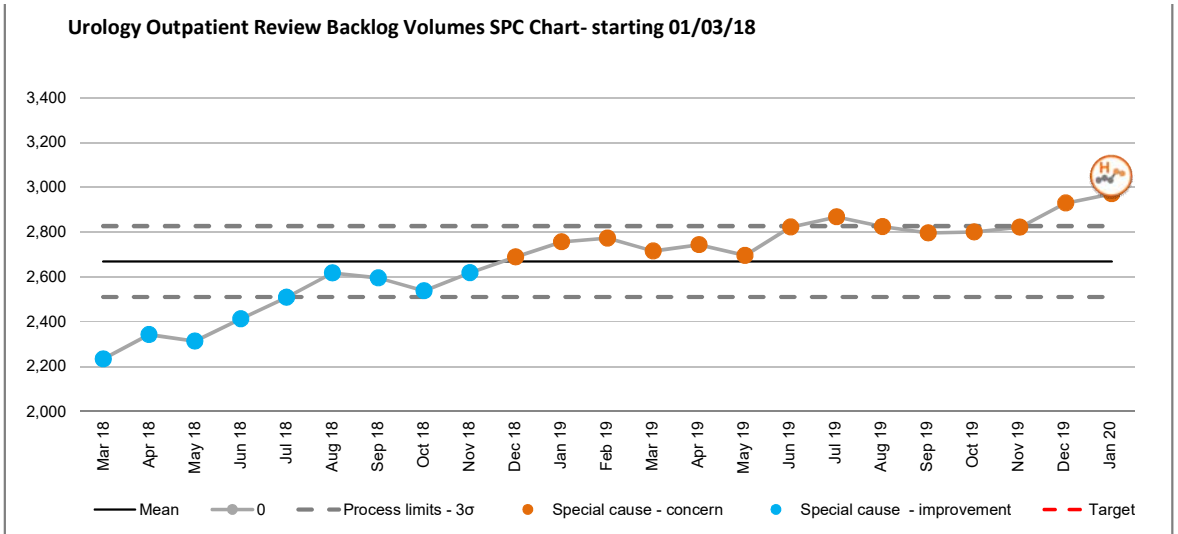
Statistical Process Control (XmR) tool

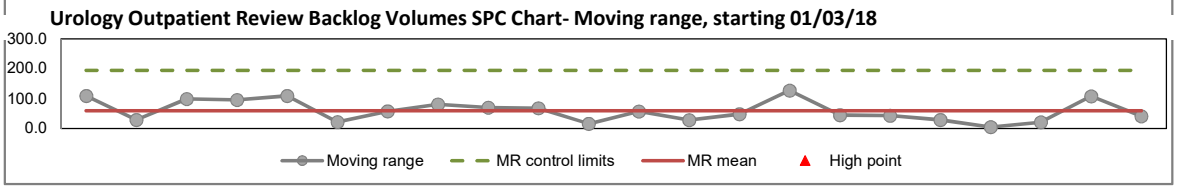
Chart title	Urology Outpatient Review Backlog Volumes SPC Chart
Team/unit name	
Your measure	
What does improvement look like?	Low is good

01/03/18 please select date <= 28th

Set baseline

Date	0	Date	0	Date	0	Date	0
Mar 18	2234						
Apr 18	2343						
May 18	2314						
Jun 18	2413						
Jul 18	2509						
Aug 18	2618						
Sep 18	2596						
Oct 18	2538						
Nov 18	2619						
Dec 18	2689						
Jan 19	2757						
Feb 19	2773						
Mar 19	2716						
Apr 19	2744						
May 19	2696						
Jun 19	2823						
Jul 19	2868						
Aug 19	2825						
Sep 19	2796						
Oct 19	2801						
Nov 19	2822						
Dec 19	2930						
Jan 20	2971						





Summary statistics

Mean observation - $\bar{x}$	2669.3
Average moving range - $\overline{mR}$	59.5
Three sigma - 3σ	158.3
Upper/lower process limit (% epressed as decimals)	2511.08/ 2827.62
Upper moving range Limit	194.6

Data observations

This type of chart (SPC) allows you to identify statistically significant changes in data. The dotted lines (process limits) represent the expected range for data points if variation is within expected limits - that is, normal. You can aply a number of rules to identify when the process is not in control - that is, special variation.

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 3 data points which are above the line. There are 5 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the UPL this is a warning that the process may be changing

Urology mentions in CPD report

April 2018

Waiters in excess of 52-weeks continue across 13 specialties, all with established capacity gaps and/or accrued backlogs within: Breast Family History; Cardiology; Diabetology; ENT; Endocrinology; Gastroenterology; General Surgery; Neurology; Ortho-Geriatrics; Orthopaedics; Rheumatology; Thoracic Medicine; and Urology.

The longest waits continue predominantly in Urology, Orthopaedics, Pain Management, Cardiology and General Surgery, with the longest routine wait within Urology (226-weeks).

May 2018

Waiters in excess of 52-weeks continue across 13 specialties, all with established capacity gaps and/or accrued backlogs within: Breast Family History; Cardiology; Diabetology; ENT; Endocrinology; Gastroenterology; General Surgery; Neurology; Ortho-Geriatrics; Orthopaedics; Rheumatology; Thoracic Medicine; and Urology.

The longest waits continue predominantly in Urology, Orthopaedics, Pain Management, Cardiology and General Surgery, with the longest routine wait within Urology (226-weeks).

June 2018

Waiters in excess of 52-weeks continue predominantly across 10 specialties, all with established capacity gaps and/or accrued backlogs within: Breast Family History; ENT; Gastroenterology; General Surgery; Neurology; Ortho-Geriatrics; Orthopaedics; Rheumatology; Thoracic Medicine; and Urology.

The longest waits continue predominantly in Urology, Orthopaedics, Pain Management, Cardiology and General Surgery, with the longest routine wait within Urology (230-weeks).

July 2018

Waiters in excess of 52-weeks are across 13 specialties, all with established capacity gaps and/or accrued backlogs within: Breast Family History; Cardiology, Endocrinology, ENT; Gastroenterology; General Surgery; Geriatric Medicine; Neurology; Ortho-Geriatrics; Orthopaedics; Rheumatology; Thoracic Medicine; and Urology.

The longest waits continue predominantly in Urology, Orthopaedics, Pain Management, ENT, Cardiology and General Surgery, with the longest routine wait within Urology (235-weeks).

August 2018

Waits in excess of 52-weeks continue across 8 specialties with the longest wait within Urology (239-weeks).

September 2018

There was a -2% variance in the Performance against Trajectory volume. (Urology IP)

There was a 10% variance in the Performance against Trajectory volume (Urology NOP)

October 2018

November 2018

Urology and Upper & Lower Gastrointestinal specialities demonstrated the majority of breaches over 62-days. October demonstrated a significant increase in the number of referrals received, with significant impact noted on Breast; Upper and Lower Gastrointestinal; and Urology.

Whilst the longest wait remains within Urology at 252-weeks, it is of note that the average waiting time is 32-weeks with the 95th percentile wait at 107-weeks within Orthopaedics.

There was a -0.3% variance in the Performance against Trajectory volume (Urology IP)

There was a +7% variance in the Performance against Trajectory volume (Urology NOP)

December 2018

62 day pathways remains challenged with 20 patients waiting longer than 62-days to commence their first treatment in November. Majority of breaches occured within Urology associated with capacity less than demand. Staff sickness absence; delays in first/review appointments and diagnostic delays have contributed to the breaches experienced across all areas. Urology continues to experience difficulties across the Region with an increase in referrals also experienced across the Region.

In December 2018, the number of patients waiting over 52 weeks has increased by +93 (+4%) and the total number waiting for Inpatient/Day Case Treatment has increased +148 (+1%) since November 2018. The longest wait is in Urology at 257-weeks.

January 2019

The Trust had one breach against the 31-day pathway target in January in Urology.

62 day pathways remains challenged with 16 patients waiting longer than 62-days to commence their first treatment in December however this is a reduction from 20 patients in November. Majority of breaches occurred within Urology. Reasons for breaches include complex diagnostic pathways, delays due to referrals between Trusts and inadequate elective and outpatient capacity. Of the completed waits on the 62-day pathway in December, the longest wait was a Urology patient, 126 days in total. This waiting period reflects the actual wait in the period and not the chronological time period.

In January 2019, the number of patients waiting over 52 weeks increased by +88 (+3%) and the total number waiting for Inpatient/Day Case Treatment has increased +113 (+1%) since December 2018. The longest wait is in Urology at 261-weeks.

As at January 2019, 19.4% of patients are waiting over 52-weeks for an out-patient appointment. The longest wait is 158-weeks within Urology.

There was a -3% variance in the Performance against Trajectory volume (Urology IP)

There was a +1% variance in the Performance against Trajectory volume (Urology NOP)

February 2019

The Trust has experienced five breaches against the 31-day pathway target since April with breaches experienced in Breast, Skin and Urology.

62-day pathway continues to be challenged with 26 patients waiting longer than 62-days to commence their first treatment in January, an increase of +10 patients from December. Majority of breaches occurred within Urology and patients who transferred between Trusts. Reasons for breaches include complex diagnostic pathways, delays to diagnostic tests and inadequate elective and outpatient capacity. Of the completed waits on the 62-day pathway in January, the longest wait was an external Urology patient, with a completed wait of 350 days of which 60 of these where within SHSCT as they transferred from SEHSCT.

In February 2019, 66% of those waiting over 52-weeks are waiting for Orthopaedic and Urology surgery. The longest routine wait is in Urology at 265-weeks.

As at February 2019, 19.8% of patients are waiting over 52-weeks for an out-patient appointment. The longest wait is 162-weeks within Urology. Neurology, Urology and General Surgery make up over 60% of the waits> 52-weeks.

There was a -2% variance in the Performance against Trajectory volume (IP)

There was a -1% variance in the Performance against Trajectory volume (NOP)

March 2019

The Trust has experienced 7 breaches against the 31-day pathway target since April with breaches experienced in Breast, Skin, Urology and Lower Gastrointestinal. Cumulative performance to date is 99.5%.

24 patients were waiting longer than 62-days to commence their first treatment in February, a decrease of -2 patients from January. The majority of breaches continue to occurr within Urology and patients transferring between Trusts.

In February 2019, 66% of those waiting over 52-weeks are waiting for Orthopaedic and Urology surgery. The longest routine wait is in Urology at 265-weeks.

As at February 2019, 19.8% of patients are waiting over 52-weeks for an out-patient appointment. The longest wait is 162-weeks within Urology. Neurology, Urology and General Surgery make up over 60% of the waits> 52-weeks.

There was a -2% variance in the cumulative performance against trajectory volume (Urology IP)

There was a -1% variance in the cumulative performance against trajectory volume (Urology NOP)

April 2019

Seven breaches occurred against the 31-day pathway target during 2018/19 a reduction from 47 breaches experienced in 2017/18. Breaches occurred in Breast, Skin, Urology and Lower Gastrointestinal.

16 patients waitied longer than 62-days to commence their first treatment in March. The majority of breaches continue to occur within Urology and patients transferring between Trusts. Reasons for breaches include insufficient capacity for assessment, diagnostics and surgery and complex diagnostic pathways in the context of increasing demand. Of the completed waits on the 62-day pathway in March, the longest wait was a Urology patient of 182 days (this reflects the actual wait in the period and not the chronological time period).

The number waiting over 52-weeks for Inpatient/Day Case Treatment has increased by +15% (343) from March 2018 to March 2019. 66% of those waiting over 52 weeks are waiting for Orthopaedic and Urology surgery with the longest routine wait in Urology at 269-weeks.

At the end of March 2019, 19.5% of the total patients waiting for an out-patient appointment are waiting over 52-weeks. This position continues to steadily increase. Of those waiting over 52-weeks, 80% are in Neurology, Urology and General Surgery and Orthopaedics specialties. Whilst the average Waiting Time is 31-weeks with the longest wait is 167-weeks within Urology.

There was a -3% variance in the cumulative performance against trajectory volume (Urology IP)

There was a -2% variance in the cumulative performance against trajectory volume (Urology NOP)

May 2019

June 2019

45 patients have waited longer than 62-days to commence their first treatment during 2019/20 as at May 2019. The majority of breaches continue to occur within Urology. Of the completed waits on the 62-day pathway in May, the longest wait was a Urology patient of 197 days (this reflects the actual wait in the period and not the chronological time period).

At the end of June 2019, 26.2% of patients are waiting over 52-weeks for Inpatient/Day Case Treatment. A trend in increasing waits continues to be demonstrated. 81% of those waiting over 52-weeks are waiting within the Orthopaedic, Urology and General Surgery Specialty areas. The Average Waiting Time is 38-weeks with the 95th percentile wait at 126-weeks (Orthopaedics) however the longest wait remains in Urology at 282-weeks.

At the end of June 2019, 20.9% of the total patients waiting for an out-patient appointment are waiting over 52-weeks. There has been an increase of +62% in the number waiting over 52-weeks since March 2018 as illustrated in the trend graph. Of those waiting over 52-weeks at the end of June 2019, 77% are in Neurology, Urology and General Surgery and Orthopaedics specialties. The Average Waiting Time is 32-weeks and the longest wait is 180-weeks within Urology.

At June 2019 there has been an increase of +12% (+3,003) in the total number of patients waiting beyond their timescale for review since March 2019. The specialities with the largest volumes of patient waiting beyond their timescale for review include ENT, Dermatology, General Surgery, Urology and Cardiology.

At the end of May 2019, there was a +30% variance in the cumulative performance against trajectory volume (Urology IP)

At the end of May 2019, there was -12% variance in the cumulative performance against trajectory volume. Overperformance was demonstrated in April however in May there was underperformance of -125 against trajectory volume. (Urology NOP)

July 2019

During 2019/2020 as at June 2019, 66 patients have waited more than 62-days to commence their first treatment with the majority of breaches occurring within Urology. Of the completed waits on the 62-day pathway in June, the longest completed wait was a Urology patient at 148 days (this reflects the actual wait in the period and not the chronological time period).

At the end of July 2019, 27% of patients are waiting over 52-weeks for Inpatient/Day Case Treatment. A trend in increasing waits continues to be demonstrated. The majority of patients waiting over 52-weeks are waiting within the Orthopaedic, Urology and General Surgery Specialty areas. The Average Waiting Time is 40-weeks with the 95th percentile wait at 128-weeks and the longest wait at 274-weeks within Urology specialty.

At the end of July 2019, 21.2% of the total patients waiting for an out-patient appointment are waiting over 52-weeks. There has been an increase of +70% in the number waiting over 52-weeks since March 2018 as illustrated in the trend graph. Of those waiting over 52-weeks at the end of July 2019, 77% are in Neurology, Urology and General Surgery and Orthopaedics specialties. The Average Waiting Time is 33-weeks and the longest wait is 184-weeks within Urology.

At July 2019 there has been an increase of +16% (+4,027) in the total number of patients waiting beyond their timescale for review since March 2019. The specialities with the largest volumes of patient waiting beyond their timescale for review include ENT, Dermatology, General Surgery, Urology and Cardiology.

At the end of July 2019, there was 585 patients waiting beyond their timescale for review which demonstrates a increase of +8% (+42) since March 2019. The specialities with the largest volumes of patients waiting beyond their timescale for review include Urology, Orthopaedics, Cardiology and Rheumatology. The longest patients waiting date back to August 2016 within Urology and Cardiology.

At the end of June 2019, there was a +16% variance in the cumulative performance against trajectory volume (Urology IP)

At the end of June 2019, there was -19% variance in the cumulative performance against trajectory volume. Overperformance was demonstrated in April however there was significant underperformance in May and June. A Consultant vacancy from the end of April with no locum cover to be in place until late July 2019 and the reduction of some OPD sessions to ensure all IPDC theatre sessions are fully utilised have contributed to underperformance. (NOP)

<u>August 2019</u>

During 2019/2020 as at July 2019, 99 patients have waited more than 62-days to commence their first treatment with the majority of breaches occurring within Urology

'At the end of August 2019, 27% of patients are waiting over 52-weeks for Inpatient/Day Case Treatment. A trend in increasing waits continues to be demonstrated. The majority of patients waiting over 52-weeks are waiting within the Orthopaedic, Urology and General Surgery Specialty areas. The Average Waiting Time is 36-weeks with the 95th percentile wait at 120-weeks and the longest wait at 278-weeks within Urology specialty.

At the end of August 2019, 21.8% of the total patients waiting for an out-patient appointment are waiting over 52-weeks. There has been an increase of +24% (+2,061) in the number waiting over 52-weeks since March 2019. Of those waiting over 52-weeks at the end of August 2019, 75% are in Neurology, Urology and General Surgery and Orthopaedics specialties. The Average Waiting Time is 33-weeks with the 95th percentile wait at 113-weeks and the longest wait is 187-weeks within Urology.

At August 2019 there has been an increase of +16% (+4,274) in the total number of patients waiting beyond their timescale for review since March 2019. The specialities with the largest volumes of

patient waiting beyond their timescale for review include ENT, Dermatology, General Surgery, Urology and Cardiology. A Review Action Plan is currently under development.

At the end of August 2019, there were 624 patients waiting beyond their timescale for review which demonstrates a increase of 15% (+81) patients since March 2019. The specialities with the largest volumes of patients waiting beyond their timescale for review include Urology, Orthopaedics, Cardiology and Rheumatology.

September 2019

As at August 2019, 120 patients have waited more than 62-days to commence their first treatment with the majority of breaches occurring within Urology. The longest wait is within Urology at 246 days (35 weeks).

At the end of September 2019, 28% of patients are waiting over 52-weeks for Inpatient/Day Case Treatment. A trend in increasing waits continues to be demonstrated. The majority of patients waiting over 52-weeks are waiting within the Orthopaedic, Urology and General Surgery Specialty areas with the 95th percentile wait at 122 weeks (ENT) and an overall average wait time of 36 weeks. The longest wait remains within Urology at 258 weeks.

At the end of September 2019, 21.6% of the total patients waiting for an out-patient appointment are waiting over 52-weeks. There has been an increase of +23% (+1988) in the number waiting over 52-weeks since March 2019. Of those waiting over 52-weeks at the end of September 2019, 74% are in Neurology, Urology and General Surgery and Orthopaedics specialties. The longest wait is 191-weeks within Urology. A parallel process of recurrent investment for recognised capacity gap and non-recurrent backlog clearance is required to demonstrate sustainable improvement. A proposal for additional validation support has been developed.

At September 2019 there has been an increase of +16% (+3,035) in the total number of patients waiting beyond their timescale for review since April 2019. The specialities with the largest volumes of patient waiting beyond their timescale for review include ENT, Dermatology, General Surgery, Urology and Cardiology.

At the end of August 2019, there were 624 patients waiting beyond their timescale for repeat procedure which demonstrates a increase of 15% (+81) patients since March 2019. The specialities with the largest volumes of patients waiting beyond their timescale for review include Urology, Orthopaedics, Cardiology and Rheumatology. The longets waits within Caridiology and Urology which have 4 and 1 patients respectively waiting since August 2016. The planned repeat backlog is being routinely reviewed to ascertain opportunities to improve.

At the end of August 2019, there was a +15% variance in the cumulative performance against trajectory volume (Urology IPDC)

At the end of August 2019, there was -9% variance in the cumulative performance against trajectory volume. Significant underperformance was demonstrated in May and June. A Consultant vacancy from the end of April has impacted the trajectory, and although Locum cover was secured in late July 2019, they left at end of August 2019 and the post remains unfilled currently. (Urology NOP)

October 2019

As at September 2019, 116 patients waited more than 62-days to commence their first treatment with the **majority of breaches occurring within Urology. The longest current wait is within Urology at 171 days (24 weeks).**

'At the end of October 2019, 28.4% of patients are waiting over 52-weeks for Inpatient/Day Case Treatment and reflects an increasing trend. The majority of patients waiting over 52-weeks are waiting within the Orthopaedic, Urology and General Surgery Specialty areas. The longest wait remains within Urology at 287 weeks.

At the end of October 2019, 21.1% of the total patients waiting for an out-patient appointment are waiting over 52-weeks. There has been an increase of +19% (+1622) in the number waiting over 52-weeks since March 2019. Of those waiting over 52-weeks at the end of October 2019, 71% are in Neurology, Urology, General Surgery and Orthopaedics specialties. The longest wait is 195-weeks within Urology.

At October 2019 there were 28,180 patients waiting beyond their timescale for review. The trend contnues to reflect and upward position. The specialities with the largest volumes of patient waiting beyond their timescale for review include ENT, Dermatology, General Surgery, Urology and Cardiology. An action plan to seek improvement is in development.

At the end of September 2019, there were 540 patients waiting beyond their timescale for review . The specialities with the largest volumes of patients waiting beyond their timescale for review include Urology, Orthopaedics, Rheumatology and Neurology. The longest waiter is within Urology at August 2016. The planned repeat backlog is being routinely reviewed to ascertain opportunities to improve.

At the end of September 2019, there was a +15% variance in the cumulative performance against trajectory volume (Urology IPDC)

At the end of September 2019, there was +4% variance in the cumulative performance against trajectory volume. (Urology NOP)

November 2019

As at October 2019, 147 patients waited more than 62-days to commence their first treatment with the majority of breaches occurring within Urology. The longest waiting patient, that breached 62-days, was within Urology at 166 days (24 weeks).

'At the end of November 2019, 29.4% of patients are waiting over 52-weeks for Inpatient/Day Case Treatment and reflects an increasing trend. The majority of patients waiting over 52-weeks are waiting within the Orthopaedic, Urology and General Surgery Specialty areas.

At October 2019 there were 28,180 patients waiting beyond their timescale for review. The trend continues to reflect and upward position. The specialities with the largest volumes of patient waiting beyond their timescale for review include ENT, Dermatology, General Surgery, Urology and Cardiology. An action plan to seek improvement is in development.

At the end of November 2019, there were 569 patients waiting beyond their timescale for review. The specialities with the largest volumes of patients waiting beyond their timescale for review include Urology, Orthopaedics, Rheumatology and Neurology. The longest waiter is within Urology at August 2016. The planned repeat backlog is being routinely reviewed to ascertain opportunities to improve.

December 2019

As at November 2019, 175 patients waited more than 62-days to commence their first treatment with the majority of breaches occurring within Urology. The longest waiting patient, that breached

62-days, is within Urology. Reasons for breaches include insufficient capacity for assessment, delays to diagnostics tests and referrals between Trusts. Pressure on the pathway continues to be felt locally and regionally. Urology pressures have been escalated to regional urology reference group and HSCB Performance Team however reflect regional challenges. The Trust has an investment proposal to increase consultant capacity however this will not impact on demand in year.

'At the end of December 2019, 30.3% of patients are waiting over 52-weeks for Inpatient/Day Case Treatment and reflects an increasing trend. The majority of patients waiting over 52-weeks are waiting within the Orthopaedic, Urology and General Surgery Specialty areas.

At December 2019 there were 29,866 patients waiting beyond their timescale for review. The trend continues to reflect an upward trend. The specialities with the largest volumes of patient waiting beyond their timescale for review include ENT, Dermatology, General Surgery, Urology and Cardiology. An action plan to seek improvement is in development.

At the end of December 2019, there were 590 patients waiting beyond their timescale for review. The specialities with the largest volumes of patients waiting beyond their timescale for review include Urology, Orthopaedics, Rheumatology and Neurology.

January 2020

As at December 2019, 267 patients waited more than 62-days to commence their first treatment with 112 of the breaches occurring within Urology. The longest waiting patient, that breached 62-days, is within Urology. Reasons for breaches include insufficient capacity for assessment, delays to diagnostics tests and referrals between Trusts. Pressure on the pathway continues to be felt locally and regionally. Urology pressures have been escalated to regional urology reference group and HSCB Performance Team however reflect regional challenges. The Trust has submitted an IPT to HSCB to support the appointment of a 7th Consultant Urologist, however this will not demonstrate any impact in 2019/2020.

At the end of January 2020, 71% of patients are waiting over 13-weeks for inpatient/daycase treatment reflecting further challenged performance against the % seen within 13 weeks. Orthopaedic patients account for 32% of those waiting and Urology accounts for 17%.

'At the end of January 2020, 31.1% of patients are waiting over 52-weeks for Inpatient/Day Case Treatment and reflects an increasing trend. The majority of patients waiting over 52-weeks are waiting within the Orthopaedic, Urology,General Surgery and ENT Specialty areas. (39% are in Orthopaedics and 25% in Urology). The longest waiter is currently 300 weeks in Urology.

At the end of January 2020, 23.3% of the total patients waiting for an out-patient appointment are waiting over 52-weeks. There has been an increase of +29.5% (+2,511) in the number waiting over 52-weeks since March 2019. The highest volume of waiters are in Neurology, Urology, General Surgery and Orthopaedics.

At January 2020 there were 29,954 patients waiting beyond their timescale for review. The trend continues to reflect an upward trend. The specialities with the largest volumes of patient waiting beyond their timescale for review include Cardiology, Dermatology, Diabetology, ENT, General Surgery, Rheumatology and Urology.

At the end of January 2020, there were 620 patients waiting beyond their timescale for review. The specialities with the largest volumes of patients waiting beyond their timescale for review include Urology and Orthopaedics.

February 2020

As at January 2020, 305 patients waited more than 62-days to commence their first treatment with 129 of the breaches occurring within Urology. The longest waiting patient, that breached 62-days, is within Urology. Reasons for breaches include insufficient capacity for assessment, delays to diagnostics tests and referrals between Trusts. Urology pressures have been escalated to regional urology reference group and HSCB Performance Team. The Trust has submitted an IPT to HSCB to support the appointment of a 7th Consultant Urologist, however this will not demonstrate any impact in 2019/2020.

At the end of February 2020, 72.8% of patients are waiting over 13-weeks for inpatient/daycase treatment reflecting further challenged performance against the % seen within 13 weeks. The majority of these patients are within Orthopaedics, General Surgery and Urology (a total of 66%).

At the end of February 2020, 31.9% of patients are waiting over 52-weeks for Inpatient/Day Case Treatment and reflects an increasing trend. The majority of patients waiting over 52-weeks are waiting within Orthopaedics (40%) and Urology (24%). The longest waiter is currently 304 weeks in Urology.

At the end of January 2020, 23.3% of the total patients waiting for an out-patient appointment are waiting over 52-weeks. There has been an increase of +29.5% (+2,511) in the number waiting over 52-weeks since March 2019. The highest volume of waiters are in Neurology, Urology, General Surgery and Orthopaedics.

At January 2020 there were 29,954 patients waiting beyond their timescale for review. The trend continues to reflect an upward trend. The specialities with the largest volumes of patient waiting beyond their timescale for review include Cardiology, Dermatology, Diabetology, ENT, General Surgery, Rheumatology and Urology. An action plan to seek improvement is in development. Specialty specific actions are being finalised and the Director has asked that specialty specific interim targets for improvement are agreed.

At the end of February 2020, there were 579 patients waiting beyond their timescale for review. The specialities with the largest volumes of patients waiting beyond their timescale for review include Urology and Orthopaedics.

March 2020

As at March 2020, 42 patients were waiting more than 62-days to commence their first treatment with 369 patients breaching the 62-day target since April 2019. 159 of the breaches occur within Urology. Of the 20 longest waiters, 19 sit within urology. The longest waiter is also within urology (40 weeks). Reasons for breaches include insufficient capacity for assessment, delays to diagnostics tests and referrals between Trusts. Urology pressures have been escalated to Regional Urology Reference Group and HSCB Performance Team.. The Trust has submitted an IPT to HSCB to support the appointment of a 7th Consultant Urologist, however this will not demonstrate any impact in 2019/2020.

At the end of March 2020, 33.3% of patients are waiting over 52-weeks for Inpatient/Day Case Treatment and reflects an increasing trend. The majority of patients waiting over 52-weeks are waiting within Orthopaedics (40%) and Urology (23%). The longest waiter is currently 308 weeks in Urology.

At the end of March 2020, 27.2% of the total patients waiting for an out-patient appointment are waiting over 52-weeks. There has been an increase of +39% (+3,337) in the number waiting over 52-weeks since March 2019. The highest volume of waiters are in Neurology, Urology, General Surgery and Orthopaedics. The longest wait is for Urology at 217 weeks.

New Outpatients - As at January 2020, cumulatively -3,896 less patients were assessed than the commissioned level of activity. Of these, 2,142 reflect services not managed by the Trust i.e. Ophthalmology and Paediatric Cardiology. In numerical terms, the top 3 specialties contributing to underperformance during 2019/2020 are: Neurology, General Medicine and Nurse-Led Dermatology.

At January 2020 there were 29,954 patients waiting beyond their timescale for review. No update available. The trend continues to reflect an upward trend. The specialities with the largest volumes of patient waiting beyond their timescale for review include Cardiology, Dermatology, Diabetology, ENT, General Surgery, Rheumatology and Urology.

At the end of March 2020, there were 735 patients waiting beyond their timescale for review. The specialities with the largest volumes of patients waiting beyond their timescale for review are Neurology, Urology and Orthopaedics.

April 2020

As at March 2020, 42 patients were waiting more than 62-days to commence their first treatment with 369 patients breaching the 62-day target since April 2019. 159 of the breaches occurred within Urology.

Of the 20 longest waiters, 19 sit within urology. The longest waiter for those that have completed their pathway is also within urology (40 weeks). Reasons for breaches include insufficient capacity for assessment, delays to diagnostics tests and referrals between Trusts.

Urology pressures have been escalated to Regional Urology Reference Group and HSCB Performance Team. The HSCB has allocated funding in response to Trusts Investment proposal for appointment of a 7th Consultant Urologist, however due to the lead in time for recrutiment this will have minimal impact in year. The Trust is working with other Trusts to consider how urology capacity can be best maximised Regionally.

The majority of patients waiting over 52-weeks are waiting within Orthopaedics (40%) and Urology (23%). The longest waiter is currently 313 weeks in Urology.

At the end of April 2020, 13,030 patients (27.%) are waiting over 52-weeks. 48,252 patients are waiting in total for a first consultant outpatient appointment.

The highest volume of waiters >52 weeks are in Neurology (19%), General Surgery (16.7%), Urology (16.4%), Orthopaedics (11.7%) and ENT (9.4%). The longest wait is for Urology at 221 weeks.

New Outpatients - As at March 2020, cumulatively - 16,241 less new outpatients were assessed than the commissioned level of activity. In numerical terms, the top 4 specialties contributing to underperformance during 2019/2020 are: Neurology, General Medicine, General Surgery and Nurse-Led Dermatology.

The trend continues to reflect an upward trend. The specialities with the largest volumes of patient waiting beyond their timescale for review include Cardiology, Dermatology, Diabetology, ENT, General Surgery, Rheumatology and Urology.

At the end of April 2020, there were 663 patients waiting beyond their timescale for review. The specialities with the largest volumes of patients waiting beyond their timescale for review are Urology and Orthopaedics.

May 2020

June 2020

In May 2020, 62 out of 65 patients received their first definitive treatment within 31 days (95.4%). Of the patients who breached the objective 2 were breast and 1 urology.

In May 2020, 66.2% of patients began their first definitive treatment within 62 days. Of the 18 patients that breached the objective 9 were Urology, 2 Gynae, 2 Lower Gastro, 2 Lung, 2 Skin and 1 Upper Gastro.

Provision for patients who require the most urgent treatment is being provided in DHH and through Elective IS capacity, managed via Regional CRG leads is in place for Urology and Breast cancer. The restart of further elective surgery will be implemented throught the Trust Rebuild Plan.

At the end of June 2020 41.1% (5,186) of patients are waiting over 52-weeks reflecting an increasing trend. The majority of patients waiting over 52-weeks are waiting within Orthopaedics (39%) and Urology (21%). The longest waiter is currently 321 weeks in Urology.

At the end of June 2020 31.7% (15,797) of patients were waiting >52-weeks. The highest volume of waiters >52 weeks are in Neurology, General Surgery and Urology equating to 48.2% of the waiting list,

The specialities with the largest volumes of patient waiting beyond their timescale for review include Cardiology, Dermatology, Diabetology, ENT, General Surgery, Rheumatology and Urology.

At the end of May 2020, there were 2026 patients waiting beyond their timescale for review which is a 205% (+1,363) increase on the April 2020 position. The specialities with the largest volumes of patients waiting beyond their timescale for review are Urology, Rheumatology and Orthopaedics.

July 2020

In June 2020, 68% of patients began their first definitive treatment within 62 days. Of the 19 patients that breached the target 1 was breast, 2 were Gynae, 3 Haematological, 3 Lower Gastro, 3 Lung, 3 Skin, 2 Upper Gastro and 2 Urology.

Information prepared for HSCB indicates that as at 30th June 2020, there have been 1,650 IPDC cancellations since March 2020 due to Covid-19 and related pressures. Available elective capacity continues to be directed to red flag/urgent cases in the first instance. Provision for patients who require the most urgent treatment is being provided in DHH and through Elective IS capacity, managed via Regional CRG leads is in place for Urology and Breast cancer.

At the end of June 2020 41.1% (5,186) of patients are waiting over 52-weeks reflecting an increasing trend. The majority of patients waiting over 52-weeks are waiting within Orthopaedics (39%) and Urology (21%). The longest waiter is currently 321 weeks in Urology.

At the end of June 2020 31.7% (15,797) of patients were waiting >52-weeks. The highest volume of waiters >52 weeks are in Neurology, General Surgery and Urology equating to 48.2% of the waiting list,

New Outpatients - As at March 2020, cumulatively - 16,241 less new outpatients were assessed than the commissioned level of activity. In numerical terms, the top 4 specialties contributing to underperformance during 2019/2020 are: Neurology, General Medicine, General Surgery and Nurse-Led Dermatology.

The specialities with the largest volumes of patient waiting beyond their timescale for review include Cardiology, Dermatology, Diabetology, ENT, General Surgery, Rheumatology and Urology.

The specialities with the largest volumes of patients waiting beyond their timescale for review are Urology,Neurology, Rheumatology and Orthopaedics.

October 2020

In September 2020, 43 out of 69 patients began their first definitive treatment within 62 days. Of the 26 patients that breached the target 1 was gynae, 1 head/neck, 4 lower GI, 1 other, 6 skin, 2 upper GI and 11 urology.

At the end of October 2020, 52.3% (6,973) of patients are waiting over 52-weeks reflecting an increasing trend. The majority of patients waiting over 52-weeks are waiting within Orthopaedics (34.3%), General Surgery (18.3%) and Urology (18.1%). The longest waiter is currently 339 weeks in Urology.

At the end of October 2020, 39.4% (22,451) of patients were waiting >52-weeks. The highest volume of waiters >52 weeks are within Neurology, ENT, General Surgery, Orthopaedics and Urology equating to 68% of the waiting list.

The specialities with the largest volumes of patient waiting beyond their timescale for review include Cardiology, Dermatology, ENT, Endocrinology, General Surgery, Rheumatology and Urology.

At the end of October 2020, there were 1,222 patients waiting beyond their clinically indicated timescale for repeat procedure which is a 84.3% (+559) increase from April 2020. The specialities with the largest volumes of patients waiting are Urology, Neurology, Rheumatology and Orthopaedics.

November 2020

In October 2020, 47 out of 76 patients began their first definitive treatment within 62 days. Of the 29 patients that breached the target 5 were haematological, 5 lower GI, 1 lung, 1 other, 5 skin, 2 upper GI and 10 urology.

'At the end of November 2020, 54.2% (7,480) of patients are waiting over 52-weeks reflecting an increasing trend. The majority of patients waiting over 52-weeks are waiting within Orthopaedics (34%), General Surgery (19%) and Urology (17%). The longest waiter is currently 343 weeks in Urology.

At the end of November 2020, 44.8% (24,162) of patients were waiting >52-weeks. The highest volume of waiters >52 weeks are within Neurology, ENT, General Surgery, Orthopaedics and Urology equating to 68% of the waiting list.

The specialities with the largest volumes of patient waiting beyond their timescale for review include Cardiology, Dermatology, ENT, Endocrinology, General Surgery, Rheumatology and Urology.

At the end of October 2020, there were 1,222 patients waiting beyond their clinically indicated timescale for repeat procedure which is a 84.3% (+559) increase from April 2020. The specialities

with the largest volumes of patients waiting are Urology, Neurology, Rheumatology and Orthopaedics.

December 2020

In November 2020, 38 out of 64 patients began their first definitive treatment within 62 days. Of the 26 patients that breached the target 4 were gynae, 1 haematological, 3 head/neck, 7 lower GI, 1 lung, 4 skin, 2 upper GI and 4 urology

At the end of December 2020, 56.2% (7,981) of patients are waiting over 52-weeks reflecting a continually increasing trend. 33.2% (2652) of patients waiting over 52-weeks are waiting within Orthopaedics, 19.8% (1582) within General Surgery and 16.5% (1314) within Urology. The longest waiter is currently 348 weeks in Urology.

At the end of December 2020, 48.8% (25,272) of patients were waiting >52-weeks. The highest volume of waiters >52 weeks are within General Surgery, Neurology and Urology. The longest wait is within Urology at 256 weeks and 9.2% (419) urology patients have been waiting +208 weeks.

At the end of December 2020 there were 41,328 patients waiting beyond their timescale for review. The ability to increase face to face clinical activity continues to be impacted by the availability of clinical accommodation. The specialities with the largest volumes of patient waiting beyond their timescale for review includeDermatology, General SUrgery, ENT, Cardiology, Rheumatology and Urology. Access to services remains a key corporate risk.

At the end of December 2020, there were 1,817 patients waiting beyond their clinically indicated timescale for repeat procedure. The number of patients waiting has increased by 174% (+1154) since April 2020. The specialities with the largest volumes of patients waiting are Urology, Neurology, Rheumatology and Orthopaedics.

January 2021

In December 2020, 31 out of 52 patients began their first definitive treatment within 62 days. Of the 21 patients that breached the target 1 was breast, 1 gynae, 3 lower GI, 2 lung, 1 skin, 3 upper GI and 10 urology.

'At the end of January 2021, 59.8% (9266) were waiting > 52 weeks. There were +5251 (131%) more patients waiting >52 weeks than at March 2020 when there were 4015 patients waiting >52 weeks. 33% (2824) of patients waiting over 52-weeks are waiting within Orthopaedics, 21% (1834) within General Surgery and 15% (1340) within Urology. The longest waiter is currently 353 weeks in Urology.

At the end of January 2021, 51.9% (27,464) of patients were waiting >52-weeks. The highest volume of waiters >52 weeks are within General Surgery, ENT, Neurology and Urology. The longest wait is within Urology at 261 weeks.

At the end of December 2020 there were 41,328 patients waiting beyond their timescale for review. The ability to increase face to face clinical activity continues to be impacted by the availability of clinical accommodation. The specialities with the largest volumes of patient waiting beyond their timescale for review include Dermatology, General Surgery, ENT, Cardiology, Rheumatology and Urology. Access to services remains a key corporate risk.

At the end of February 2021, there were 1,462 patients waiting beyond their clinically indicated timescale for repeat procedure. By comparison, In February 2020, there were 579 patients waiting,

representing an increase of +883 (+152.5%). The specialities with the largest volumes of patients waiting are Urology, Neurology, Rheumatology and Orthopaedics.

February 2021

In January 2021, 44% (30 out of 70) patients began their first definitive treatment within 62 days. Of the 40 patients that breached the target 4 were breast, 1 gynae, 2 haematoligical, 2 head/neck, 7 lower GI, 8 skin, 2 upper GI and 14 urology.

'At the end of February 2021,64.5% (9433) were waiting > 52 weeks. There were +5418 (135%) more patients waiting >52 weeks than at March 2020 when there were 4015 patients waiting >52 weeks. 31% (2945) of patients waiting over 52-weeks are waiting within Orthopaedics, 21% (1986) within General Surgery and 15% (1390) within Urology. The longest waiter is currently 356 weeks in Urology.

At the end of February 2021, 52.6% (30,098) of patients were waiting >52-weeks. The highest volume of waiters >52 weeks are within General Surgery, ENT, Neurology and Urology. The longest wait is within Urology at 264 weeks.

At the end of December 2020 there were 41,328 patients waiting beyond their timescale for review. The ability to increase face to face clinical activity continues to be impacted by the availability of clinical accommodation. The specialities with the largest volumes of patient waiting beyond their timescale for review include Dermatology, General Surgery, ENT, Cardiology, Rheumatology and Urology.

At the end of February 2021, there were 1,462 patients waiting beyond their clinically indicated timescale for repeat procedure. By comparison, In February 2020, there were 579 patients waiting, representing an increase of +883 (+152.5%). The specialities with the largest volumes of patients waiting are Urology, Neurology, Rheumatology and Orthopaedics.

March 2021

In March 2021, 55.5% (45 out of 81) patients began their first definitive treatment within 62 days. Of the 36 patients that breached the target 5 were breast, 9 lower GI, 3 lung, 4 skin, 2 upper GI and 13 urology.

At the end of March 2021, 66.6% (9,880) patients were waiting >52 weeks. This is an increase of +146% (+5,865) patients waiting >52 weeks in comparison to March 2020 (4015). 30% (2,990) of patients waiting over 52-weeks are waiting within Orthopaedics, 21% (2,118) within General Surgery and 14% (1,407) within Urology. The longest waiter is currently 360 weeks within Urology.

At the end of February 2021, 52.6% (30,098) of patients were waiting >52-weeks. The highest volume of waiters >52 weeks are within General Surgery, ENT, Neurology and Urology. The longest wait is within Urology at 264 weeks.

At the end of January 2021 there were 43,089 patients waiting beyond their timescale for review. The ability to increase face to face clinical activity was greatly impacted by the availability of clinical accommodation. The specialities with the largest volumes of patient waiting beyond their timescale for review include Dermatology, General Surgery, ENT, Cardiology, Rheumatology and Urology. Access to services remains a key corporate risk.

At the end of March 2021, there were 1,446 patients waiting beyond their clinically indicated timescale for repeat procedure. By comparison, in March 2020, there were 735 patients waiting,

representing an increase of +711 (+96.7%). The specialities with the largest volumes of patients waiting are Urology, Neurology, Rheumatology and Orthopaedics.

April 2021

May 2021

In April 2021, 58% (33 out of 56) patients began their first definitive treatment within 62 days. Of the 30 patients that breached the target 3 were breast, 4 gynae, 1 haematological, 2 head/neck, 3 lower GI, 5 skin, 2 upper GI and 10 urology.

At the end of May 2021, 63.6% (9,719) patients were waiting >52 weeks. This is an increase of +104.1% (+4957) patients waiting >52 weeks in comparison to May 2020 (4762). 30% (2,946) of patients waiting over 52-weeks are waiting within Orthopaedics, 22% (2,159) within General Surgery and 14% (1,367) within Urology. The longest waiter is currently 369 weeks within Urology.

At the end of May 2021, there were 1,209 patients waiting beyond their clinically indicated timescale for repeat procedure. By comparison, in May 2020, there were 1204 patients waiting, representing a minimal increase of +5 (+0.4%). The specialities with the largest volumes of patients waiting are Urology, Neurology, Rheumatology and Orthopaedics.

June 2021

'At the end of June 2021, 63.5% (9,652) patients were waiting >52 weeks. This is an increase of +86.1% (+4466) patients waiting >52 weeks in comparison to June 2020 (5186). 31% (2,906) of patients waiting over 52-weeks are waiting within Orthopaedics, 22% (2,127) within General Surgery and 14% (1,356) within Urology. The longest waiter is currently 373 weeks within Urology. Recurrent investment for capacity gaps along with non-recurrent backlog clearance is required to see improvement against this objective

At the end of June 2021, 50.5% (31,356) of patients were waiting >52-weeks. The highest volume of waiters >52 weeks are within ENT, General Surgery, Urolog and Neurology. The longest wait is within Urology at 282 weeks

At the end of June 2021, there were 1,065 patients waiting beyond their clinically indicated timescale for repeat procedure. The specialities with the largest volumes of patients waiting are Urology, Neurology and Rheumatology. The longest wait is currently from April 2019.

July 2021

August 2021

At the end of August 2021, 63.1% (9,761) patients were waiting >52 weeks. This is an increase of +65.2% (+3853) patients waiting >52 weeks in comparison to August 2020 (5908). 31% (3,021) of patients waiting over 52-weeks are waiting within Orthopaedics, 22% (2,179) within General Surgery and 14% (1,329) within Urology. The longest waiter is currently 382 weeks within Urology.

At the end of August 2021, 50.2% (32,645) of patients were waiting >52-weeks. The highest volume of waiters >52 weeks are within ENT, General Surgery, Neurology, Orthopaedics and Urology. The longest wait is within Urology at 291 weeks

At the end of August 2021, there were 1,025 patients waiting beyond their clinically indicated timescale for repeat procedure. The specialities with the largest volumes of patients waiting are Urology, Neurology and Rheumatology. The longest waiter is currently April 2017 (Urology).

September 2021

At the end of September 2021, 63% (9,999) patients were waiting longer than 52 weeks. 31% (3,124) of patients waiting over 52-weeks are waiting within Orthopaedics, 22% (2,229) within General Surgery, 13% (1,333 within ENT) and 13% (1321) within Urology. The longest waiter is currently 387 weeks within Urology.

At the end of September 2021, 50.9% (33,329) of patients were waiting longer than 52-weeks. The highest volume of waiters longer than 52 weeks are within ENT, General Surgery, Neurology, Orthopaedics and Urology. The longest wait is within Urology at 295 weeks.

At the end of August 2021, there were 1,025 patients waiting beyond their clinically indicated timescale for repeat procedure. (2017/18 - 4; 2018/19 - 27; 2019/20 - 147; 2020/21 - 528; 2021/22 - 319). The specialities with the largest volumes of patients waiting are Urology, Neurology and Rheumatology. The longest waiter is currently April 2017 (Urology).

October 2021

'At the end of October 2021, 63.1% (10,264) patients were waiting longer than 52 weeks. 31% (3,229) of patients waiting over 52-weeks are waiting within Orthopaedics, 22% (2,283) within General Surgery, 13% (1,371) within ENT and 13% (1,332) within Urology. The longest waiter is currently 377 weeks within Urology.

At the end of October 2021, 50.9% (33,486) of patients were waiting longer than 52-weeks. The highest volume of waiters, longer than 52 weeks, are within Dermatology, ENT, General Surgery, Neurology, Orthopaedics and Urology. The longest wait is within Urology at 300 weeks.

At the end of October 2021, there were 1,088 patients waiting beyond their clinically indicated timescale for repeat procedure. (2017/18 - 5; 2018/19 - 26; 2019/20 - 139; 2020/21 - 396; 2021/22 - 522). The specialities with the largest volumes of patients waiting are Neurology, Pain, Rheumatology and Urology. The longest waiter is currently April 2017 (Urology).

November 2021

At the end of November 2021, 63.3% (10,337) patients were waiting longer than 52 weeks. 31% (3,237) of patients waiting over 52-weeks are waiting within Orthopaedics, 22% (2,303) within General Surgery, 14% (1,417) within ENT and 13% (1,319) within Urology. The longest waiter is currently 381 weeks within Urology.

At the end of November 2021, 51% (33,432) of patients were waiting longer than 52-weeks. The highest volume of waiters, longer than 52 weeks, are within Dermatology, ENT, General Surgery, Neurology, Orthopaedics and Urology. The longest wait is within Urology at 304 weeks.

At the end of November 2021, there were 1,055 patients waiting beyond their clinically indicated timescale for repeat procedure. If the longest waiting 31 patients (out of the 1,055 patients) were seen it would reduced the longest waiting backlog patient from 2017/18 to 2019/2020. The specialities with the largest volumes of patients waiting are Neurology, Pain, Rheumatology and Urology. The longest waiter is currently April 2017 (Urology).

December 2021

January 2022

In December 2021, 45.7% (30 out of 68) patients began their first definitive treatment within 62 days. Of the 38 patients that breached the target 1 was Breast, 4 Gynae, 1 Haematological, 9 Lower GI, 3 Lung, 6 Skin, 3 Upper GI and 11 Urology.

At the end of January 2022, 62.4% (10,606) patients were waiting longer than 52 weeks. 32% (3,343) of patients waiting over 52-weeks are waiting within Orthopaedics, 22% (2,369) within General Surgery, 14% (1,460) within ENT and 13% (1,329) within Urology. The longest waiter is currently 390 weeks within Urology.

At the end of January 2022, 51.2% (34,004) of patients were waiting longer than 52-weeks. The highest volume of waiters, longer than 52 weeks, are within Dermatology, ENT, General Surgery, Neurology, Orthopaedics and Urology. The longest wait is within Urology at 312 weeks.

At the end of December 2021, there were 1,030 patients waiting beyond their clinically indicated timescale for repeat procedure. If the longest waiting 30 patients (out of 1,030) were seen it would reduce the longest waiting backlog patient from 2017/2018 to 2019/2020. The specialities with the largest volumes of patients waiting are Neurology, Pain, Rheumatology and Urology. The longest waiter is currently April 2017 (Urology).

<u>February 2022</u>

In January 2022, 39.2% (20 out of 51) patients began their first definitive treatment within 62 days. Of the 39 patients that breached the target, 2 were Breast, 4 Gynae, 1 Head/Neck, 2 Lower GI, 3 Lung, 13 Skin, 5 Upper GI and 9 Urology.

At the end of February 2022, 61.8% (10,632) patients were waiting longer than 52 weeks. 31% (3,332) of patients waiting over 52-weeks are waiting within Orthopaedics, 22% (2,386) within General Surgery, 14% (1,472) within ENT and 12% (1,310) within Urology. The longest waiter is currently 394 weeks within Urology.

At the end of February 2022, 50.8% (34,023) of patients were waiting longer than 52-weeks. The highest volume of waiters, longer than 52 weeks, are within Dermatology, ENT, General Surgery, Neurology, Orthopaedics and Urology. The longest wait is within Urology at 316 weeks.

At the end of February 2022, there were 1,150 patients waiting beyond their clinically indicated timescale for repeat procedure. If the longest waiting 30 patients (out of 1,150) were seen it would reduce the longest waiting backlog patient from 2017/2018 to 2019/2020. The specialities with the largest volumes of patients waiting are Neurology, Pain, Rheumatology and Urology. The longest waiter is currently April 2017 (Urology).

<u>March 2022</u>

In January 2022, 39.2% (20 out of 51) patients began their first definitive treatment within 62 days. Of the 39 patients that breached the target, 2 were Breast, 4 Gynae, 1 Head/Neck, 2 Lower GI, 3 Lung, 13 Skin, 5 Upper GI and 9 Urology.

At the end of March 2022, 61.5% (10,724) patients were waiting longer than 52 weeks. The main specialties (volumes and % of total waits) are:

* Orthopaedics 3,307 patients - 31%;

* General Surgery 2,455 - 23%;

* ENT 1,492 - 14%; and

* Urology 1,263 - 12%.

The longest waiter is currently 399 weeks (circa 7.5 years) within Urology.

At the end of March 2022, 50.4% (33,891) of patients were waiting longer than 52-weeks. The highest volume of waiters, longer than 52 weeks, are within Dermatology, ENT, General Surgery, Neurology, Orthopaedics and Urology. The longest wait is within Urology at 321 weeks.

At the end of March 2022, there were 1,165 patients waiting beyond their clinically indicated timescale for repeat procedure. If the longest waiting 30 patients (out of 1,165) were seen it would reduce the longest waiting backlog patient from 2017/2018 to 2019/2020. The specialities with the largest volumes of patients waiting are Neurology, Pain, Rheumatology and Urology. The longest waiter is currently April 2017 (Urology).

Southern Health and Social Care Trust

Quality Care - for you, with you

Regional Review of Urology Services

Team South Implementation Plan

V0.3 revised 09 Nov 10

Contents

Tables

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1. Background

A regional review of (Adult) Urology Services was undertaken in response to service concerns regarding the ability to manage growing demand, meet cancer and elective waiting times, maintain quality standards and provide high quality elective and emergency services. It was completed in March 2009. The purpose of the regional review was to:

'Develop a modern, fit for purpose in 21century, reformed service model for Adult Urology Services which takes account of relevant guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician through the entire pathway from primary care to intermediate to secondary and tertiary care.'

One of the outputs of the review was a modernisation and investment plan which included 26 recommendations to be implemented across the region. Three urology centres are recommended for the region. Team South will be based at the Southern Trust and will treat patients from the southern area and also the lower third of the western area (Fermanagh). The total catchment population will be approximately 410,000. An increase of two consultant urologists, giving a total of five, and two specialist nurses is recommended.

The Minister has endorsed the recommendations and Trusts have been asked to develop implementation plans to take forward the recommended team model.

The Trust submitted an Implementation Plan for Team South in June 2010 (draft v0.2). Further work was undertaken on the patient pathways and these were revised and submitted under separate cover. They have not been replicated in this document.

2. Current Service Model

The current service model is an integrated consultant led and ICATS model. The service's base is Craigavon Area Hospital where the inpatient beds (19) and main theatre sessions are located. There are general surgery inpatient beds at Daisy Hill Hospital (and at the Erne Hospital).

The ICATS services are delivered from a purpose built unit, the Thorndale Unit, and a lithotripsy service is also provided from the Stone Treatment Centre on the Craigavon Area Hospital site.

Outpatient clinics are currently held at Craigavon Area Hospital, South Tyrone Hospital, Banbridge Polyclinic and Armagh Community Hospital.

Day surgery is carried out at Craigavon and South Tyrone Hospitals. A Consultant Surgeon at Daisy Hill Hospital who maintains close links with the urology team also undertakes urology outpatient and day case work. It is important that capacity to deal with the demand from the Newry and Mourne area is built into the new service model as it will need to be absorbed by the Urology Consultants following Mr Brown's retirement.

The Urology Team

The integrated urology team comprises:

- 3 Consultant Urologists,
- 2 Registrars (1 of the Registrar posts will revert to a SHO Doctor from August 2011),
- 2 Trust Grade Doctors (1 post is currently vacant)
- 1 GP with Special Interest (7 sessions per week)
- 1 Lecturer Practitioner in Urological Nursing (2 sessions per week)
- 2 Urology Specialist Nurses (Band 7)

The ICATS Service

Referrals to urology are triaged by the Consultant Urologists and are booked directly to either an ICATS or consultant led clinic by the outpatient booking centre. Red Flag referrals are managed within the Cancer Services Team. Consultant to consultant referrals go through the central referral and booking office and are booked within the same timescales as GP referrals.

The following services are provided within ICATS:

- Male Lower Urinary Tract Services (LUTS)
- Prostate Assessment and Diagnostics

- Andrology
- Uro-oncology
- GPwSI (general urology clinic)
- Haematuria Assessment and Diagnostics
- Histology Clinics
- Urodynamics

Current Sessions

Outpatient, day surgery and inpatient theatre sessions are given in Table 1.

Table 1: Current Urology Sessions

	Craigavon	South Tyrone	Banbridge	Armagh	Total
Consultant Led OPs					
General	2.75 per week[1]	1 per month	2 per month	2 per month	4 per week
Stone Treatment	1 weekly				1 week

ICATS	Weekly	Personnel
Prostate Assessment	1.5	Specialist Nurse & Registrar
Prostate Biopsy	1	Consultant Urologist/Radiologist & Specialist Nurse
Prostate Histology	1.5	Specialist Nurse & Consultant/Registrar
LUTS	3	Specialist Nurse & Registrar
Haematuria	2	Specialist Nurse & Registrar
Andrology	2.5	GPwSI & Nurse Lecturer
General Urology/Stable Prostate Cancer	2.5	GPwSI
	14	

Main Theatres (CAH)	Weekly	
	6	3 all day lists

	Craigavon	South Tyrone
Day Surgery		
GA	1 weekly[2]	1 monthly
Flexible Cystoscopy	1.5 weekly[3]	
Lithotripsy	2 weekly	

1) 1 consultant led outpatient clinic at CAH is every week except the 3rd week in the month
2) Numbers treated on the weekly GA list at Craigavon are restricted by anaesthetic cover
3) 2 lists/1 list on alternate weeks

Current Activity

In 2009/10 the integrated urology service delivered the core service shown in Table 2. In house additionality and independent sector activity has also been included in the table. It should be noted that in 2009/10 240 new outpatient attendances at the Stone Treatment Centre were erroneously recorded as review attendances. This mistake has been corrected in the figures in Tables 2 and 3 below.

Table 2: 2009/10 Actual Activity for the Urology Service

		Core Activity	IHA	IS	Totals
2009/10	Cons Led New OP	850	474	0	**1324**
	ICATS/Nurse Led New OP	1220	30		**1250**
	Total New OP	2070	504	0	**2574**
	Cons Led Review OP	2151	70	0	**2221**
	ICATS/Nurse Led Rev OP	1509	0	0	**1509**
	Total Review	3660	70	0	**3730**
	Day Case	1502	3	383	**1888**
	Elective FCE	1199	29	140	**1368**
	Non Elective FCE	629	0	0	**629**

Activity by consultant for 2009/10 is provided in Table 3.

Table 3: Activity by Consultant for 2009/10

		Mr Young	Mr O'Brien	Mr Akhtar[2]	All Core Activity
2009/10	New OP	482	174	193	**849**
	Review OP	724	903	327	**1954**
	Total OP	1206	1077	520	**2803**
	Day Case	696	452	354	**1502**
	Elective FCE	380	512	307	**1199**
	Non Elective FCE	233	210	186	**629**
	FCEs + DCs	**1309**	**1174**	**847**	**3330**
	Day Case Rates [1]	65%	47%	54%	56%

[1] INCLUDES flexible cystocopies (M45) and DCs/FCEs with no primary procedure recorded.
[2]Mr Akhtar undertakes an alternative weekly biopsy list at Thorndale. These patients are recorded under ICATS.

Notes:
1) Source is Business Objects
2) Day case and elective FCEs exclude in house additionality (3 DCs & 29 FCEs) and also independent sector activity (383 DCs and 140 FCEs)
3) Outpatient Activity is consultant led only & has been counted on specialty of clinic. It excludes in house additionality (474 new, 70 review).
4) There were an **additional 1 new and 197 review** attendances which have not been allocated to a particular consultant as they were recorded under 'General Urologist'.

There is a substantial backlog of patients awaiting review at consultant led clinics. The Trust has submitted a plan to deal with this backlog and implementation of this plan is in progress.

Pre-operative Assessment

Pre operative assessment is already well established. All elective patients are sent a pre-assessment questionnaire and those patients who require a face to face assessment are identified from these. For urology the percentage is high due to the complexity of the surgery and also the nature of the patient group who tend to be older patients with high levels of co-morbidity. It is not possible to provide the number of urology patients who come to hospital for a pre-assessment appointment as all patients are recorded under a single speciality.

Between 1 Apr 09 and 31 Dec 09 692 of 853 elective episodes had a primary procedure recorded. Of the 692, 404 (**58.4%**) were admitted on the day their procedure was carried out. A surgical admission ward was established in July 2009. It closes at 9pm each evening (so beds are not 'blocked'). This has enabled significant improvements to be made in the numbers of patients being admitted on the day of surgery, in part because consultants have confidence that a bed will be available for their patient. Figures have improved further since December 2009 and across all surgical specialties between 85% and 100% of patients are now admitted on the day of their surgery.

Suspected Urological Cancers

It is not feasible to extract the numbers of suspected urological cancers. However, the figure can be estimated using the numbers of patients attending for prostate and haematuria assessment in 2009/10 – 434.

The urology team multi disciplinary meetings (MDMs) are already established. A weekly MDT meeting is held and it is attended by consultant urologists, consultant radiologist, consultant pathologist, specialist nurses, and cancer tracker. The first part of the meeting is the local MDT meeting and the local team then link in with the regional MDT meeting.

The Southern Trust provides chemotherapy only for prostate and bladder cancer patients (at Craigavon Hospital). Chemotherapy for all other cancers and radiotherapy for all cancers is provided by Belfast Trust. The Trust is transferring all radical pelvic operations to Belfast Trust.

3. Benchmarking of Current Service

It is the Trust's intention to use the opportunity of additional investment in the urology service to enhance the service provided to patients and to improve performance as demonstrated by Key Performance Indicators such as length of spell, new to review ratios and day case rates.

The Regional Health and Social Care Board (HSCB) has provided comparative data for the Trusts in Northern Ireland. Table 4 below provides a summary of the Trust's performance compared to the regional position.

Table 4: Regional Benchmarking

		2006/07	2007/08	2008/09	2009/10
New : Review Ratio	All Trusts	1.96	2.03	1.79	1.68
	SHSCT	**4.04**	**3.27**	**3.28**	**2.09**
Day Case Rates	All Trusts	50.1	48.5	49.8	48.5
	SHSCT	**43.8**	**45.5**	**48.8**	**40.0**
Average LOS (elective)	All Trusts	3.7	3.5	3.4	2.9
	SHSCT	**3.7**	**4.3**	**3.9**	**2.7**
Average LOS (non elective)	All Trusts	4.8	4.7	4.6	4.4
	SHSCT	**4.5**	**4.8**	**4.6**	**4.7**

1) Data for 2009/10 is up to the end of February 2010

2) Day cases exclude flexible cystoscopies and uncoded day cases (Prim Op M70.3 and Sec Op 1 Y53.2 also excluded)

Table 5 compares the Southern Trust's average length of spell for specific Healthcare Resource Groups (HRGs) with the Northern Ireland peer group for the period 1st January – 31st December 2009 for elective and non elective admissions.

Table 5: Peer Group Comparison for Length of Spell (Northern Ireland Peer Jan 09 – Dec 09)

HRG v3.5	Spells	SHSCT LOS	Peer LOS
L55 - Urinary Tract Findings <70 without complications & comorbidities	11	3.5	0.3
L32 - Non-Malignant Prostate Disorders	16	3.6	2
L21 - Bladder Minor Endoscopic Procedure without complications & comorbidities	670	0.3	0.1
L14 - Bladder Major Open Procedures or Reconstruction	4	11	6.7
L98 - Chemotherapy with a Urinary Tract or Male Reproductive System Primary Diagnosis	3	4.3	0.5
P21 - Renal Disease	13	1.8	0.7
L28 - Prostate Transurethral Resection Procedure <70 without complications & comorbidities	21	4.4	3.1
L52 - Renal General Disorders >69 or with complications & comorbidities	9	5.9	3.7
L69 - Urinary Tract Stone Disease	37	2.3	1.9
L22 - Bladder or Urinary Mechanical Problems >69 or with complications & comorbidities	28	6.7	3.2
L02 - Kidney Major Open Procedure >49 or with complications & comorbidities	34	9.5	7.8
L25 - Bladder Neck Open Procedures Male	11	6.4	4.8
L08 - Non OR Admission for Kidney or Urinary Tract Neoplasms <70 without complications & comorbidities	5	2	1.3
L07 - Non OR Admission for Kidney or Urinary Tract Neoplasms >69 or with complications & comorbidities	20	9.1	8.4
L27 - Prostate Transurethral Resection Procedure >69 or with complications & comorbidities	78	5.3	4.2
L17 - Bladder Major Endoscopic Procedure	77	4.7	3.8
L03 - Kidney Major Open Procedure <50 without complications & comorbidities	9	5.7	4.8
L13 - Ureter Intermediate Endoscopic Procedure	91	2.3	1.6
L10 - Kidney or Urinary Tract Infections <70 without complications & comorbidities	61	4.2	3
L43 - Scrotum Testis or Vas Deferens Open Procedures <70 without complications & comorbidities	45	1.4	1.2
L23 - Bladder or Urinary Mechanical Problems <70 without complications & comorbidities	16	2.2	1.9

The British Association of Day Surgery (BADS) produces targets for short stay and day case surgery for the various surgical specialties. The Trust compared its performance to the BADS targets for 2008/09 (clinical coding is complete) and 2009/10 (clinical coding is incomplete) and submitted an analysis of its performance in version 0.2 of the Implementation Plan.

The Trust recognises that there is the potential to improve the performance of the urology service and will take this forward through the development of the new service model.

4. Demand for Team South Urology Service

The Trust has agreed the methodology for calculating the outpatient demand for the service with the Performance Management and Service Improvement Directorate, based on the actual activity for 2009/10. It is important that when the demand and the capacity of the current and future services are being calculated, that the **whole service** is considered. A significant amount of both new and review activity is undertaken within the ICATS service. However the service is not an independent ICATS service. Consultants triage all urology referrals and decide which are suitable to be treated at ICATS clinics. They also supervise the clinics. Table 6 presents the projected demand for **outpatient slots** for the overall service.

It has been assumed that the Trust's proposal to manage the review backlog will be funded separately and the capacity required to eradicate the backlog has not been included in the demand analysis.

Using actual activity for 2009/10 as a proxy for demand:

Table 6: Projected Outpatient Activity for Team South

	New Attendances	Notes
2009/10 Actual Consultant Led	1084	1
2009/10 Actual Stone Treatment Centre	240	2
2009/10 Actual ICATS	1250	3
2009/10 Fermanagh referrals	318	4
DNA rate @ 3%	87	5
Growth @ 12%	357	6
Total **SLOTS**	**3336**	
2009/10 Actual Newry & Mourne	610	7
DNA rate @ 3%	18	
Growth @ 12%	75	
	704	

Notes:

1) Actual attendances at consultant led clinics, as shown in Table 6 of the Trust's Implementation Plan. In house additionality is included.

2) In 2009/10 240 Stone Treatment Clinic new attendances were recorded as review.

3) Actual attendances at ICATS clinics.

4) Fermanagh referral figure was taken from the Board's model (it is lower than the SHSCT original estimate).

5) The same DNA rate was used as in the Board's model. The actual DNA rate in 2009/10 was 5.5%.

6) The same growth rate was used as in the Board's model.

7) A General Surgeon based at Daisy Hill Hospital also sees urology patients. It is estimated that 610 new attendances at his clinics in 2009/10 were urology patients. **Capacity for the future needs to be built into the service model for these referrals although this work will continue to be undertaken by the General Surgeon.**

For the purposes of calculating the required outpatient sessions 3336 new attendance slots has been used (ie excluding Newry and Mourne demand).

Projected inpatient and daycase activity has not been changed since the submission of version 0.2 of the Trust's Implementation Plan. It is summarised in Table 7 overleaf.

Table 7: Projected Activity for Team South

		2009/10 Actual Activity					
		Core Activity	**IHA**	**IS**	**Growth in WL**	**SHSCT Activity to be Provided**	**Team South Capacity Required [3]**
2009/10	Day Case	1502	3	383	47	1935	**2283**
	Elective FCE	1199	29	140	28	1396	**1647**
	Non Elective FCE	629	0	0		629	**742**

1) Source is Business Objects
2) 2009/10 breaches have been used to estimate growth in waiting list for day cases and FCEs
3) 18% added for Fermanagh, based on population size relative to SHSCT population

5. Proposed Service Model

The proposed service model will be an integrated consultant led and ICATS model. The Trust has submitted the proposed pathways, as requested to the Performance Management and Service Improvement Directorate.

The main acute elective and non elective inpatient unit for Team South will be at Craigavon Area Hospital with day surgery being undertaken at Craigavon, South Tyrone, and the Erne Hospitals (availability of sessions to be confirmed). Day surgery will also continue to be provided at Daisy Hill by a Consultant Surgeon. It is planned that staff travelling to the Erne will undertake an outpatient clinic and day surgery/flexible cystoscopy session in the same day, to make best use of time.

There is potential to have outpatient clinics held at Craigavon, South Tyrone, Armagh Community Hospital, Banbridge Polyclinic and the Erne Hospital. Outpatient clinics will also continue to be provided at Daisy Hill by a Consultant Surgeon. All outpatient referrals will be directed to Craigavon Area Hospital and they will be triaged on a daily basis. Suspected cancer referrals will be appropriately marked and recorded. For patients being seen at the Erne Hospital it is anticipated that Erne casenotes will be used with a copy of the relevant notes being sent to Craigavon Area Hospital when elective admission is booked. The details of this process have to be agreed with the Western Trust.

The majority of nurse led/ICATS sessions will be provided over 48 weeks with consultant led sessions being provided over 42 weeks. Due to the limited availability of theatre capacity, particularly in main theatres, a 3 session operating day is currently being discussed.

The projected demand from Tables 6 and 7 was used to calculate the number of sessions which will be required to provide the service. These are summarised in Table 8 below with the detail of the calculations provided as Appendix 1. **Note –** as previously stated, demand from Newry and Mourne has not been included in the calculations.

Table 8: Weekly Sessions for New Service Model

	Weekly Sessions	Weeks	Personnel
Consultant Led OPs			
General	5.5	42	
Stone Treatment	1.5	42	
ICATS			
Prostate Assessment	1.5	48	Registrar & Specialist Nurse
Prostate Biopsy [1]	2	48	Consultant Urologist/ Radiologist & Specialist Nurse
Prostate Histology [2]	1	48	Specialist Nurse & Consultant/Registrar
LUTS	3	48	Specialist Nurse & Registrar
Haematuria	1.5	**42**	Specialist Nurse & Registrar
Andrology/General Urology/Stable Prostate Cancer	5	42	GPwSI & Nurse Lecturer
Urodynamics	1.5	48	Specialist Nurse
	15.5		
Main Theatres	9	42	
Day Surgery			
GA	4	42	
Flexible Cystoscopy	3	42	
Lithotripsy	2	42	

The detail of job plans is to be agreed with the existing Consultants but they will be based around the sessions identified in Table 8. The expected weekly consultant led sessions, which are subject to confirmation and agreement with consultants, are given in Table 9 overleaf.

Table 9: Proposed Consultant Led Sessions

	Weekly Sessions
Outpatients (including Stone Treatment)	
Craigavon	4.5
South Tyrone	1
Armagh	0.5
Banbridge Polyclinic	0.5
Erne	0.5
Total OPD	**7**
Prostate Biopsy	**2**
Day Surgery	
CAH	1
STH	2.5
Erne	0.5
Lithotripsy	2
Total Day Surgery	**6**
Main Theatre	**9**

The Trust accepts the need to move towards delivering activity volumes at outpatient clinics which comply with BAUS guidelines and has made good progress in this regard. The original consultant templates enabled the Trust to deliver the outpatient volumes in 2009/10 which are shown in Table 10.

Table 10: Draft Outpatient Volumes at Consultant Clinics in 2009/10

		Core Activity
2009/10	Consultant Led New OP	850
	Consultant Led Review OP	2151
	Total Activity	3001

Revised templates which provide significantly more new outpatient capacity have been agreed with the consultant urologists and these have been implemented. They are shown in Table 11 overleaf.

Table 11: Current Consultant Templates (Recently Revised and Extended)

Consultant	Location	Day	Frequency	Sessions/ Annum	Travel Time	New	Review	New/ Annum	Review/ Annum
Mr Young	BBP	Mon am	Monthly	10	45	6	6	60	60
	ACH	Mon am	Monthly	10	50	6	6	60	60
	CAH (STC)	Mon am	Weekly	42	0	5	11	210	462
	CAH	Fri pm	1,2,4 & 5	32	0	5	7	160	224
Mr O'Brien	BBP	Mon am	Monthly	10	45	5	7	50	70
	ACH	Mon am	Monthly	10	50	5	7	50	70
	CAH	Tues pm	Weekly	42	0	5	7	210	294
Mr Akhtar	CAH	Mon pm	Weekly	42	0	4	7	168	294
	STH	Tues pm	Monthly	10	60	6	3	60	30
Total Annual Slots								**1028**	**1564**

These templates will be used initially as the basis of the new (5 consultant) service model giving a projected capacity of 1533 new and 2310 review appointments at consultant clinics, subject to the agreement of consultant job plans (Table 12 overleaf). It is anticipated that an overall new to review ratio across the service (consultant led and ICATS) of 1:2 will be achieved initially.

Following the appointment and commencement of all new staff, within 12 – 18 months the Trust anticipates aligning all consultant templates with the BAUS guidelines. Draft templates which are subject to agreement with the consultants, are shown in Table 13 overleaf. Travelling time has been accommodated within the templates. The new to review ratio across the service (consultant led and ICATS) will be reduced to the recommended 1:1.5.

Table 12: Draft Initial Consultant Outpatient Templates for 5 Consultant Model (for first 12 – 18 months)

Consultant	Location	Day	Frequency	Sessions/ Annum	Travel Time	New	Review	New/ Annum	Review/ Annum
Consultant 1	CAH	Fri am	2/Month	21	0	6	8	126	168
	STH	Thurs pm	2/Month	21	60	5	8	105	168
	Stone Centre	Mon am	2/Month	21	0	6	11	126	231
Consultant 2	CAH	Tues pm	Weekly	42	0	6	8	252	336
	ACH	Mon am	Monthly	10.5	50	5	8	52.5	84
	Erne	Mon pm	Monthly	10.5	60	5	8	52.5	84
Consultant 3	CAH	Mon pm	2/Month	21	0	6	8	126	168
	STH	Tues pm	2/Month	21	60	5	8	105	168
Consultant 4	CAH	Fri am	2/Month	21	0	6	8	126	168
	ACH	Mon am	Monthly	10.5	50	5	8	52.5	84
	Erne	Mon pm	Monthly	10.5	60	5	8	52.5	84
Consultant 5	CAH	Mon pm	2/Month	21	0	6	8	126	168
	STH	Thurs pm	2/Month	21	60	5	8	105	168
	Stone Centre	Mon am	2/month	21	0	6	11	126	231
Total Annual Slots								**1533**	**2310**

* Please note that templates are draft at present. An additional 0.5 weekly Stone Treatment OP session will be required which still has to be worked in to the job plans.

Table 13: Draft Final Consultant Outpatient Templates for 5 Consultant Model

Consultant	Location	Day	Frequency	Sessions/ Annum	Travel Time	New	Review	New/ Annum	Review/ Annum
Consultant 1	CAH	Fri am	2/Month	21	0	6	9	126	189
	STH	Thurs pm	2/Month	21	60	5	8	105	168
	Stone Centre	Mon am	2/Month	21	0	6	11	126	231
Consultant 2	CAH	Tues pm	Weekly	42	0	6	9	252	378
	ACH	Mon am	Monthly	10.5	50	5	8	52.5	84
	Erne	Mon pm	Monthly	10.5	60	5	8	52.5	84
Consultant 3	CAH	Mon pm	2/Month	21	0	6	9	126	189
	STH	Tues pm	2/Month	21	60	5	8	105	168
Consultant 4	CAH	Fri am	2/Month	21	0	6	9	126	189
	ACH	Mon am	Monthly	10.5	50	5	8	52.5	84
	Erne	Mon pm	Monthly	10.5	60	5	8	52.5	84
Consultant 5	CAH	Mon pm	2/Month	21	0	6	9	126	189
	STH	Thurs pm	2/Month	21	60	5	8	105	168
	Stone Centre	Mon am	2/month	21	0	6	11	126	231
Total Annual Slots								**1533**	**2436**

* Please note that templates are draft at present. An additional 0.5 weekly Stone Treatment OP session will be required which still has to be worked in to the job plans.

6. Timetable for Implementation

Task	Timescale
Submission of Team South Implementation Plan	23 June 10
Re-submission of Team South Implementation Plan	09 Nov 10
Approval to Proceed with Implementation from HSCB	17 Nov 10
Completion of Job Plans/Descriptions for Consultant Posts	Nov 10
Completion of Job Plans/Descriptions for Specialist Nurses	Nov 10
Consultant Job Plans to Specialty Advisor	Dec 10
Advertisement of Consultant Posts	January 11
Advertisement of Specialist Nurse Posts	January 11
New Consultants and Specialist Nurses in post	July 11

APPENDIX 1

Calculation of Sessions Required for Team South

Calculation of Sessions Required for Team South

Prostate Pathway (Revised)

A reduction from the current 4 appointments to 3 appointments is planned in the current service model with the assessment and prostate biopsy taking place on the same day (for appropriate patients).

1st appointment – the patient will be assessed by the specialist nurse (patient will have ultrasound, flow rate, U&E, PSA etc). A registrar needs to be available for at least part of the session eg to do DRE, take patient off warfarin etc. 5-6 patients can be seen at an assessment clinic (limited to a maximum of 6 by ultrasound). In the afternoon appropriate patients from the morning assessment would have a biopsy. 4-6 patients can be biopsied in a session (though additional biopsy probes will need to be purchased). Not all patients will need a biopsy and the session will be filled with those patients from previous weeks who did not have a biopsy on the same day as their assessment (because they needed to come off medication, wanted time to consider biopsy etc). Based on 2009/10 figures it is estimated that 434 patients will require biopsy.

321 patients for assessment @ 5 per session = 64 sessions per annum = 1.4 assessment sessions per week.

378 patients had prostate biopsy in 2009/10 (Note some patients will come directly for biopsy from the ward or OPD). Uplifting this for Fermanagh region gives a requirement for 434 slots @ 5 per session = 87 sessions per annum. 2 biopsy sessions per week (over 48 weeks).

The majority of patients with benign pathology will be given their results by telephone (Specialist Nurse time needs to be built in to job plans for this).

2nd appointment will be to discuss the test results – patients with positive pathology and those patients with benign pathology who are not suitable to receive results by telephone. 180 patients had positive pathology. Uplifting this for Fermanagh region gives a requirement for 215 patients needing a second appointment. These patients will be seen by a consultant or registrar.

3rd appointment will be discussion of treatment with the estimated 215 patients per annum, following MDT. The consultants would prefer to see their own patients and feel that the appropriate model is for each to have a weekly 'Thorndale session' to do:

- 2nd and 3rd prostate appointments,
- Check urodynamic results/patients
- Other urgent cases.

LUTS

419 new patients. The new to review ratio is 1:0.8, therefore there will be approximately 336 reviews.

419 new patients @ 4 per session = 105 sessions

336 reviews @ 8 per session = 42 sessions

103 + 42 = 147 sessions per annum = **3 sessions per week** (over 48 weeks)

Registrar input is required.

Haematuria (Revised)

Currently ultrasound, history, bloods, urines etc done by the Specialist Nurse/Radiographer. Patients come back to DSU to have flexi carried out by a Registrar.

This will move to a 'one stop' service with the flexi being done on the same day in Thorndale (by a Registrar). 5 patients per session (may be a slightly longer session than normal) have been agreed.

241 new patients @ 5 per session = 48.2 sessions = **1.5 per week** (over 42 weeks)

Note – some patients will require IVP. The view of the clinical staff is that it may be rather onerous for the older patient to have this along with the other investigations done on the same day. However this will be considered further and the potential for protected slots discussed with Radiology.

Andrology/General Urology ICATS

For planning purposes it has been agreed to use a new to review ratio of 1:1.5 with 3 new and 5 review at a clinic. It is assumed that sessions will only run over 42 weeks.

639 @ 3 news per session = 213 sessions = **5 per week** (over 42 weeks)

Urodynamics

These will be located alongside consultant clinics.

306 cases at 5 per all day session = 61 all day sessions. 1.5 per week will be built in to the service model.

Time will also need to be built into the Specialist Nurses' job plans to pre assess the patients (this may not need to be face to face) as there otherwise would be a high DNA rate for this service.

Consultant Clinics

1405 new patient slots are required at consultant clinics, including the capacity to review urodynamics results/patients. The table below provides the draft outpatient clinic templates for the 5 consultant model. These templates will provide a capacity for 1533 new and 2310 review outpatient slots initially as shown below. Following the appointment and commencement of all new staff, within 12 – 18 months the Trust anticipates increasing the templates to provide 1533 new and 2436 review slots.

Stone Treatment

311 attendances @ 6 news = 52 sessions. 1.3 session per week will be required.

Day Cases

Flexible Cystoscopy

Based on the current day case rates 2283 day cases (including flexible cystoscopies) would be undertaken.

2008/09 activity has been used to apportion flexible cystoscopies etc, as coding is incomplete for 2009/10.

1243 flexible cystoscopies were carried out as day cases (primary procedure code = M45) and this was 56% of the total daycases (2203), in 2008/09.

It has therefore been assumed that 56% of 2283 cystoscopies will be required = 1279. 237 of these will be done in Thorndale (Haematuria service), leaving1042.

Numbers on lists vary between 6 -10, depending on where the list is undertaken, and whether any patients who have MRSA are included on the list. An average of 8 per list has been used for planning purposes.

1042 @ 8 per list = 131 lists = **3 flexi list per week** (over 48 weeks)

Lithotripsy

268 day cases were carried out in 2008/09. This was 12.2% of the total day cases. Assuming 12.2% of 2283 will be lithotripsy gives a requirement for 279.

279 @ 4 per session = 70 sessions. This equates to 1.5 per week if delivered over 48 weeks (will required a second consultant with SI in stone treatment) and 2 per week if delivered over 42 weeks.

Other Day Cases

The day case rate for specific procedures will be increased (assuming suitable sessions and appropriate equipment can be secured).

In 2008/09 2203 day cases and 1273 elective FCEs were carried out (3476 in total and a day case rate of 63.4%). If the British Association of Day Surgery recommended day case rates had been achieved for the basket of procedures for urology in 2008/09 then an additional 215 day cases would have been carried out increasing the total day case rate from 63.4% to 69.6%

For Team South we have projected 2283 day cases and 1647 FCEs (Day case rate of 58%). If a day case rate of 69.6% is applied to the total elective activity of 3930 then this changes the mix to 2735 day cases and 1195 elective FCEs.

Of the 2735 day cases:

- 1279 are flexible cystoscopies;
- 279 are lithotripsy
- 103 had no procedure (add 18% to account for Fermanagh region) = 121
- 279 are introduction of therapeutic substance in to bladder + 18% = 329

This leaves 727 day cases to be carried out. Some will be done in dedicated day surgery sessions and some will be more suited to main theatre via the elective admissions ward (in case an overnight stay is required). 4 patients are normally done in dedicated day surgery sessions at present but consultants feel that this could be increased to 5.

727 @ 5 per list = 146 lists = 3.5 lists (over 42 weeks). To maximise the potential to treat patients on a day case basis, 4 weekly lists are planned .

Inpatients

1195 elective FCEs are projected. A limited number of patients may not have a procedure carried out. However some non elective cases are added to elective theatre lists. The numbers of procedures carried out on a list also varies significantly and on occasions a single complex case can utilise a whole theatre list. For the purposes of planning, 3 cases per list has been taken as an average.

1195 @ 3 per list = 399 lists = 9 lists (over 48 weeks).

Southern Health and Social Care Trust

Quality Care - for you, with you

Senior Revalidation and Appraisal Manager Band 8b

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

JOB TITLE	Senior Revalidation and Appraisal Manager
BAND	8b
DIRECTORATE	Medical Directors Office
INITIAL LOCATION	Craigavon Hospital
REPORTS TO	Assistant Director, Medical Directors Office
ACCOUNTABLE TO	Medical Director and Executive Director of Nursing

JOB SUMMARY

The postholder will work closely with the Medical Director (MD), Executive Director of Nursing (EDON) and other senior staff to facilitate the implementation of the strategic and operational objectives of the Trust. This will be in line with organisational and corporate plans. In particular, the postholder will be responsible for leading on the strategic modernisation and implementation of the revalidation of medical staff, Physician Associate (PA) registrants and nursing staff.

In particular, the postholder will be responsible for designing, developing and implementing specific programmes in order to support the implementation of professional governance arrangements within the Trust. S/he will initiate and lead the planning, implementation, monitoring and progression of a range of initiatives on behalf of the Medical Director, Executive Director of Nursing. This will be realised through his/her leadership of a Revalidation Team. A key responsibility will be to evaluate the effectiveness of the initiatives and provide assurances to the Medical Director, Executive Director of Nursing and Assistant Director of Clinical and Social Care Governance on same. The postholder will also provide assurances on the efficient management of the team budget and other resources. S/he will develop collaborative working channels and have subject expertise in order to provide expert advice and guidance to General Medical Council (GMC) and Nursing and Midwifery Council (NMC) registrants, senior managers and others.

KEY DUTIES / RESPONSIBILITIES

Policy & Service Development and Business Planning

1. Identifying the strategic changes required to transform the medical and nursing revalidation and appraisal system to meet the needs of the service, as identified by the MD, EDON and relevant national and regional strategic drivers
2. Proposing and implementing Trust wide policies which are in line with GMC and NMC expectations for the delivery of high class revalidation and appraisal of our medical, nursing and PA staff
3. Design and implement revised procedures for revalidation and appraisal of medical, nursing and PA staff

Section 1: Medical and PA revalidation and appraisal

This postholder will lead on the modernisation of the medical revalidation and appraisal process, transforming the current process into the three identified areas of:

- Professional Appraisal
- Professional Performance Management
- Professional Governance

Professional Appraisal

4. Leading on the implementation and management of Appraisal for medical and PA registrants within the Trust including developing subject matter expertise in order to provide expert advice and guidance on all aspects of Appraisal / KSF and Revalidation.
5. Implementing an effective scheme of Appraisal / KSF which will meet the requirements of Revalidation as defined by the General Medical Council including developing relevant supporting documentation, such as structured reflective templates, aide memoire, relevant guidance and checklists.
6. Implementing a suitable audit programme that provides assurance to the Medical Director (Responsible Officer) on the quality of appraisal / KSF including the production of an annual audit report and an annual training needs analysis, leading to a training programme.
7. The maintenance of an in-house bespoke information system to monitor and record:
    - The Appraisal / KSF and Revalidation process;
    - The registration of professional registrants; and
    - Their continuing professional development / study leave / mandatory training.

8. Updating the Regional Appraisal and Revalidation System and running regular reports to monitor Trust progress in relation to appraisal and revalidation

9. Develop solutions to overcome barriers that may arise which could jeopardise individual doctor's ability to revalidate successfully, e.g., non-engagement in the medical appraisal scheme which may result in non-engagement or deferral recommendations being made to the GMC;

10. Collating and providing all supporting information for professional appraisal to medical staff in a timely manner. This includes liaising and following up any queries with relevant departments for information. Information will include evidence of:

    - CPD
    - Audit/QI projects
    - Education roles
    - PDP

11. Ensuring that all revalidating doctors are registered for Colleague and Patient / Client Feedback before their Revalidation date and monitoring the completion of same.

12. Ensuring all documentation prepared for revalidating doctors for their initial and sign-off revalidation meetings to confirm they meet the requirements of Revalidation before a recommendation is made to the General Medical Council.

13. Following up on those professional registrants not engaging sufficiently in the Appraisal / KSF and Revalidation process and providing one to one support as necessary, keeping the Lead for Medical Revalidation advised of any concerns.

14. Accurately recording all information in relation to professional registrants and generating reports as required ensuring the confidentiality and security of all information is maintained.

15. Ensuring relevant and timely communication with professional registrants and the management of contact lists to ensure they are up-to-date and accurate at all times.

16. Dealing with queries and providing expert advice in all aspects of Appraisal / KSF and Revalidation to professional registrants.

17. Chair quarterly Medical Appraisal and Revalidation Team meetings to ensure consistency and quality assurance of medical appraisal and revalidation processes.

18. Ensuring arrangements are in place to support revalidating doctors to fully participate in the two stage meeting process to confirm they meet with all of the GMC requirements for revalidation, including the management of an extensive schedule of pre- and sign-off revalidation meetings

19. Representing the Southern Trust at regional meetings relating to medical revalidation and appraisal

20. Taking the lead within the Southern Trust for the design and implementation of the on-line medical revalidation system

21. Developing and implementing an appraisal induction process for all new medical and PA employees

22. Lead on the development and implementation of a suitable audit programme that provides assurance to the Medical Director (Responsible Officer) on the quality of medical appraisal and revalidation processes including the production of a report on the analysis / findings of the quality assurance audit.

Professional Performance Management

23. On behalf of the Medical Director, be responsible for development, implementation and evaluation of a robust framework to provide assurance regarding Medical Performance management, including the provision of performance management data, such as:

    - CLIP data
    - Job plan

24. Develop a project plan for implementation with project milestones.

25. Support Divisional Medical Directors and operational managers with the roll out of the medical performance management programme across all Trust operational directorates

26. Develop processes to quality assure Medical Performance Management Processes

27. Develop systems to record, track and report on Medical Performance Management progress Trustwide providing reports to the Medical Director, DMDs and Trust Board as appropriate

Professional Governance

28. Work with colleagues within the Governance structures of the Southern Trust to collate and provide all governance supporting information to medical staff in a timely manner. This includes liaising and following up any queries with relevant departments to obtain information such as:-

    - Complaints
    - M&M
    - Incidents - SEA, SAI, IR1
    - Governance engagement
    - Training passport

New Medical Employees / Leavers

29. Managing the processes for new medical staff, ensuring they receive timely information in relation to Trust requirements in relation to appraisal and revalidation, mandatory training, paying patients etc., including undertaking checks with previous Responsible Officers.

30. Maintaining the Trust's GMC Connect online account accurately and in strictest confidence for those medical staff commencing or leaving the Trust.

Medical Mentoring and Coaching Scheme

The postholder will on behalf of the Medical Director: -

31. Be responsible for leading the development and implementation of a Medical Mentoring Scheme for existing and new Consultant and SAS Grade doctors in the Trust. The postholder will:-

- Undertake research to ascertain best practice in the area of Medical Mentoring;
- Develop and implement a policy to support the Medical Mentoring Scheme and lead on the development and implementation of effective governance arrangements to support Medical Mentoring;
- Design and develop a training programme for Mentors/potential Mentors in order to meet the objectives of the Medical Mentoring Scheme;
- Establish and chair a bi-annual Medical Mentor Support Group and be responsible for maintaining a directory of Medical Mentors;
- Evaluate the Medical Mentoring Scheme on an annual basis and make recommendations for improving / refining as required.

Paying / Private Patients

The postholder will on behalf of the Medical Director be specifically responsible for overseeing processes to ensure the Trust is able to recoup income generated by Consultant staff undertaking Paying / Private Patient work on Trust premises. S/he will:-

32. Be responsible for developing and implementing appropriate mechanisms in relation to Private / Paying Patients to ensure Trust compliance with DHSSPS Handbook 'Management of Private Practice in Health Service Hospitals in NI' November 2007 including:-

- The development, management and evaluation of the Trust's arrangements and policy / guidance to manage the process of Paying / Private Patient for Medical Staff;
- In conjunction with Finance Staff / Paying Patients Officers, design and deliver training sessions to Consultants on their Private / Paying Patients responsibilities

and develop a dedicated section on the SouthernDocs website to keep doctors up-to-date;

- Development and management of all the supporting documentation to ensure the effective implementation of the revised Guidance (Undertaking to Pay Forms, FAQs, information for administrative staff etc);
- Ensuring doctors who undertake Paying / Private Patient work reference this within their individual Job Plans and, where there is any deviation from defined processes, follow this up directly with the Consultant.

33. Chair quarterly Paying / Private Patient Implementation Group meetings with the Paying Patients Officers from both DHH and CAH sites

34. Chair bi-annual Paying / Private Patients Working Group meetings with Consultant medical colleagues to keep under review the revised Paying / Private Patient Guidance and associated supporting documents in light of operational experience.

35. Be the main point of contact with Internal Audit to ensure recommendations, for which the Medical Director's office is responsible for, are implemented on time including NIAO reports/recommendations.

36. Have responsibility for ensuring a database of doctors who have been approved to undertake Private Patient has been developed, implemented and is maintained as per Internal Audit recommendations

37. Ensure the provision of timely reports to the Medical Director, SMT, Audit Committee and Internal Audit on Paying / Private Patient work.

Section 2: Nursing Revalidation and Appraisal

The postholder will on behalf of the Executive Director of Nursing and Assistant Director of Nursing Governance:-

38. Lead on designing, developing and implementing a programme to support the statutory revalidation of nurses and midwives across all Directorates within the Trust as per legislative requirements and Nursing and Midwifery Council (NMC) guidance.

This will include: -

- Leading a Trust-wide discussion with senior staff on the development of a bespoke management information system to support nursing and midwifery revalidation until such times as HRPTS has the required capability;
- Analysing the outputs of these discussions along with other sources of information in order to inform the development of a Trust-wide management information system action plan;
- Co-ordinating the planning and implementation of the management information system and delegating the development of key elements as appropriate;
- Monitoring progress on the development of the management information system through the facilitation and management of the Revalidation Team;
- Providing a critical oversight through facilitative and collaborative discussion with NMC registrant managers and senior managers on the effectiveness of the management information system in providing assurance on the implementation of nursing and midwifery revalidation;
- Development of subject matter expertise in order to provide expert advice and guidance to NMC registrants and managers, including producing detailed guidance on the NMC revalidation processes;
- Develop solutions to overcome barriers that may arise in relation to the development of the management information system, e.g., the collection and verification of information needed to progress this programme of work;
- Provide regular updates to Executive Director of Nursing, Assistant Director of Nursing Governance and Senior Management Team (SMT)

on the development and implementation of the management information system across the directorates.

39. Be responsible for developing and implementing standard operating procedures and guidance for nurses, midwives, managers and heads of service in relation to NMC Revalidation and the application of the management information system and associated processes.

40. Lead on the development and implementation of a suitable audit programme that will provide assurance to the Executive Director of Nursing and Assistant Director of Nursing Governance on the quality of outputs of the nursing and midwifery revalidation management information system.

41. Be responsible for ensuring that monthly revalidation reports are issued to individual nursing / midwifery managers to support local arrangements for the timely revalidation of nurses and midwives for whom they have responsibility.

42. Be responsible for centralising information arrangements to ensure that NMC registrants' annual registrations are up to date and that regular reports are issued to managers throughout each month to ensure registrants maintain their registration.

43. On behalf of the Executive Director of Nursing / Assistant Director of Nursing Governance, ensure the timely production of reports on nursing and midwifery revalidation for presentation at Senior Management Team, Governance Committee and Trust Board meetings, including contributing to the production of an Annual Report on Nursing and Midwifery Revalidation.

44. Be a member of the Southern Trust's Nursing and Midwifery NMC Revalidation Implementation Group and represent the Trust at regional HRPTS Nursing Revalidation meetings, share outputs with HRPTS staff and feedback Trust responses on proposed action plans.

45. Once capability has been developed, be responsible for migrating the management information system for NMC revalidation onto HRPTS ensuring relevant testing is carried out before full implementation in order to provide assurance to the Executive Director of Nursing / Assistant Director of Nursing Governance of the efficacy of HRPTS.

46. Develop collaborative working channels with regional colleagues, the DHSSPS and the Nursing and Midwifery Council to support the implementation of the NMC's statutory revalidation arrangements.

47. Take a lead role and participate fully in Regulation and Quality Improvement Authority (RQIA) reviews relating to nursing and midwifery revalidation.

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 MANAGEMENT RESPONSIBILITIES

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

7. The post holder will ensure that they take all concerns raised with them seriously and act in accordance with: The Code (NMC 2018) particularly sections 16 and 17, as well as the Employer's Raising Concerns Policy.

8. The post holder will, in the event of a concern being raised with them, ensure that feedback/learning is communicated at individual, team and organisational level (as per HSC Trust policy) regarding concerns and how they were resolved.

- 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 co-ordination of the Trust's PPI Strategy within the Division or other sphere of responsibility . This will include supporting 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.

<Insert Date of Development>

Southern Health and Social Care Trust

Quality Care - for you, with you

PERSONNEL SPECIFICATION

JOB TITLE AND BAND Senior Revalidation and Appraisal Manager 8b

DEPARTMENT / DIRECTORATE Medical Directors Office

HOURS 37.5

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

Notes to applicants:

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

ESSENTIAL CRITERIA

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

Factor	Criteria	Method of Assessment
Experience	1. Hold a relevant University Degree or recognised Professional Qualification (ie *business, administrative, corporate function)* or equivalent qualification AND 1 year's experience at a minimum of Band 8a within the last 2 years, must include managing professional governance issues in relation to medical or nursing staff. **OR** HNC / HND or equivalent / higher qualification in Qualification (ie *business, administrative, corporate function)* or equivalent qualification AND 2 year's experience at a minimum of Band 8a within the last 2 years, one of which must include	Shortlisting by Application Form

	managing professional governance issues in relation to medical or nursing staff. **OR** 4 years' experience at a minimum of Band 8a within the last 2 years, one of which must include professional governance issues in relation to medical or nursing staff. 2. Have a minimum of two years' experience in a lead role delivering objectives which have led to a significant improvement in service (Significant is defined as contributing directly to key Directorate objectives) 3. Have a minimum of two years' experience working with a diverse range of internal and external stakeholders in a role which has contributed to the successful implementation of a significant change initiative 4. Experience in the use of databases and Microsoft office products including Word, Excel, Powerpoint, or equivalent.	
Qualifications / Registration		Shortlisting by Application Form
Other	Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. *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	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	Interview / Test

	• Connecting our service • Sharing the vision • Engaging the team • Holding to account • Developing capability • Influencing for results.	
Knowledge		Interview / Test

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 king Together	ether for the best outcome for people we upport. We work across Health and Social ith other external organisations and ecognising that leadership is the ty of all.	• I work with others and value everyone's contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible
ompassion	itive, caring, respectful and understanding ose 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 • I learn from others by listening carefully to them • I look after my own health and well-being so that I can care for and support others
Excellence	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 • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking 'could we do this better?'
ness & Honest	nd honest with each other and act with ndour.	• I am open and honest in order to develop trusting relationships • I ask someone for help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice

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

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Medical and Dental Oversight Group

Terms of Reference
2020

Summary & Purpose

The Purpose of the Medical and Dental Oversight Group is to support the Responsible Officer / Medical Director in the discharge of statutory responsibilities by ensuring there is;

- a process for review of all cases where a practitioners practice, conduct, health gives cause for concern,
- regular review of all cases where a practitioner is subject to procedures under Maintaining High Professional Standards in a Modern HPSS (MHPS),
- regular review of all cases where a practitioner is subject to Fitness to Practice procedure (or restriction to practice or similar sanction) of the GMC, GDC or any national professional regulatory body of another sovereign state,
- no undue delays in addressing practitioner performance issues.
- Adequate support, guidance for clinical managers and individual practitioners
- Consistency in approach and decision making where appropriate across the organisation

Terms of Reference

The panel will review the case files of all medical and dental practitioners employed in the Trust, or engaged via Agency for whom there concerns have been raised about their professional practice. This applies to any medical or dental practitioner registered with the GMC and/or GDC who is currently employed or was employed at the time concerns arose. Termination of employment, for whatever reason, does not necessarily end Trust responsibility in terms of MHPS or regulatory Fitness to Practice procedures.

Concerns about professional practice shall include;

- all Fitness to Practice procedures with regulatory agencies,
- all practitioners subject to procedures under MHPS (or equivalent procedures for doctors in training),
- restrictions, undertakings, suspensions or other sanctions imposed by a regulatory agency,
- all cases where NCAS have provided advice or assessment,
- all practitioners subject to a remediation process,
- practitioners whose performance has been called into question through appraisal and/or governance systems (as determined by the Responsible Officer),
- and all doctors for whom a recommendation to revalidate could not be provided at the time requested by GMC.

The Oversight Panel shall regularly review each case file with the Medical/Dental manager for the practitioner.

The Oversight Group shall ensure that any investigations taken under the management of performance comply with relevant guidance and occur in a timely manner.

The Oversight Group will at all times have due regard for ensuring patient safety.

The Oversight Group is required to provide additional assurance to the Trust that procedures under MHPS are undertaken in a fair and proportionate manner

All procedures under MHPS will be undertaken in accordance with this guidance and **SHALL NOT** be delayed until the next meeting of the Panel.

MEMBERSHIP

The members of the Medical and Dental Oversight Group will comprise:

- Responsible Officer / Medical Director (Chair)
- Senior Manager MD Office
- Director of HR / Deputy Director of HR
- Head of Medical HR
- Associate Medical Director and/or Relevant representation from the Service (as set out below)*

*The Director or a nominated deputy.

The Oversight Panel may request additional members (including a legal representative) to provide expertise in particular areas. In the event of a member being unable to attend meetings an alternative professional representative may attend on his/her behalf.

ROLES AND RESPONSIBILITIES

To be discussed and completed here after further discussions with AMD's

The oversight panel shall consider each case and may give direction on further actions required. If the practitioner is a doctor in training then the Director of Medical Education and/or a representative of NIMDTA shall attend.

All meetings will be attended by a minute taker. Detailed minutes will be recorded of each meeting and retained.

All meetings will be chaired by the chairperson or in his/her absence, by a member nominated by the chairperson.

It is best practice that AMD's discussing cases at the Oversight Panel should ensure individual doctors are aware of the above process and that their case may be discussed as part of the Trust's process for handling concerns.

QUORUM

The Panel will not normally meet unless 2 members are present and meetings can only take place if the chairman (The Medical Director) is present or a nominated deputy.(Deputy Medical Director)

FREQUENCY OF MEETINGS

Meetings shall be held monthly

REPORTING ARRANGEMENTS

Minutes of the meetings of the Panel will be formally recorded and action notes distributed to Panel members and a full copy retained on the Medical Directors file.

REVIEW OF TERMS OF REFERENCE

The Terms of Reference will be reviewed at the first meeting of the Forum and thereafter annually. Any amendments to the Terms of Reference will be approved by the Medical Director; in the event of significant changes to the Terms of Reference these shall be presented to SMT for approval.

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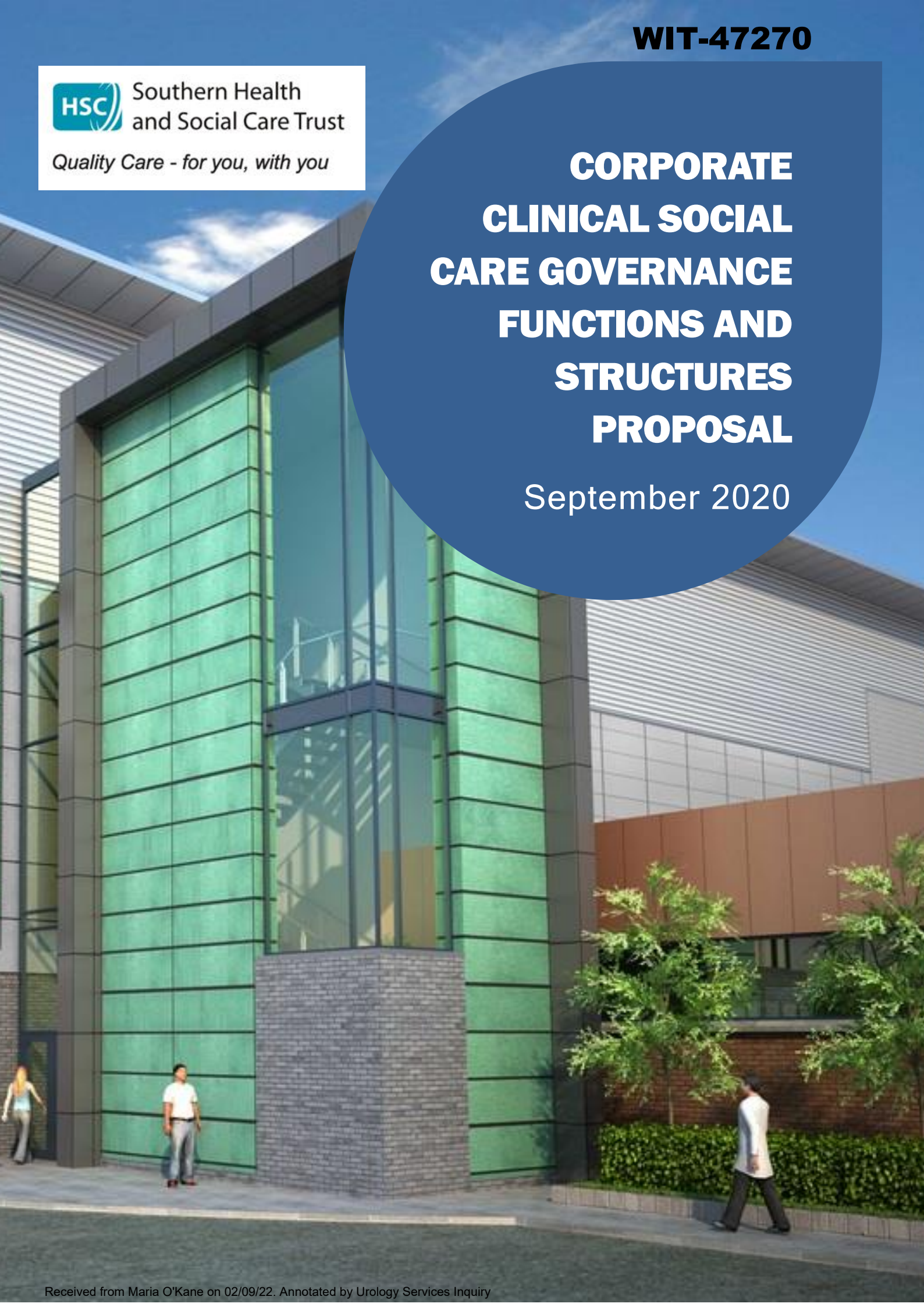
CORPORATE CLINICAL SOCIAL CARE GOVERNANCE FUNCTIONS AND STRUCTURES PROPOSAL

September 2020



Southern Health and Social Care Trust
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CORPORATE CLINICAL SOCIAL CARE GOVERNANCE FUNCTIONS AND STRUCTURES PROPOSAL

1st September 2020

PURPOSE OF PAPER

- **To outline the Trust vision to become a top performing organisation in the UK as a consequence of Learning from Experience, Improvement and providing Safe Patient and Service User Care**
- **To detail the elements of continuous improvement in Clinical and Social Care Governance including upholding of standards, embedding learning from experience and improving overall patient and staff experience**
- **To provide an overview of Trust-wide Clinical and Social Care Functions, Structure and Resourcing required to deliver the vision**
- **To set out two proposals in response to the Trust governance review 2019 and CSCG work scoping exercise 2020**
    - **Proposal to Realign Clinical and Social Care Governance Structures**
    - **Proposal to Increase Resourcing in the Trust Clinical and Social Care Governance Function**
- **To provide outline details of the functions and benefits of the proposed additional resourcing and revised structures**
- **To provide details on costing of the proposal**
- **To provide details on a phased approach to implementation of the proposals**

INTRODUCTION

1. Clinical governance is “a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." (Scally and Donaldson 1998). Within public healthcare services in Northern Ireland we can expand this definition to include social care governance.

2. Clinical and Social Care governance is an umbrella term. It describes activities that not only sustain and continuously improve high standards of patient care, but also provide quality assurance.

3. Healthcare providers that have effective Clinical Governance and Leadership structures which consider learning, communication and safety as defined goals have been shown as high-performing healthcare organisations (NHS Scotland, Quality Improvement Hub, 2017).

4. All Health and Social Care (HSC) organisations now have a duty to the communities they serve for maintaining the quality and safety of care. Whatever structures, systems and processes an organisation puts in place, it must be able to show evidence that standards are upheld.

5. The Department of Health (UK) and Social Care identified the core elements of Clinical Governance in the 1999 publication '*Quality in the new NHS'*. The framework was designed to specify the elements of clinical governance systems that could both assure and improve quality. The results, known as the seven pillars of clinical governance, are:
    - People who use services, carer and public involvement
    - Clinical effectiveness
    - Clinical audit
    - Risk management
    - Training and personal/professional development
    - Use of information
    - Staffing and staff management.

6. The Department of Health (Northern Ireland) Quality standards for Health and Social Care - Supporting Good Governance and Best Practice in the HPSS (2006) outlines the requirements for Health and Social Care organisation governance. Theme One of these standards outline the following requirements:

    - ***The organisation has a coherent and integrated organisational and governance strategy, appropriate to the needs, size and complexity of the organisation with clear leadership, through lines of professional and corporate accountability.***

    - ***The organisation has structures and processes to support, review and action its governance arrangements including, for example, corporate, financial, clinical and social care, information and research governance.***

7. In determining if an organisation is safe there is a need to identify what type of information is needed to give us a comprehensive and rounded picture of the organisation's safety. We can group these into five broad classes: (Measurement and Monitoring of Safety, Charles Vincent, Health Foundation 2013)

Element	Details
Past Harm	This encompasses both psychological and physical measures
Reliability	This encompasses measures of behaviour and systems
Sensitivity to Operations	The information and capacity to monitor safety on an hourly or daily basis
Anticipation and Preparedness	The ability to anticipate, and be prepared for, problems
Integration and Learning	The ability to respond to, and improve from, safety information

8. Prior to 2019 the Trust last underwent a review of Clinical and Social Care Governance in 2011 with the publication of 'A System of Trust' which provided the template for services that are currently delivered by the Trust. However not all of the proposals in the 2011 review were implemented and additionally some that were did not embed within the service areas. Significant changes have occurred in regional Clinical and Social Care requirements for Health and Social Care organisations since this time.

Learning from Recent Experiences

9. **The Francis Inquiry Report (2013)** into the failures in leadership and governance present at Mid-Staffordshire NHS Foundation Trust highlights what amounts to a 'perfect storm' of systematic failures which included:
    - 'Somebody Else's Problem' attitude
    - an institutional culture that cared more about the needs of the hospital staff than the patients
    - an unacceptable willingness to tolerate poor standards of patient care
    - a failure to accept and respond to legitimate complaints
    - a failure of leadership

10. More recently the **Review of Leadership and Governance at Muckamore Hospital (DOH, August 2020)** explored a range of Clinical and Social Care activity as delivered by Belfast Health and Social Care Trust. It notes there was a disconnect between the various levels of the organisation in terms of how governance information was identified, actioned and improvement quality assured. '*The review team concluded that the Trust had adequate governance and leadership arrangements in place but that these were not appropriately implemented at various levels of the organisation. This failure resulted in harm to patients.'*

11. Although both reports are wide ranging in the identification of factors that caused or contributed to the service outcomes, the importance of robust and effective clinical governance along with complementary continuous improvement strategies is listed as core to ensuring that health and social care services remain safe.

Trust Clinical and Social Care Governance Review 2019

12. In 2019 the Trust Chief Executive and Medical Director commissioned an external review of clinical and social care governance to scope improvements in services. The review report details 48 recommendations, 13 of these relate to Board Governance which are not included, the remaining recommendations and themes are summarised below.

Domain	No. Of Recommendations	Short Term	Medium Term	Long Term
Being Open	1	0	1	0
Controls Assurance	2	0	1	1
Risk Management Strategy	5	1	2	2
Adverse Incidents including SAIs	6	2	1	3
Management of Health and Safety	3	1	1	1
Complaints Management	3	0	3	0
Litigation Management	1	0	1	0
Policies, Standards and Clinical Guidelines	4	0	1	3
Clinical Audit	2	1	1	0
Mortality and Morbidity	2	1	1	0
Shared Learning for Improvement	1	0	1	0
Governance Information Management	1	0	1	0
CSCG Structures	2	1	1	0
CSCG Interfaces	2	0	2	0
Total	35	7	18	10

Table 1 – Breakdown of 2019 Governance Review Recommendations

13. The Clinical and Social Care Governance Team has developed a response document to the 48 recommendations which include commentary on the implications for each (See Appendix A). If the Trust is to meet the requirements as set out in these recommendations the Trust will be required to significantly change how we deliver our clinical and social care governance function over the next 2 years.

Clinical and Social Care Governance Scoping Exercise August 2020

14. To complement the 2019 governance review the senior team within the corporate clinical and social care governance office developed a work scoping exercise which identified further work to improve services in line with regional documentation and other best practice sources, in particular those relating to the Trust patient safety function (See Appendix B). The exercise identified further areas for development.

Domain	Actions Required
Management of Adverse Incidents	17
Management of Complaints	60
Risk Management	9
Hyponatraemia Oversight	9
Learning from Experience	4
Morbidity and Mortality	12
Patient Safety Supporting Tasks	25
Standards and Guidelines	4
Clinical Audit	6
Clinical Guidelines	5
Deteriorating Patients	12
Total	**163**

Table 2 – Breakdown of 2020 Governance Scoping Exercise

15. The 163 actions identified require significant resourcing to achieve. An exercise to create a prioritisation matrix to support a staged implementation is under development.

Proposals to Strengthen Trust Clinical and Social Care Governance Functions

16. Section 2 of this document outlines two proposals for SMT consideration with regards to bringing forward systematic changes both to the functions, structures and resourcing for the Trust Clinical and Social Care Governance function.

Considerations and Exclusions in this Document

17. The following considerations and exclusions are noted:
    - Costings for operational directorate teams resourcing is currently ongoing and will be complete by October 2020.
    - If accepted the proposal will require a phased implementation over an 18-24-month period, this will include integrating the timetable for strengthening the Trust Medical Leadership model.
    - Funding will be required for any new posts identified.

PROPOSAL 1 – REALIGNMENT CLINICAL AND SOCIAL CARE GOVERNANCE STRUCTURES

18. The Trust has traditionally operated a model of distributed clinical and social care governance. The Medical Director serves as the overall Director with responsibility for the function. The model has the following key characteristics:

- Each Operational Directorate has a senior Governance Coordinator post which reports directly to the service director
- Each Operational Directorate retains responsibility for the approval and final sign off of all clinical and social care governance activity relating to their service areas
- Each Operational Directorate decides at a local level the funding and resourcing requirements for their clinical and social care governance service areas.
- Each Operational Directorate is responsible for designing systems and processes for delivering on their clinical and social care governance function (for example staff designing and delivering, training, adverse incident and serious adverse incident screening and completion, complaint management processes, management and oversight and standard and guideline implementation etc)

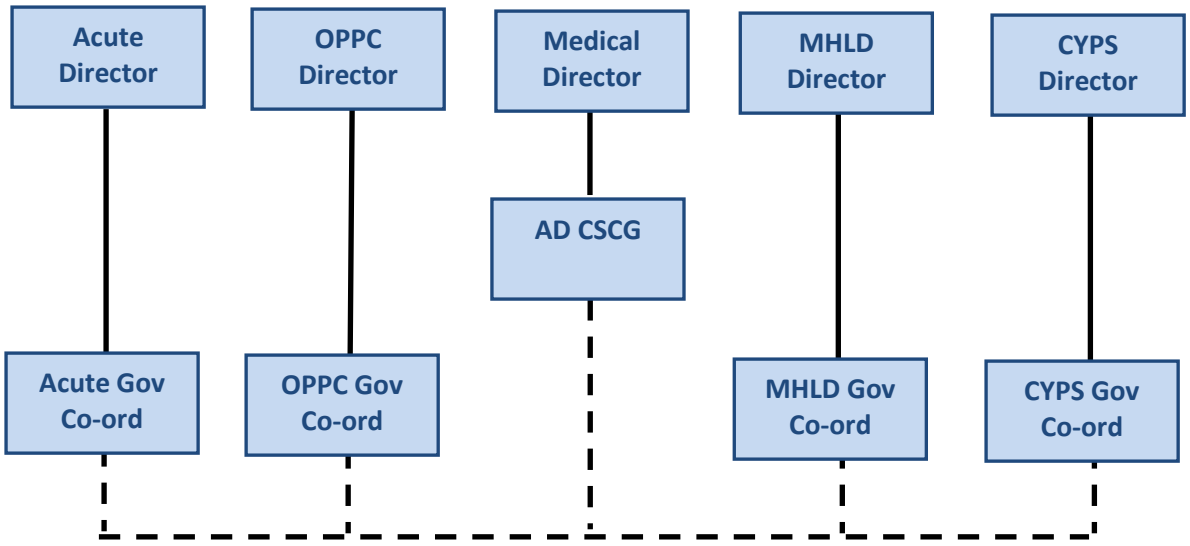

Figure 1 – Current Clinical and Social Care Governance Structure within the Trust

Challenges with a distributed Clinical and Social Care Governance Structure

19. The following weaknesses have been identified in the current distributed structure:

- Corporate quality assurance of Clinical and Social Care Governance processes and outputs

- Local management of resources does not allow for cross cover of functions across directorates when the need arises
- Variable understanding of the elements of Clinical and Social Care Governance
- Variable understanding of the elements of learning and improvement
- Processes are non-standard across service areas including:
    i. Screening processes for SAI identification
    ii. Processes governing the conducting of SAI reviews
    iii. Monitoring of Learning and assurance of implementation
    iv. Recording and development of action plans in response to RQIA, National Audits, Morbidity and Mortality, Adverse and Serious Adverse Incidents
    v. Processes governing the identification and implementation of Standard and Guideline processes
    vi. Provision of localised training at directorate level
    vii. Processes for managing and responding to complaints
- Gaps in service provision have been identified by BSO internal audit findings including Risk Management, Management of Incidents and Morbidity and Mortality which correctional improvement actions are hindered by non-standardised processes.

20. The lack of standardisation of systems and processes across directorate teams inhibits the ability for clear corporate quality assurance and oversight.

Potential Benefits of a Corporate Business Partner Model for Clinical and Social Care Governance

21. The benefits of a corporate lead service include:
    - Corporate overall oversight of all Clinical and Social Care Governance Processes including SAIs, Complaints, Adverse Incidents, Morbidity and Mortality.
    - Allowing 'depth' of governance function to ensure that staffing levels remain consummate with task requirements
    - A standardised focus on the elements of Clinical and Social Care Governance
    - A standardised focus on the elements of learning and improvement
    - Standardisation of processes across service areas including (as above):
        i. Screening processes for SAI identification
        ii. Processes governing the conducting of SAI reviews

iii. Monitoring of Learning and assurance of implementation
iv. Triangulation of Data to inform Improvement Plans and Learning
v. Recording and development of action plans in response to RQIA, National Audits, Morbidity and Mortality, Adverse and Serious Adverse Incidents
vi. Processes governing the identification and implementation of Standard and Guideline processes
vii. Provision of Trust-wide standardised staff training
viii. Processes for managing and responding to complaints

22. The structure detailed below illustrates how the accountabilities would move.

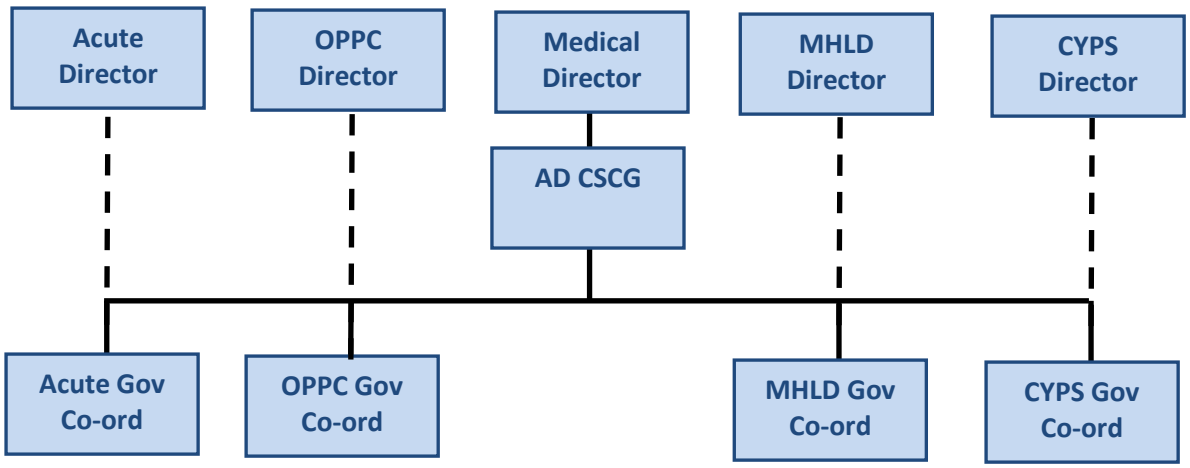

Figure 2 – Proposed Clinical and Social Care Governance Structure

23. This proposal advocates the development of a Corporate lead clinical and social care governance structure with operational management transferring to the Medical Directorate.

24. Operational directors will retain responsibly for the commissioning and oversight of clinical and social care governance activity in the same model as is delivered by other corporate services such as Finance and Procurement, Human Resources and Organisational Development and Performance and Reform.

Options Appraisal

Option 1 – Do Nothing – Existing Directorate Led Model Remains in Place

The current system continues without the ability for robust corporate clinical and social care governance oversight. Risks continue to exist regarding resourcing for directorate level clinical and social care governance team resourcing. Standardisation of processes will

continue to present a challenge and inhibit the development of patient safety

Option 2 – Realignment Clinical and Social Care Governance Structures

The Trust realigns its Clinical and Social Care Governance function transferring to a corporately led model. This will allow for the implementation of corporate quality assurance and oversight of directorate activity. Resourcing will be centrally managed and processes will be standardised across all services. Continuing to nest the current governance teams within the directorates with the increased involvement of the Corporate CSCG team will ensure that the benefits of local knowledge and relationships are not lost.

PROPOSAL 2 - INCREASE RESOURCING IN THE TRUST CLINICAL AND SOCIAL CARE GOVERNANCE FUNCTION

25. Further to the findings of the 2019 Governance Review and 2020 Governance Scoping Exercise a resourcing deficit has been identified within the corporate clinical and social care governance team. Regardless of the decision made with respect to Proposal 1, this proposal requires separate consideration.

Staffing Comparison with Analogous Corporate Functions

26. As a benchmark of corporate service staffing the below table provides a snapshot view of the Trust Clinical and Social Care Governance function in comparison with other Trust corporate services (Data supplied by Trust Workforce Information Team, 20th August 2020)

Directorate	Division	Headcount	WTE
Medical Directorate (Pt Safety and CSCG)	Patient Safety Data and Improvement	9	7.44
	Adverse Incidents, SAIs, Complaints, S&G, Datix	28*	25
Total		**36**	**30.5**
Finance and Procurement**	Finance Accounting	76	66
	Financial Management	49	47.3
Total		**125**	**113.3**
Human Resources and Organisational Development***	Education Learning & Development Division	14	12.21
	Employee Relations Division	34	27.53
	Equality Assurance Division	3	2.60
	Litigation Division	14	12.93
	Occupational Health Division	17	13.87
	Staff Side Division	10	8.10
	Vocational Workforce Assessment Division	10	8.11
	Workforce Information Division	13	11.81
Total		**115**	**97.16**
Performance and Reform	Best Care Best Value Division	9	8.40
	Corporate Planning Division	14	11.84
	Informatics Division****	135	125.25
	Performance Improvement Division	18	16.02
Total		**176**	**161.51**

**Including both corporate and directorate clinical and social care governance staffing count*

***Excluding Estate Services*

**** Medical Staffing and HR Resourcing divisions removed as these contained locum and bank staff in their headcount*

*****Informatics includes IT staffing complement*

27. Based on the findings of the 2019 Governance Review and the suggested structure the following page outlines the proposed staffing model including posts that are currently funded, those which have partial funding and those which are new, unfunded positions within the corporate team.

28. As stated in the introduction a separate paper detailing the requirements of directorate clinical and social care governance teams will be required when full scoping is complete.

29. The medical directorate acknowledges that this is a high value funding proposal and suggest that a phased approach to team growth is adapted to allow new team members to embed in their roles and functions and ensure that the model as designed is delivering its objectives. The phased implementation can be found on page 20 of this document.

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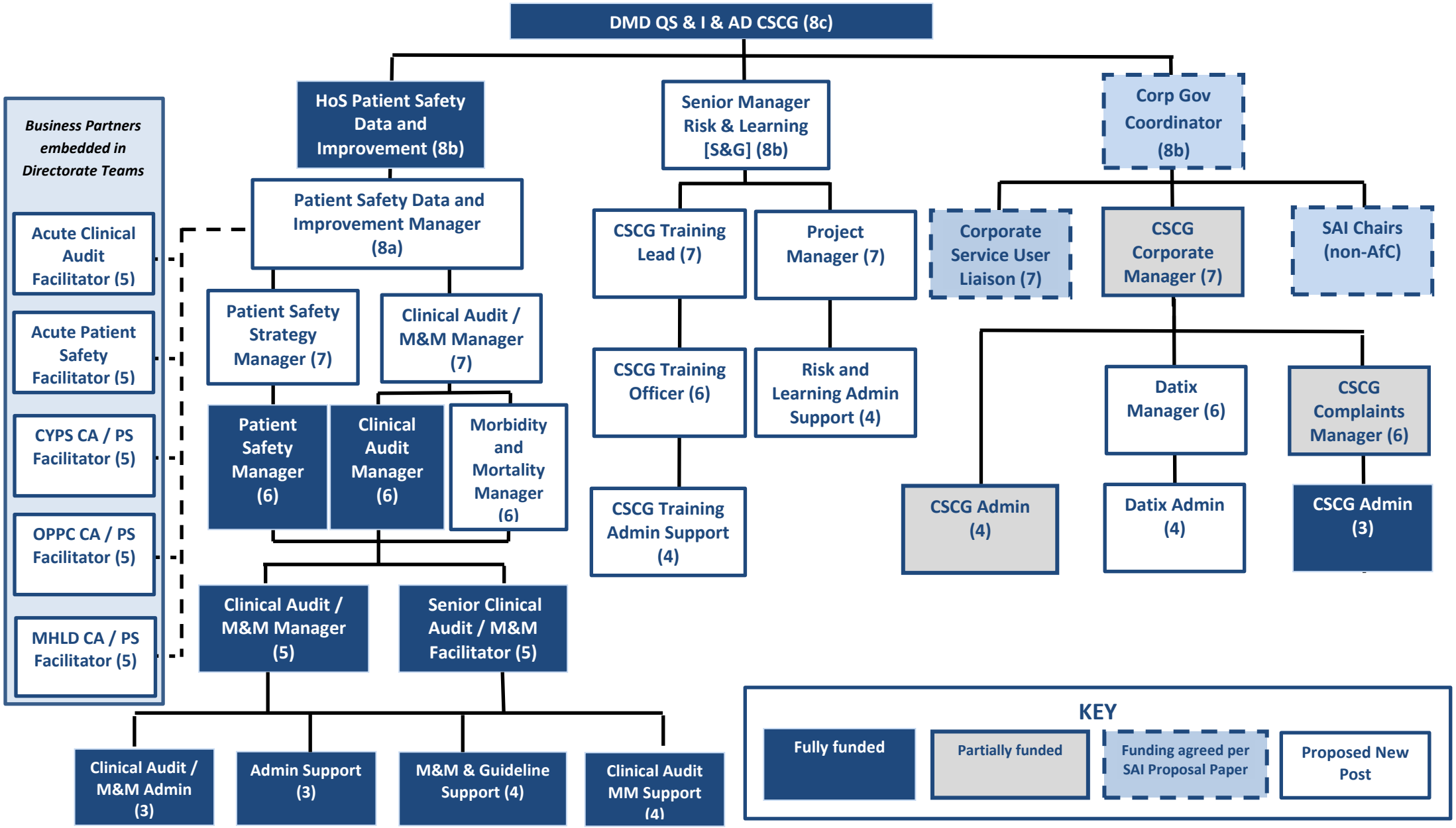
PROPOSED REVISED CORPORATE CLINICAL AND SOCIAL CARE GOVERNANCE STRUCTURE



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

FUNCTIONS AND BENEFITS OF THE REVISED STRUCTURE

30. The revised structure will allow the Trust to that ensure that the elements of providing safe and constantly improving care to patients and service users are recognised and prioritised, that safety data can be triangulated, that there is embedded learning from experience and that the Trust can Quality Assure the CSCG processes in place.

31. The following functions and benefits have been identified:

Workplan Element	Overview of Elements
Management of Standard and Guidelines	• Development of a standardised, robust framework for the management of standards and guidelines within the Trust • Develop a mechanism to link standard and guideline assurance formally to clinical audit activity • Develop dynamic oversight reporting and risk analysis of standard and guideline compliance
Development of a Trustwide Patient Safety Strategy	Development of a structured patient safety strategy for the Trust that will: • Improve understanding of safety by drawing intelligence from multiple sources of patient safety information • Equip patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system • Allow for the design and support of programmes that deliver effective and sustainable change in the most important areas
Support for Morbidity and Mortality Processes	• Further increase administrative support and facilitation for Morbidity and Mortality processes • Provide support for multidisciplinary and specialty input and increase the range of Patient Safety inputs available for each meeting • Ensure the Trust Morbidity and Mortality structure fully benefits from the Learning from Experience programme
Strengthening Response to Serious Adverse Incidents	• Provide corporate team involvement in oversight of reviews in progress • Provide availability of corporate team support for teams conducting reviews to advise on review technical issues • Provision of resource to provide bespoke training / guidance to local teams in the conduct of review elements

	• Provision corporate support available to assist with the coordination of cross directorate / cross Trust or interagency reviews • Provide corporate support available to assist with improving the process of learning • Provide corporate support for developing recommendations and embedding learning in response to incident review findings • Provide corporate support to assist with the consolidation of themed recommendations across services and directorates
Development of Trust Risk Management Systems	• Implementation of the organisation wide Risk Management Strategy • Trust level coordination of work relating to the risk management and Risk Appetite aspects of the Health Care • Development of an action plan to ensure achievement and continuous maintenance of required standards including the development and implementation of an effective risk identification and management process. • Development and maintenance of effective incident reporting systems across the Trust, ensuring that structures and process are in place to facilitate lessons learned and integration with complaints and claims • Provision of advice to Trust services on any necessary changes/developments required to meet the Risk Management Standards
Improving our Service User Complaints Processes	• Development of a Trustwide customer service training programme including support for construction of responses to service users • Improve our complaints trend analysis programme using complaints to better inform service improvements • Develop processes to support the management of Independent Sector Providers
Supporting Trust Learning from Experience Processes	• Oversight and management of the Trust Learning from Experience programme • Identify and coordinate sources of learning both internal and external into standardised communication channels • Link learning from experience into clinical audit and other assurance processes to ensure learning and improvement is embedded is services.

32. The following new and revised role high level descriptions are provided below:

Role Title	Band	Details
Senior Manager of Risk and Learning	8b	• Oversight and responsibility for Corporate Risk Register • Oversight and responsibility for Trust Standard & Guidelines process • With operational change leads develop action plans to direct operational Standard & Guidelines implementation including the review and update of legacy Standard & Guidelines • Support the creation and provision of an education and learning programme which integrates learning between SAI's/M&M/Litigation/Datix Trust-wide • Support the creation and implementation of governance e-learning packages • Support the implementation of the Datix system upgrade and adaptation of modules
Patient Safety Data and Improvement Manager	8a	• Lead for the implementation, coordination, management and delivery of Trustwide monitoring and improvement programmes for patient safety initiatives • Production of patient safety performance data & reports, to identify areas for increasing collaborative, multidisciplinary working and to inform new ways of working. • Responsible for monitoring Trust patient safety performance metrics interpretation and benchmarking of Process & Outcome data with other participating Trusts on Interventions • Reporting to the Trust Governance Forums through monitoring of the Patient/Client Safety Quality Improvement Plan on behalf of the Trust, identifying deviations from the plan's goals & objectives and taking corrective action where appropriate.
Patient Safety Strategy Manager	7	• Lead on the development and implementation of a Trustwide Patient Safety Strategy • Monitor clinical process and outcomes and system issues related to quality of patient care and provide and monitor written communication for performance improvement activities • Where appropriate assist in the development of clinical practice guidelines

		• Identify and investigate performance improvement events, opportunities, trends and sentinel events • Help operational teams outline remedial actions in response to patient safety improvement programmes • Participate in performance improvement committees and provide staff education on performance improvement topics
Corporate Clinical Audit and M&M Manager	7	• Responsible for line management of the M&M and Clinical Audit Team • Integration of M&M outcomes and the Clinical Audit programmes. • Facilitate and manage an annual programme of clinical audits, ensuring programmes meets local and national requirements for assigned specialities. • Liaising and communicate with all levels of healthcare professionals including managers ensuring opportunities for clinical audit are identified, pursued and supported. • Facilitating multi-disciplinary groups within specialities to plan and oversee clinical audit projects. To analyse and interpret a range of complex data and facts and report the findings in a variety of formats suitable for the particular audience associated with the individual audit projects. • Demonstrating the ability to employ a range of alternative methods, including the use of modern technology, to deliver well planned and effective clinical audit projects • Assisting assigned specialities to identify improvements to patient care through the clinical audit programme
CSCG Training Manager and Training Officer	7 and 6	• Create and sustain an education and learning programme which integrates learning from SAI's/M&M/Litigation/Complaints/Datix Incidents Trust-wide • Support the creation and implementation of governance e-learning packages • Support the implementation of the Datix System upgrade and adaptation of modules • Line Manage the Risk and Learning Admin support
Corporate Service User	7	• Create interfaces with services user/family and staff involved in

Liaison Officer (CSULO)		incidents/sudden death/complaints, SAI's, Coroner Inquests, GMC/NMC hearings • Create and maintain interfaces with PCC, NIPSO, PSNI, Coroner's Office, Litigation, DLS, Bereavement Coordinator • Support the extraction and circulation of learning from case management to all SHSCT streams of learning education while working the premise of Being Open
CSCG Corporate Manager	7	• Responsible for the line management of Datix Manager, Corporate Complaints Manager, Datix admin support, and 2 CSCG Admin • Support the Compilation, updates and assurance in relation to all Governance Reports for audit and submission Regionally, Trust Board and Trust Senior Management Team • Compile and provide SHSCT Patient Safety Data and Complaints data regionally for audit including DoH, HSCB along with Trust Board and Trust Senior Management Team • Support the creation and maintenance of Datix patient safety dashboards Trust-wide • Support the implementation of Trust-wide education & learning programme in-conjunction with the CSCG Training Officer and CSULO • Support the Datix Manager to implement the Datix system upgrade and customise all relevant modules for use. Provide interface with IT and IT systems to ensure Datix sustainability • Oversee the creation and management of Trust-wide SAI recommendations and action plans for each Trust Directorate • Provide support and oversight of the dissemination of Standards & Guidelines coming in to the Trust for the Senior Manager of Risk and Learning • Oversee and monitor the screening and recording of Trust-wide complaints using the Health Care Analysis Tool
Morbidity and Mortality Manager	6	• Coordination and support for the Trust M&M Function • Management of the RMMRs function • Provision of reporting and analysis of RMMRs performance in support of M&M monthly meetings review of case discussion and completion

		• Develop processes of learning from M&M Outcomes that link to safety improvement initiatives and clinical audit.
Datix Manager	6	• Lead the Trust-wide upgrade of the Datix System • Adapt and secure Datix web modules in relation to Morbidity & Mortality, SAI Management, Litigation, Complaints • Maintain interface with IT systems team to ensure maintenance of the Datix System • Lead and support the education and learning in relation to incident reporting on the Datix system across the trust • Support the CSCG Training Office to create and update e-learning in relation to incident management • Support any CSCG patient safety or programmes of audit with data available from Datix system or create the ability to access same where possible • Manage and monitor and Datix system access and accounts Trust wide
Corporate Complaints Manager	6	• Responsible for the initial screening, management (and escalation as appropriate) of all complaints submitted to the SHSCT inc informal/formal complaints, MLA queries, Ombudsman queries, Freedom of Information requests, queries from DoH • Responsible for the screening of all complaints to ensure rapid escalation of any high-risk complaints • Responsible for overseeing the implementation and application of the Health Care Analysis Tool to every Trust compliant • Responsible for the gathering of data, learning and themes of complaints to support all SHSCT reports and Regional guidance as relevant • Responsible for ensuring local resolution of complaints is made when at all possible and follow up with written correspondence to service user and Specialty Teams involved • Responsible for providing timely and appropriate acknowledgement of all Trust complaints

Patient Safety / Clinical Audit Facilitators	5	• Provide support to directorate teams to undertake quality and safety data analysis, reporting and audit activities and plans for safety improvement. • Support processes for monthly Patient Safety Meetings providing an effective process of mortality and morbidity assurance which will meet regionally developed standards, supporting the use of the regional RMMRS system and producing relevant supporting documentation

REVISED STRUCTURE COSTING

33. The following costing table outlines the costs for the corporate service

Role Title	Band	No. of Posts	Funded	Currently Funded (Mid-Point of Scale with Goods and Services)	Additional Cost (Mid-Point of Scale with Goods and Services)
Assistant Director CSCG	8c	1	Yes	*£94,106*	
HoS Patient Safety Data and Improvement	8b	1	Yes	*£80,188*	
Corporate CSCG Coordinator*	8b	1	Yes	*£80,188*	
Senior Manager of Risk and Learning [S&G]	8b	1	No		*£80,188*
Patient Safety Data and Improvement Manager	8a	1	No		*£67,076*
Patient Safety Strategy Manager	7	1	No		*£60,037*
Project Manager	7	1	No		*£60,037*
M&M and Clinical Audit Manager	7	1	No		*£60,037*
CSCG Training Lead	7	1	No		*£60,037*
Corporate Service User Liaison Officer*	7	1	Yes	*£60,037*	
CSCG Corporate Manager	7	1	Partial	*£39,034*	*£21,003*
Datix Manager	6	1	No		*£48,375*
Morbidity and Mortality Manager	6	1	No		*£48,375*
CSCG Training Officer	6	1	No		*£48,375*
Corporate Complaints Manager	6	1	Partial	*£39,034*	*£9,341*
Patient Safety Manager	6	1	Yes	*£48,375*	
Clinical Audit Manager	6	1	Yes	*£48,375*	
M&M and Clinical Audit Facilitator	5	2	Yes	*£39,034*	
Clinical Audit Support	4	1	Yes	*£34,250*	
Audit and Guidelines Administrator	4	1	Yes	*£35,250*	
Risk & Learning and Support Administrator	4	1	No		*£35,250*
CSCG Training Support Administrator	4	1	No		*£35,250*
CSCG Administrator (Adverse Incidents and SAIs)	4	1	Partial	*£29,824*	*£4,426*
Datix Administrator	4	1	No		*£35,250*
Clinical Audit Administrator	3	2	Yes	*£59,648*	
CSCG Administrator (Complaints)	3	1	Yes	*£29,824*	
SAI Chairpersons [Medical]*	NA	2	Yes	*£55,000*	
SAI Chairpersons [Non-Medical]*	8b	0.4	Yes	*£32,075*	
Total Cost				**£804,242**	**£673,057**

**Funding previously agreed by Trust Senior Management Team as part of Serious Adverse Incident proposal paper*

34. The following costing table outlines the costs for the business partner posts

Role Title	Band	No. of Posts	Funded	Currently Funded (Mid-Point of Scale in Goods and Services)	Additional Cost (Mid-Point of Scale in Goods and Services)
Acute Clinical Audit Facilitator	5	1	No		*£39,034*
Acute Patient Safety Facilitator	5	1	No		*£39,034*
CYPS CA / PS Facilitator	5	1	No		*£39,034*
MHLD CA / PS Facilitator	5	1	No		*£39,034*
OPPC CA / PS Facilitator	5	1	No		*£39,034*
Total Cost					***£195,170***

35. The following costing table outlines the costs for directorate teams (work in due for completion October 2020).

Directorate	Role Title	Funded	Currently Funded (Mid-Point of Scale in Goods and Services)	Additional Cost (Mid-Point of Scale in Goods and Services)
Acute	Governance Officer Band 7	No		*£60,037*
	Governance Admin Support Band 2	No		*£39,034*
OPPC	ISP Governance Officer 8a	No		*£23,075*
	Governance Officer Band 7	No		*£60,037*
CYPS TBC				
MHLD TBC				
	Total Cost *			***£182,183***

Phased Implementation Proposal

36. In order to ensure the most effective use of resource, the Cooperate and Clinical Social Care Governance division purposes a phased implementation approach, which we believe supports greatest value. A phased approach will provide time for transitional learning and training in a controlled environment which would maximise value for money for the Trust and a stabilised skilled workforce.

Phase	Action	Timescales
Phase 1	• Patient Safety Data and Improvement Manager, Band 8a • Senior Manager Risk & Learning, Band 8b • Datix Manager Band 6 • Patient Safety Strategy Manager, Band 7 • Project Manager Band 7	In post within 3 months of proposal acceptance and investment
Phase 2	• Corporate Clinical Audit Manager, Band 7 • CSCG Training Officer Band 7 • Morbidity and Mortality Manager Band 6 • Directorate Clinical audit and patient safety posts Band 5	Within 3-6 months of proposal acceptance and investment
Phase 3	• Datix Admin, Band 4 • Risk and Learning Admin Support Band 4 • Training admin Support Band 4 • Business Partner posts Band 5	Within 9-12 months of proposal acceptance and investment

Options Appraisal

Option 1 – Do Nothing – No Investment in Additional Resourcing

Resourcing remains static, the Trust is unable to deliver on the recommendations of the 2019 Governance Review or 2020 Governance Scoping Exercise and will be unable to deliver in a timely manner on specific governance actions such as supporting the implementations of recommendations into hyponatraemia related deaths.

Option 2 – Funding for Resourcing is Agreed

The Trust will be able to commence developing functions that can meet the requirements of 2019 Governance Review and 2020 Governance Scoping Exercise and deliver on governance actions a timely and robust fashion commencing with Phase 1 of the proposal.

Southern Health and Social Care Trust

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Corporate Liaison Officer

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JOB DESCRIPTION

JOB TITLE	Corporate Liaison Officer
BAND	7
DIRECTORATE	Medical Directorate
INITIAL LOCATION	Beechfield House, CAH
REPORTS TO	Corporate Clinical and Social Care Governance (CSCG) Co-Ordinator
ACCOUNTABLE TO	Assistant Director of CSCG (ADCSCG)

JOB SUMMARY

The post holder will have responsibility for management of the proactive liaison service for service users, relatives and carers who have had involvement in a serious adverse incident and/or structured judgement review process or submitted a complaint to the Trust regarding service user safety. The post holder will be the key central point of contact between the affected service users, relatives[1] and carers and will ensure they remain fully supported, including pastoral and tangible supports where required, throughout and following any Trust review processes.

The post holder will ensure the Trust maintains a responsive liaison service for patients, relatives, carers at all times. This will include liaising with internal Trust services and external agencies to ensure that appropriate supports are provided to service users and families who may require access.

The post holder will provide advice and support to SHSCT staff who have had involvement in a serious adverse incident and/or structured judgement review process or a complaint submitted to the Trust regarding service user safety.

[1] *The definition of family includes any person(s) who may be affected as a result of a healthcare related incident regardless of their personal connection to the services provided*

KEY DUTIES / RESPONSIBILITIES

1. Provide a central point of contact for service users, relatives and carers who have had contact with a serious adverse incident and/or structured judgement review or submitted a complaint to the Trust regarding service user safety. The contact may be in person, by telephone, e-mail or written correspondence.

2. Facilitate meetings with service users, relatives and carers who have had involvement in a serious adverse incident and/or structured judgement review process or submitted a complaint to the Trust regarding service user safety. This will include dealing with situations which are highly emotive and challenging where information may be of a sensitive and complex clinical nature.

3. Where necessary, advise and support service users to access alternative sources of information, including advocacy services, other healthcare organisations, or voluntary sector services suited to their needs.

4. Keep service users, relatives and carers who have had had involvement in a serious adverse incident and/or structured judgement review process or submitted a complaint to the Trust regarding service user safety continuously informed of Trust review processes and expected timescales for completion.

5. In cases where service users, families or carers require on-going help and support to regarding their involvement in a serious adverse incident and/or structured judgement review process or complaint, chair liaison meetings between Trust staff and service users, families or carers to discuss any concerns they have.

6. With the consent of service users, families or carers, provide links to Trust services, General Practitioner services or external counselling agencies.

7. Lead on communication with service users, families or carers when sharing sensitive and complex information and with input from clinical subject matter experts the factors that led to adverse events affected them.

8. With operational directorate teams, make objective analysis and assessment of concerns that may be complex and/or sensitive, make judgements and through liaison with chair / reviewer to ensure the appropriate level of reviews are carried out and if required, facilitate negotiations with all concerned to find solutions.

9. With operational directorate teams, communicate the outcome of any review to individuals in response to concerns or feedback raised, either verbally and/or in writing.

10. Keep accurate and contemporaneous records of all communications with service users, relatives and carers including outcomes and actions and input data onto the Datix system.

11. Work collaboratively with directorates to monitor the progress of action plans as a result of concerns and patient feedback and ensure that lessons are learned and shared with affected service users, relatives and carers.

12. Work closely with directorates to embed a culture which views adverse events, complaints, concerns and service user feedback as opportunities for learning and support services to ensure adequately supported and empowered to deal with complaints quickly, effectively and objectively at local level.

13. Represent the Trust at regional meetings and forums including the patient and client council regional working group.

14. Lead and manage multidisciplinary service improvement projects designed to create improved systems and processes for the identification and dissemination of learning from adverse events and complaints.

15. Provide guidance to the Chief Executive, operational directors, senior managers and clinicians on the management of communications with patients, relatives and carers.

16. Using evidence based approaches, design and deliver specialist training for multiprofessional staff to support them when communicating with patients, families and carers.

17. Lead on the local development of guidance in respect of service user, relative and carer engagement processes by leading on the assessment, interpretation and implementation of national and regional guidance and policies.

18. Lead and oversee an ongoing review of organisational engagement processes with regard to patients, relatives and carers and lead on the development of appropriate levels of staff, public and service user consultations.

19. Lead on the development of quality metrics and targets based on national and regional policies and provide action plan and monitoring information to the Medical Director.

20. Have input in the governance agenda by highlighting patient safety issues raised through concerns, complaints and service user feedback to both the

Corporate Clinical and Social Care Governance (CSCG) Co-Ordinator and Assistant Director for Clinical and Social Care Governance (ADCSCG).

21. Assist the Corporate CSCG Co-Ordinator, ADCSCG and Head of Patient Safety Data with improvement analysing trends and themes arising from concerns/complaints or feedback and assist in the production of reports to Care Groups and departments.

22. Work to undertake surveys, audits and other projects relevant to the department.

23. Ensure that members of the public know how to raise concerns and complaints and that any barriers preventing this are addressed.

24. Provide assistance to the Corporate CSCG Coordinator and ADCSCG in collating and presenting data in preparation for external audits.

25. Contribute to Trust-wide training on customer services including; staff supporting service users; relatives and carers; frontline resolution of concerns and complaints, in order to ensure that staff are supported and enabled to meet patients' needs in practice.

26. Provide advice and support to SHSCT staff who have had involvement in a serious adverse incident and/or structured judgement review process or a complaint submitted to the Trust regarding service user safety.

27. Responsible for maintaining own professional development and to be aware of current practices and developments within the Trust and the Health and Social Care in order to fulfil the role effectively.

ORGANISATIONAL RESPONSIBIITIES

1. Support the development of processes which provide corporate assurance that both the operational and professional aspects of CSCG are of a sufficiently high standard.

2. Support the development, implementation and audit of organisational wide CSCG policies and procedures.

3. Work collaboratively and effectively with the SHSCT Corporate CSCG Co-Ordinator and ADCSCG to ensure there is a clear, two-way line of communication from each operational Director, SMT Governance teams and Trust Governance Committees.

4. Support the Corporate CSCG Co-Ordinator and ADCSCG in the planning and implementation of Trust wide policies and procedures as required and actively bring forward strategic plans for driving forward the CSCG agenda within the Southern Trust, influencing and shaping this agenda regionally.

5. Support robust monitoring arrangements, to ensure that at all times the Directorates are complying with and operating within the CSCG policies, procedures and standards that the Trust has agreed. Where monitoring indicates any exception or deviation, this must first be brought to the attention of the Corporate CSCG Co-Ordinator for escalation as required to the ADCSCG and then the Medical Director.

INFORMATION MANAGEMENT

1. Ensure the effective implementation of all Trust information management policies and procedures.

2. Ensure the systems and procedures for the management and storage of information by the post holder meet internal and external reporting requirements.

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.

PERSONAL AND PUBLIC INVOLVEMENT RESPONSIBILITIES (PPI)

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

GENERAL REQUIREMENTS

The post holder will be required to:

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

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

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

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

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

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

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

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

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

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

<January 2022>

Southern Health and Social Care Trust

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PERSONNEL SPECIFICATION

JOB TITLE AND BAND	Corporate Liaison Officer, Band 7
DEPARTMENT / DIRECTORATE	Corporate CSCG/Medical Directorate
SALARY	£40,057 - £45,839
HOURS	Full-Time (37.5 hours)

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 the process when the criteria will be measured is stated below.

Factor	Criteria	Method of Assessment
Experience/ Qualifications/ Registration	1. Relevant professional clinical qualification[2] 2. Current professional registration[2] 3. Worked for at least 2 years in a Band 6 or above role in a major complex organisation[3]	Shortlisting by Application Form

	4. Experience of providing direct liaison support to service users, families or carers 5. Expert knowledge of health and social care delivery, legislative, professional and statutory requirements of clinical and social care governance, demonstrated by achieving successful outcomes for at least 2 years 6. Possess a qualification in Counselling (or an undertaking to complete an appropriate course of study within 2 years of taking up post) *[2] A relevant Professional Clinical Qualification and registration with a recognised professional body is considered to be:* • *a full, current registration with the General Medical Council (UK) with Licence to Practice* • *a full, current registration with the Nursing and Midwifery Council (UK),* • *current registration with the Northern Ireland Social Care Council on the social work part of the register* • *current registration with British Psychological Society as a registered Psychologist* • *Allied Health Professional with current registration with the Health and Care Professions Council (HCPC)* *[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*	
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 / Knowledge	1. Excellent communication skills (written, oral, presentational and interpersonal) with the ability to communicate effectively with service users, families, carers and all levels of staff with a positive and caring attitude 2. Evidence of highly effective planning	Interview

	and organisational skills 3. Demonstrate the ability to assess risk and problem-solve based on excellent analytical skills 4. Ability to work effectively as part of a multiprofessional team 5. Ability to work flexibly to meet the needs of the service 6. A good level of computer literacy 7. Demonstrate the ability to write clear and concise reports related to complex subject matter 8. Demonstrate a working knowledge of Governance structures within the SHSCT and across the region	

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	1. At least 1 year's experience in a role directly supporting service users, families or carers during/following trauma and/or bereavement related to and not exclusive to sudden death or serious adverse incident	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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ue	What does this mean?	What does this look like in practice? - Behaviours
W king Together	ether for me for people we upport. We work across Health and Social ith other external organisations and ecognising that leadership is the ty of all.	• I work with others and value everyone's contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible
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 • I learn from others by listening carefully to them • I look after my own health and well-being so that I can care for and support others
Excellence	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 • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking 'could we do this better?'
ness & Honest	nd honest with each other and act with ndour.	• I am open and honest in order to develop trusting relationships • I ask someone for help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice

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

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73820032
Serious Adverse Incident Chairperson (2 PAs)

Beechfield House,Craigavon Area Hospital
Job Information Pack

Closing Date for Receipt of Completed Applications is:
Tuesday 19th May 2020
at 12.30pm

All communication relating to your application will be sent to you via email, you should continually check your email account for correspondence, this includes checking junk mail

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JOB DESCRIPTION

POST: Serious Adverse Incident Chairperson

DIRECTORATE: Medical Directorate

RESPONSIBLE TO: Assistant Director of Clinical and Social Care Governance

ACCOUNTABLE TO: Medical Director

COMMITMENT: 2 PA

LOCATION: Trustwide

Context:

The Serious Adverse Incident Chairperson will be responsible for leading and overseeing the serious adverse incident review process from commencement to conclusion for individual incident reviews. The chairperson will be responsible for ensuring that the serious adverse incident review is carried out in a thorough, systematic, fair and transparent manner and that recommendations and learning from each review are clearly identified to facilitate service improvements.

Job Purpose:

In partnership the Assistant Director Clinical and Social Care Governance and Corporate Governance Coordinator work with directorate governance teams and operational teams to conduct serious adverse incident reviews.

Main Duties / Responsibilities

1. As chairperson of serious adverse incident reviews, oversee and direct the review process from initiation to conclusion

2. Review all pre-existing information that is pertinent to the adverse incident, including case notes, interview materials and audit outcomes

3. In conjunction with the service users, families or carers and Trust staff oversee the development and agreement of adverse incident review terms of reference

4. Lead on communication with service users, families or carers when explaining the factors that led to adverse events they were affected by

5. During the course of the serious adverse incident review highlight patient safety issues and concerns as they arise to operational managers

6. Identify any requirements for subject matter expertise, specialist advice and guidance to support the serious adverse incident review

7. Identify information sources and persons to be interviewed to progress the adverse incident review

8. Direct and where appropriate participate in interviews and oversee and agree interview transcripts

9. Identification of any supplementary information that may be required during the course of the serious adverse incident review

10. Oversight of use of agreed methodology and validated tools to identify key causal and contributory factors related to the serious adverse incident

11. Responsibility for writing and finalising the serious adverse incident review report

12. Responsibility for identifying and authoring recommendations for service improvement that are clear and 'strong' in their effectiveness and ability to implement

13. With operational directorate teams, communicate the outcome of any review to individuals in response to concerns or feedback raised, either verbally and/or in writing

General Responsibilities

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.

- 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.

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

- Take responsibility for his/her own ongoing learning and development.

- 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.

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 Serious Adverse Incident Chairperson (2 PA's)

BASED AT: Beechfield House, Craigavon Area Hospital
The base hospital for this post is Craigavon Area Hospital however the post holder may be required to work on any site within the Trust.

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*** 1. Hold full registration with the GMC with a licence to practise[1]. 2. Have expert knowledge of health and social care delivery, legislative, professional and statutory requirements of clinical and social care governance demonstrated by achieving successful outcomes for a minimum of 2 years. 3. Have experience facilitating engagements with service users, relatives and carers who have had contact with a serious adverse incident or submitted a complaint to the Trust regarding service user safety. 4. Have experience leading on and conducting healthcare serious adverse incident reviews ***The following are essential criteria which will be measured during the interview stage.*** **KNOWLEDGE, TRAINING & SKILLS** 5. Experience conducting healthcare serious adverse incident

[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.*

	reviews that are proportionate, systematic and delivered in a timely manner
Other	1. Hold a full current driving licence valid for use in the UK and have access to a car on appointment[2]. 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*;

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

[2]*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

Corporate Complaints Officer Band 6

Southern Health and Social Care Trust

Quality Care - for you, with you

SOUTHERN HEALTH & SOCIAL CARE TRUST

JOB DESCRIPTION

JOB TITLE	Corporate Complaints Officer
BAND	Band 6
DIRECTORATE	Medical Director
INITIAL LOCATION	Craigavon Area Hospital
REPORTS TO	Corporate Clinical Governance and Social Care Coordinator
ACCOUNTABLE TO	Assistant Director of Clinical and Social Care Governance

JOB SUMMARY

The post holder will be responsible for the provision of delivering a high quality first point of contact for service users, sign posting them around the organisation, assisting them in problem solving and facilitating them to access and use the HSC complaints process. The post holder will ensure that best practice is adopted with regards to the management of patient/client complaints/feedback, ensuring that the complaints process is managed in an open and responsive manner.

The post holder will be responsible for screening service user contacts and determining if these are enquiries or complaints. They will facilitate either resolution of the enquiry or complaint following de-escalation to an informal enquiry/complaint or they will facilitate the service user in the process of the HSC formal complaints procedure. They will also provide the function for enquiries and complaints from external sources such as MLA's and DoH. The post holder will also provide significant support to the Directorate Governance offices in the management of complaints, alerting them to significant issues at an early stage and resolving those that can be managing through local clinical teams or provision of information.

The post holder will also produce a suite of Complaints and Compliment reports from the Clinical and Social Care Governance reporting system and Care Opinion. Reports will be created and adapted dependent on the audience and will identify key themes and areas for improvement. The post holder will escalate any exceptions to the relevant Directorates in both a Clinical and Non Clinical setting.

The role will also include management of administrative staff within the Clinical and Social Care Governance Team and the overseeing of administrative systems.

The post holder will also be responsible for the provision of training to Trust staff in relation to screening and managing complaints in an open, sensitive and responsive manner.

KEY DUTIES / RESPONSIBILITIES

Operational Delivery

1. To ensure all compliments, enquiries, complaints, and other forms of service user feedback are handled in accordance with Trust Policies and Procedures.

2. Develop and manage a screening system for all enquiries and complaints.

3. Audit and report on the implementation of enquiries and complaint procedures within the organisation to the Corporate Clinical and Social Care Governance Coordinator and Assistant Director of Clinical and Social Care Governance.

4. To receive and instigate responses to complaints from service users, their relatives or representatives, dealing with these in a timely, courteous and sensitive manner, providing support when necessary.

5. To liaise with a range of staff including the Directors, Assistant Directors, Consultant's, Heads of Service, Governance Coordinators and other healthcare professionals and ensure complaints are responded to appropriately including meeting the statutory timescales for producing complaints responses.

6. To draft and quality assure response letters to complaints based on information received from clinical and other staff or from patient records or other means and following up, when required to ensure all issues are adequately responded to. This will include monitoring of the Care Opinion feedback platform.

7. To collate and produce information on individual complaints when requested by the Ombudsman and produce any necessary documents, information and responses within the deadline set.

8. To act as the Directorate focal point for the co-ordination of complaint responses this may involve cross-directorate support and information.

9. Deliver training which includes the planning and coordination of various workshops and training days within the organisation as required relating to Being Open Customer Care, presentation to complaint trends and all elements of responding to complaints.

10. To develop and maintain a support network with all Directorate Complaints

Officers which will highlight and deliver training needs, allow timely circulation of learning from complaints, escalate complaint trends, ensure comprehensive report compilation and ensure all Directorates are supporting the culture of Being Open in all aspects of their role.

Work closely with the Clinical and Social Care Governance Officer to link any incidents with complaints.

11. Attend Clinical and Social Care Governance meetings as required to provide high quality support and information concerning those areas for which the post holder is responsible.

12. Attend Regional Complaints forums and provide information and analysis in relation to Trust and Regional key performance indicators and trends.

13. Provide cover to the Clinical and Social Care Governance office where applicable.

Information Management

1. To attend the Directorate and Divisional Governance Meetings as required and report on complaints, Care Opinion feedback and compliments.

2. To operate and manage the Datix database in relation to compliments and complaints ensuring the maintenance of good record keeping for each contact dealt with, ensuring that there is a evidence trail of the attempts to resolve and/or escalation to the appropriate Directorate and ensuring all relevant information is stored in a sensitive and secure manner.

3. Manage and monitor the Directorates use of the complaints element of the Datix system, liaising with relevant Heads of Service and the Information Technology Team to ensure standardisation, high quality information and data accuracy.

4. Produce a suite of complex reports for target audiences in relation to trends in complaints and tailor reports in response to ad hoc requests for specific analysis of information and validate all information as well as highlighting and escalating exceptions and trends to the Directorates in a timely way.

Key Working Relationships

1. To work closely with the Directorate Complaints Officers, communicating effectively regarding compliments, enquiries and complaints.

2. Liaise with clinical staff of all levels, patients and their families as well as those external to the Trust, including elected representatives, in an open, sensitive, confidential and appropriate manner.

3. Develop and maintain working relationships with senior colleagues to ensure achievement of corporate and directorate objectives.

4. Contribute to the Trust's overall governance processes to assure safe and effective care for patients and clients and compliance with public sector values and code of conduct.

Quality

1. Plan, co-ordinate and deliver complaints and 'Customer Care' training within the Directorate to specific teams, which is underpinned by the 'Being Open' ethos.

2. To promote and compile learning from complaints and liaise with services and management to ensure learning and other improvement measures are actioned and circulated via the Learning from Experience forum.

3. Audit and report on the implementation of learning from complaints within the Clinical and Social Care teams within the Directorates.

4. Inform the Assistant Director and Corporate Clinical and Social Care Governance Coordinator if any of the Clinical and Social Care Governance processes are sub optimal within the Directorates and assist with designing and implementing an improvement plan.

Financial and Resource Management

1. Ensure the effective implementation of all Trust financial policies and procedures as appropriate.

2. To be an authorised signatory for the Corporate Governance Team in respect of ordering of stock and authorisation of invoices.

3. Ensure the effective management of all staff reporting to the post holder and the appropriate use of all physical assets available.

Human Resources Management Responsibilities

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

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

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

3. Review the organisation plan and establishment level of the service for which he/she is responsible to ensure that each is consistent with achieving objectives, and recommend change where appropriate.

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

5. Participate, as required, in the selection and appointment of staff reporting to him/her in accordance with procedures laid down by the Trust.

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

7. 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.

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

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

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

11. 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.

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 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.

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.

9. 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.

10. 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.

SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE Corporate Complaints Officer

DIRECTORATE Medical Director

SALARY Band 6

HOURS 37.5 hpw

Notes to applicants:

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

ESSENTIAL CRITERIA

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

Factor	Criteria	Method of Assessment
Qualifications/ Registration and Experience	1. Relevant, Degree or recognised professional qualification or equivalent / Higher qualification AND 2 years' experience in a role involving dealing directly with patients and relatives and communicating with external stakeholders and/or risk management. 2. **OR** HNC / HND or equivalent / higher qualification AND 3 years' experience in a role involving dealing directly with patients and relatives and communicating with external stakeholders and/or risk management.	Shortlisting by Application Form

	3. **OR** 5 years' experience in a role involving dealing directly with patients and relatives and communicating with external stakeholders and/or risk management. 4. Experience in the use of Microsoft office products including Word, Excel, Outlook and PowerPoint. Specifically in relation to the management and presentation of data within Excel. 5. Experience in staff 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/ Knowledge	1. Have an excellent understanding of Clinical and Social Care Governance within the Trust setting 2. Effective Planning & Organisational skills with an ability to prioritise own workload 3. Highly effective Communications skills to meet the needs of the post in full and the ability to deal with difficult and/or distressing situations. 4. Ability to constructively question and challenge existing practices. 5. Ability to effectively manage and lead a team. 6. Ability to identify solutions to problems and implement them effectively. 7. Ability to work to tight timescales whilst meeting targets.	Interview

DESIRABLE CRITERIA		
SECTION 3: these will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these criteria. Failure to do so may result in you not being shortlisted		
Factor	**Criteria**	**Method of Assessment**
Experience	• At least one year's staff management within a Health and Social Care setting	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.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Successful applicants may be required to attend for a Health Assessment

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

Southern Health and Social Care Trust

Quality Care - for you, with you

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

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

Southern Health and Social Care Trust

Quality Care - for you, with you

#teamSHSCT
#bettertogether

Follow us on:

WORKING TOGETHER · EXCELLENCE · COMPASSION · OPENNESS & HONESTY

PATIENT SAFETY & CLINCAL AUDIT RESOURCING PROPOSAL (new posts)

STRENGTHENING STRUCTURE & FUNCTION

Medical Directorate

March 2022

Approved in principle by SMT 18/01/2022

Table of Contents

1. Purpose of paper

The paper sits within the context of the Clinical & Social Care (CSCG) Governance Review 2019 and the CSCG structure and function proposal 2020. It's purpose is to;

1. Outline **benefits** and **challenges** of separating the patient safety and clinical audit functions currently provided within a single, mixed function team;
2. To detail the **additional resources** required to strengthen both these functions in the role of providing assurance of safe and effective care;
3. Provide high level detail on the additional resourcing required to deliver re-aligned and re-purposed structures.
4. Provide an indicative costing for the proposal of:

- The Full Year additional cost of Enhancement of the Patient Safety Data and Improvement Team is £378,844 or £ 390,209 after an allowance of 3% for the 2021/22 Pay Award.
- The Current year effect 2022/23 for the Enhancement of the Patient Safety Data and Improvement Team is £ 212,,051 or £218,413 after an allowance of 3% for the 2021/22 Pay Award.
- The Full Year additional cost of Establishing a Clinical Audit Team is £352,199 or £362,765 after an allowance of 3% for the 2021/22 Pay Award.
- The Current year effect 2022/23 of Establishing a Clinical Audit Team is £150,367 or £154,878 after an allowance of 3% for the 2021/22 Pay Award.

2. Introduction

2.1 Good Governance[1]

Is the framework for assurance, decision-making, accountability, and optimal use of resources, which provides a safe and supportive environment for the delivery of high quality care to patients, service users, and citizens. Governance covers the culture, vision, values, structures, policies, processes and over-arching assurance framework that support an organisation to take decisions and meet agreed strategic objectives.

[1] Good Governance Handbook, Healthcare Quality Improvement Partnership (HQIP) and the Good Governance Institute (GGI) March 2021

(See Figure 1).

The good governance elements that relate specifically to this proposal include;

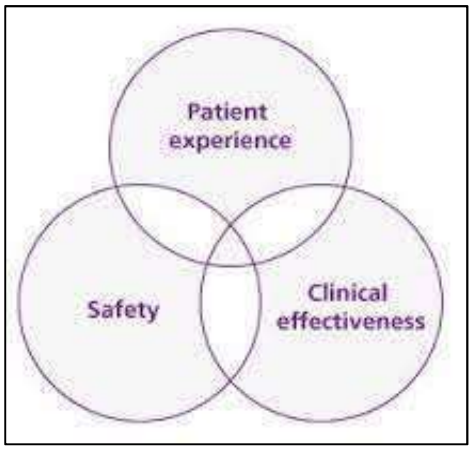
- Quality & Safety: Systems and Structure and
- Effectiveness and Added Value (audit)

Figure 1: The 10 Key Elements of Good Governance

2.2. Clinical and Social Care Governance.

Clinical governance is “a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." (Scally and Donaldson, 1998). Within public healthcare services in Northern Ireland we can expand this definition to include social care governance. Clinical and Social Care governance is an umbrella term. It describes activities that not only sustain and continuously improve high standards of patient care, but also provide quality assurance.

2.3 Quality, Improvement and Assurance



Lord Darzi (2008) defined **'High quality care for all: NHS next stage review'** under the three dimensions in **Figure 2**, which must all be present to provide a high quality service:

Figure 2: Dimensions of High Quality Care

- **Patient experience**: quality care is delivered for a positive experience, including being treated according to individual wants or needs, and with compassion, dignity, and respect.
- **Clinical effectiveness**: quality care is delivered according to the best evidence regarding what is clinically effective in improving an individual's health outcomes
- **Patient safety**: quality care is delivered to prevent all avoidable harm and risks to an individual's safety.

Two other areas of work within quality are also recognised within health and social care organisations;

- **Quality improvement** in healthcare is a process that seeks to enhance patient experience and individual health outcomes, through measuring and improving the effectiveness and safety of clinical services.
- **Quality assurance** in healthcare is the planned and systematic monitoring of activity to ensure that the standards for safe, clinically effective services and positive patient experience are met.

3. The Current Patient Safety Function - CSCG

The Patient Safety function of the CSCG Division of the Medical Director's Office currently comprises of:

- **Clinical Audit** – National Audit Programmes, central audit registry and NCEPOD local reporter role
- **Patient Safety Peer Review Process** – Mortality and Morbidity (M&M) outcome

review

- **Patient Safety Indicator Monitoring** – Continuous surveillance of key patient safety indicators e.g. Falls, VTE assessment, Pressure Ulcers
- **Clinical Guidelines** – Maintenance of the central repository for locally developed / adopted guidelines for aspects of care[2]

Currently the Patient Safety Data and Improvement Team has a role in each function, however lack of capacity has, over time prevented a robust focus on clinical audit and full facilitation of the Patient Safety Peer Review Process.

Figure 1 on page 2 includes **quality, safety** and **audit** as key elements integral to good governance, as their role in improvement and assurance underpins quality service provision, part of the over-riding objective of safe and effective care.

This proposal in addition to the identified investment for a dedicated and strengthened clinical audit function also seeks to enhance the current Patient Safety Data and Improvement Team to ensure the patient safety function is adequately supported, facilitated and resourced.

3.1. Clinical Audit: Role, Function and Audit Cycle

The role of clinical audit as a tool for governance sits in context of the SHSCT Board Assurance Framework (BAF) where clinical audit has a key role to play across the three lines of defence at departmental, organisational oversight and independent external review levels. These three lines of defence provide assurance to Trust Board on the quality and safety of care. The following excerpts state it's endorsement as an accepted core organisational governance function.

'Clinical audit needs to capture the imagination of boards, clinicians and commissioners as a worthy, cost effective and successful endeavour. It needs to provide assurance of safe and improving service delivery both within and beyond professional, departmental and organisational boundaries'[3]

'Clinical audit is a significant mechanism for providing assurance on the quality of services provided. It also contributes to a) a culture of safety and b) an

[2] This function is due to transfer to Management of Standards, Risk and Learning
[3] Clinical audit: a guide for NHS boards and partners, HQIP March 2021, page 3

organisational system of learning and development'[4].

'a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement.'[5]

HQIP[6] a leading authority on clinical audit, defines clinical audit as a quality improvement cycle that involves **measurement of the effectiveness** of healthcare against agreed and proven standards for high quality, and **taking action** to bring practice in line with these standards so as to improve the quality of care and health outcomes. **Figure 3** demonstrates the four stages of the clinical audit cycle:

Stage 1: Preparation and Planning: to agree required standards and clinical audit methodology

Stage 2: Measuring Performance: data collection in order to evaluate performance against required standards

Stage 3: Implementing Change: using action planning where shortfalls are identified

Stage 4: Sustaining Improvement: through monitoring and service development, with repeated clinical audit cycles as required

Clinical audit against evidence-based standards as part of an ongoing, planned annual quality assurance programme ensures that high quality care is being delivered. Support of this core function across the organisation is therefore required.

Figure 3: Stages of the Audit Cycle

[4] Vincent, C. Burnett, S and Carthy, K @ Health Foundation (2013).
[5] The National Institute for Health and Clinical Excellence (NICE) published 'Principles for Best Practice in Clinical Audit', 2002
[6] The Healthcare Quality Improvement Partnership (HQIP) was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality improvement. We are an independent organisation led by the Academy of Medical Royal Colleges, The Royal College of Nursing and National Voices.

3.2. Current Challenges for Clinical Audit

Since 2015/2016[7] a number or reports have highlighted and identified that a strengthened clinical audit function in SHSCT is required. This is to facilitate and provide assurance (across the organisation) that the four stage audit function and it's governance is embedded and operating effectively. Firstly in each directorate at a local level in relation to SHSCT designed and based audits, through to larger cross directorate or regional audits and participation in full scale National Programmes.
Most significantly the Clinical Audit Strategy (2018) acknowledged that there was insufficient resourcing to support the audit function and programmes.

As will be set out in section 4 the current staffing resource sits within a mixed function patient safety data and improvement team. As an estimate the equivalent of 0.5 – 1 w.t.e post within this complement currently supports the clinical audit function[8]. There is no resource for ensuring access to health records for audit. Therefore additional investment remains the requirement to support strengthened and improved systems and process for designing, implementing and undertaking clinical audit programmes as well as the governance and monitoring of those programmes.

Whilst the 2018 Strategy identified administrative support, it is acknowledged that infrastructure is also required at a clinical audit / QI lead level to create an

[7] Internal audit Report 2015/16, 2018 Clinical Audit Strategy and the CSCG Governance Review
[8] NCEPOD Local Reporter Role and part of facilitator role in supporting Specialty Patient Safety Meetings

organisational network of clinical leaders and champions. The latter investment is being progressed via the recent medical leadership proposals). The 2020 CSCG paper set out an initial proposal for a centralised clinical audit team, working alongside directorates to support and facilitate clinical audit activity.

Since Sept 2020, the Medical Director has established a Systems Assurance Division, charged with progressing the clinical audit function[9] aspect of the 2020 CSCG paper. As a result this paper proposes the removal of clinical audit from the mixed function CSCG Patient Safety Data and Improvement Team to allow both to be developed, and re-aligned in order to perform the required organisational functions. This proposal recommends that a separate team function be established and dedicated to provide focus on this work, in the short to medium term (1 – 5 years).

High level systems and processes need to be strengthened that govern and report clinical audit performance to relevant Trust Board Committees (currently Governance Committee), highlighting priorities, gaps, risks and areas of best practice.

A strengthened clinical audit function requires as a matter of priority:

- Updated Clinical Audit Strategy
- Clinical Audit Policy and Procedures
- Clinical Audit Resource Plan (outlined in this proposal)
- Clinical Audit Training Plan
- Assurance Reporting Schedule

4.0. Patient Safety Function: (Morbidity & Mortality)

There are many different methods available for studying adverse events that arise within a healthcare system; studying Mortality and Morbidity (M&M) outcomes aims to reduce the frequency of these events through learning from past experience and changing practice. It is therefore important that Trusts demonstrate they are systematically and continuously reviewing patient outcomes.

In October, 2018 the SHSCT adopted regional guidance (DoH 2016) for the Regional Mortality and Morbidity (M&M) Process. The key aims outlined in the Regional Policy

[9] 0.6 w.t.e Head of Clinical Audit Post approved July 2021 to establish the strategic direction and governance function.

and subsequent SHSCT Guidance were to;

- Outline expectations and provide guidance and direction on systems and processes for mortality and morbidity functions within Trusts.
- 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.

Although there is still additional developmental work required to fulfil all the requirements, the Trust is making steady process to comply with the regional process. A staff team of 4.6 w.t.e supports this and the clinical audit function across Bands 7 – 3.

4.1. The SHSCT Patient Safety Peer Review Process.

There are several elements included in this process;

a) Specialty Mortality Review and Patient Safety Meetings, (SMR&PS meetings), known as M&M Meetings.
b) The M&M Chairs and Strategic Oversight Group meetings
c) Use of the Regional Mortality and Morbidity Review system (RM&MRs)
d) Random Case Selection
e) Introduction of the Structured Judgment Review (SJR) Process

4.1.1. Specialty Mortality Review and Patient Safety Meetings, (SMR&PS meetings), known locally as 'M&M' or 'Patient Safety' Meetings.

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.'***

There are key areas to be reviewed as outlined in **Appendix 1.**

The M & M Meeting Structure, including the break-down and number of M&M meetings (as of November 2021) are shown in **Appendix 2.**

4.1.2. Linkages to 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"*

Attendance and participation in M&M meetings plays 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.

4.1.3. The M &M Chairs and Strategic Oversight Group meetings

The M&M Chairs meetings are held quarterly, with main responsibilities to:

- Inform the further development of arrangements and processes for sharing best practice and learning arising from M&M.
- Provide advice on the management of specialty M&M meetings, identifying areas for organisational improvement.
- Ensure the effective management of specialty M&M meetings, in line with the Regional M&M guidance, providing an early alert within operational directorate governance arrangements and to the Medical Director, where appropriate
- Promote key actions arising from the RM&MRS database

The Strategic Oversight Group.

The forum was set up to provide assurance and oversight of the M&M process, attendance and outcomes. This is corporately led, multi-disciplinary in nature with attendees drawn from senior medical and nursing management, along with Directors and governance senior staff. In addition they 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).
- High level issues arising from the M&M meetings
- Consideration of learning outcomes and potential improvements.
- Monitoring progress of regional and Internal audits in relation to the M&M process and subsequent action plans.

4.2. 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 to identify and analyze the causes of harm, learning and thus avoiding the repeating of harm."
- Monitoring of expected timescales for each functions above.

5.0. Patient Safety Indicator Monitoring

This role is carried out by the Patient Safety Assurance Manager (1.0.w.t.e, Band 6) with part-time administrative support. The function of this post is to hold a comprehensive portfolio of long-term patient safety audits and quality indicators. This includes reporting on compliance of targets relating to;

- The Deteriorating Patient, (NEWS2),
- Regional QI Sepsis work
- WHO Surgical Checklist
- MUST
- Ventilator Associated Pneumonia
- Crash Call
- Falls, Pressure Ulcers, Delirium, VTE, Surgical Site Infection
- Stroke
- Critical Meds

6.0. Clinical guidelines

The maintenance of the central repository for locally developed / adopted clinical guidelines is currently provided by a Patient Safety and Guideline Support Officer (1.0.wte, Band 4). Approximately 20 hours (53%) of this post is aligned to this function,

with the remainder aligned to M&M support. As part of the proposed structural changes, the clinical guideline system maintenance component of this post will transition to the Medical Directorate's new Standards, Risk and Learning service. The plan is that with additional funding for 17.5 hours (47% and outside of this proposal paper) this post will be retained as a full time Senior Governance Assistant post (Band 4) whose role will support the wider standards, risk and learning remit. Within the Patient Safety Data and Improvement Team an additional 20 hours of funding will be required to secure a full time Band 4 post that will be used to focus solely on M&M support.

7.0. Current Challenges: Patient Safety Data and Improvement Team

There are significant challenges within the Patient Safety Data and Improvement Team which need additional resources, restructuring and job planning to resolve.
These include;

- Current staffing levels have prevented facilitation of sub-specialty M&M meetings, leading to delays in completing administration tasks, extract learning and ensure performance processes are completed as per regional M&M guidance.
- The Patient Safety and Improvement Team[10] have only 3 staff members (2.8 wte) providing facilitation to 10 key meetings and there is minimal administrative support for this function, currently, provided by 2 x Band 4s (1.8 wte), and 1 x Band 3 (1 wte). Facilitators are working to maximum capacity and therefore additional staff, (at the appropriate grade) are required to provide increased support. Additional staff would be 2 x wte Band 5 facilitators and 1 x wte Band 4 support

Appendix 3 shows meetings supported by a facilitator and those with ad-hoc or no support.

- The level of work required to facilitate an M&M meeting can be substantial and is intensive before, during and after meetings. It is the close working with meeting Chairs, timely preparation and production of documentation that makes

[10] Led by 1 x 8b Head of Patient Safety Data & Improvement

this role so beneficial.

- A lack of clarity in relation to roles and responsibilities with different bandings carrying out similar functions. Staff members, for a variety of historical job role reasons, have also developed discrete areas of directorate work and therefore cross cover, contingency and succession planning is difficult. The workload is also disproportionately distributed.
- System level improvement capturing trends in data, collating, triangulating and sharing learning for potential service improvement have not been possible within the current structure. This includes Trust-wide patient safety strategy development and implementation.
- There is a need for a designated team lead post to bring the team together and manage HR requirements, e.g. recruitment, supervision, appraisal, training, application of policies and guidance in relation to staffing.
- Whilst M&M processes are in place, the required timescales for Consultant review and discussion at M&M groups is not consistently followed[11] and some deaths have not been reviewed or discussed at M&M meetings as required. Furthermore, the process is not yet capturing learning in consistent and effective manner. Therefore, this is a manual function provided by the Patient Safety and Improvement Team.
- The COVID-19 pandemic has required daily reporting of deaths to the PHA since April 2020 including all week-ends and bank holidays. This became part of the remit of the team and is provided by only 3 members of staff and senior cover by the HoS for the team. Although remunerated, it is entirely voluntary to participate, and despite efforts to increase staff on this small rota, this has not been possible for 19 months.
- New interim arrangements have been put in place during the pandemic.. This has resulted in additional workload for those with a M&M support function, who are working with minimal or no additional support. This has increased the length of meetings, and can also lead to accumulation of cases requiring review, again increasing workloads for facilitators.
- The Patient Safety Indicator Monitor function is provided by 1 member with no

[11] Monitoring against timescales is not supported by an RM&MRS reporting tool and so pilot internal systems have to be developed to undertake this function.

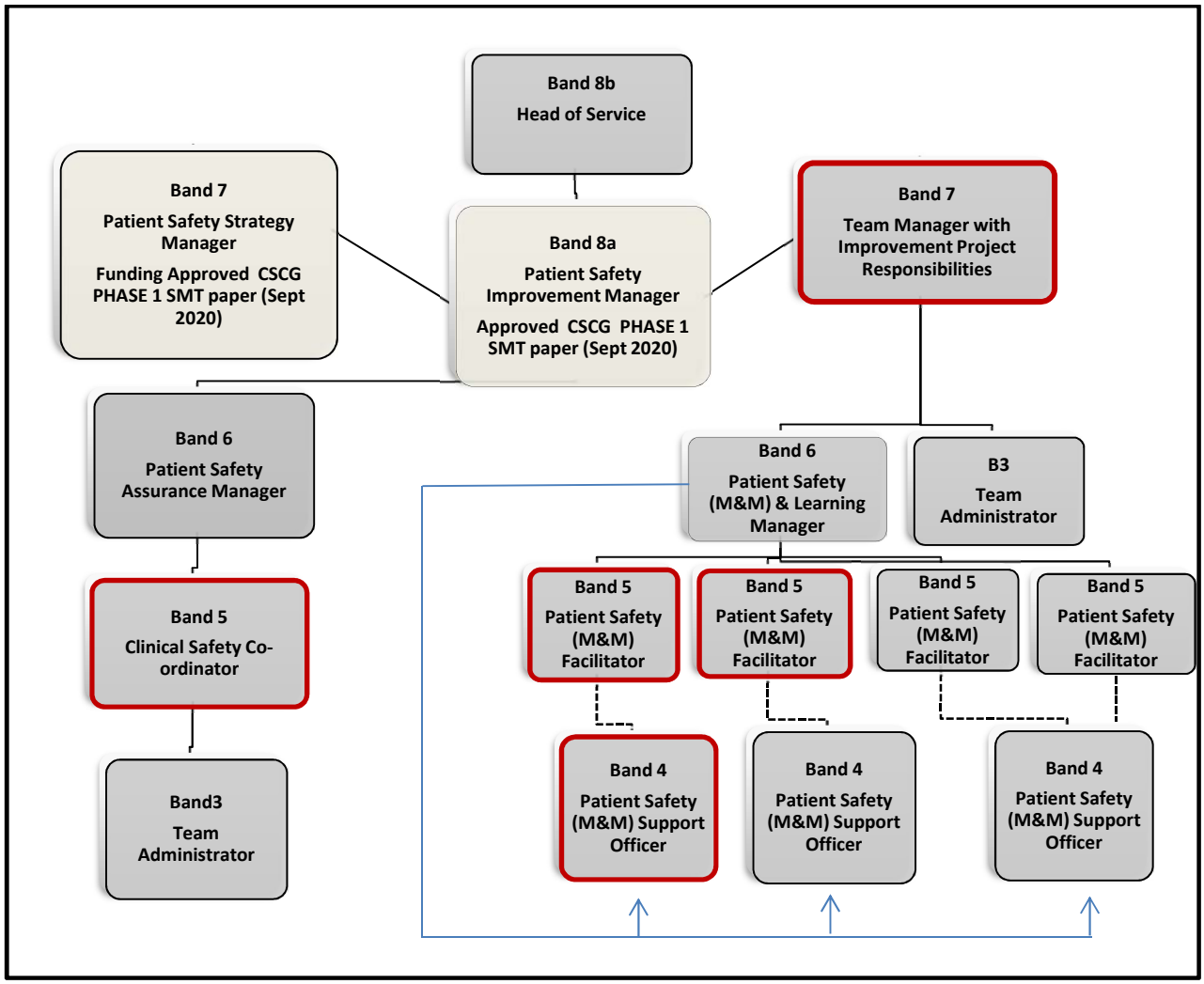
cross cover or contingency planning.

8. Patient Safety Data & Improvement Team – Proposed New Structure (existing and additional posts)

A major difficulty within the team's function was the inability to fulfil its audit function due to lack of capacity. With additional resources and new posts a greater number of M&Ms could be facilitated and improvement initiatives taken forward.

Figure 3 outlines the proposed new structure. Existing staff (grey), Posts approved 20/21 (taupe, noted on diagram) and new (red).

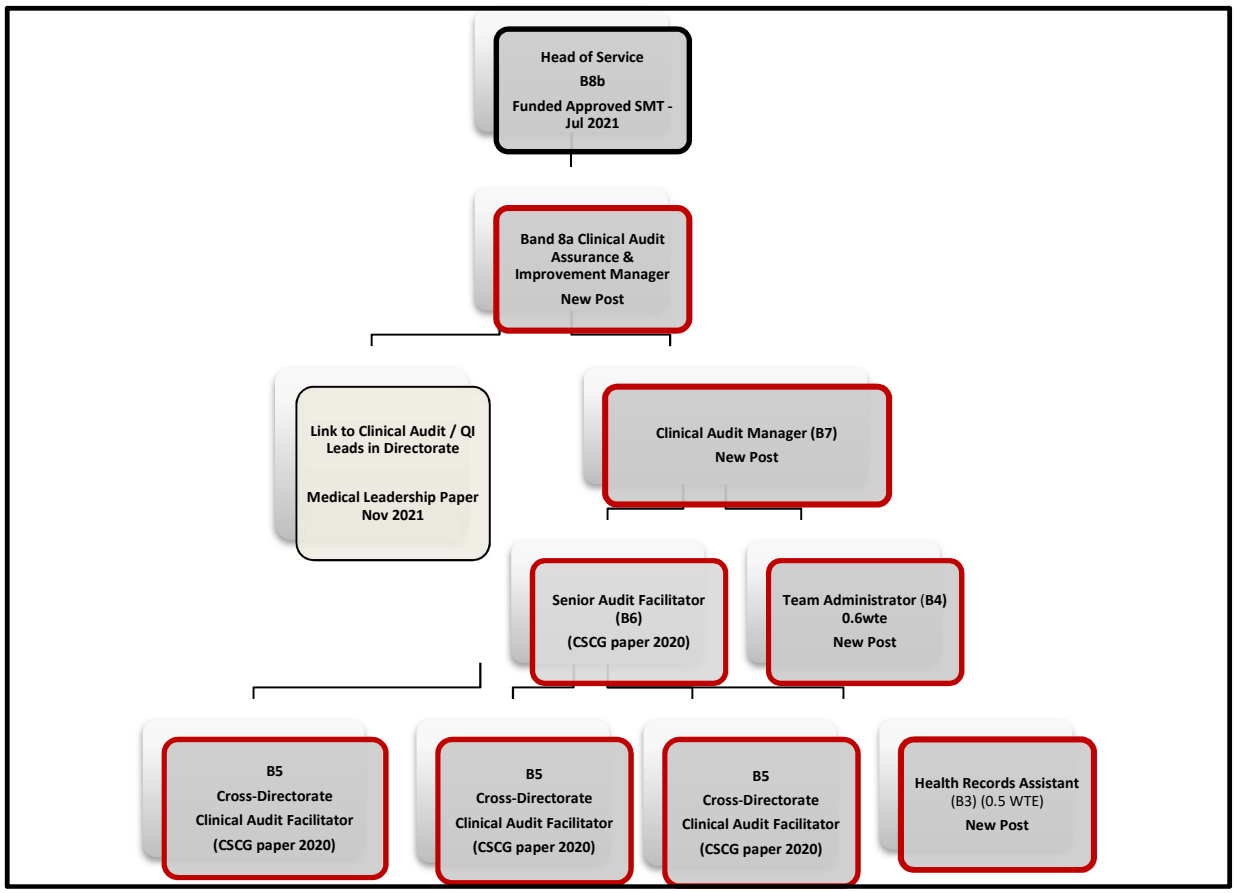
Figure 3: Existing & Proposed Additional Staff



9. Patient Safety Data & Improvement Team – New Staff Functions

Role Title	Band	High Level Responsibilities
Patient Safety Data and Improvement Manager (post approved Sept 2020)	8a	- Improving patient safety as a recommendation of the Inquiry into Hyponatreamia Related Deaths - Underpin Trust's strategic aims and objectives to promote a Trust safety culture that is progressive and values driven. - Responsible for leading the improvement and development of the Trust's Corporate Patient Safety Team a - Be a key support to the timely and effective provision and communication of a corporate safety analysis service.
Patient Safety Strategy Manager (post approved Sept 2020)	7	- Implementation of the New SHSCT Patient Safety Strategy - Monitoring of the Patient Safety Strategy
Patient Safety & Improvement Team Manager (with improvement project responsibilities)	7	- Manage the Patient Safety and Improvement Team - Implement and monitor compliance with HR Policies, Procedures and Guidance, including supervision, appraisal, performance management, leave and overtime. - Develop a training plan for the team - Clarify roles, responsibilities and processes within the team - Oversee and report on key team functions - Oversee, and participate in. service improvement initiatives.
Clinical Patient Safety Co-ordinator	5	- Work along-side the Patient Safety Assurance Manager to: - Ensure long-term patient safety audits and quality indicators are met including reporting on compliance of targets, identifying trends and be involved with resulting service improvement initiatives. - Produce reports, spreadsheets and data in relation to patient safety indicators. - Take part in COVID19 reporting on rota
Patient Safety (M&M) Facilitator x 2	5	- Work within a pool of Facilitators, covering leave when required, - Facilitate allocated M&M meetings, including liaison with M&M leads, recording notes and learning from meetings, recording attendances, organising presentations, retrieving notes and other duties. - Extract Learning to contribute to learning data bases and dissemination - Contribute to service improvement projects as directed by line management - Supervise Band 4 staff where allocated. - Take part in COVID19 reporting on rota
Patient Safety (M&M) Support Officer x 1.53	4	- Work with the Patient Safety Facilitator in their M&M role, providing administrative support.

10. Clinical Audit - Proposed New Team Structure



11. Clinical Audit - New Staff Functions

Role Title	Band	High Level Responsibilities
Clinical Audit Assurance & Improvement Manager (New Post)	8a	- Promote clinical engagement – clinical directorate leads required as part of medical leadership model and to strengthen professional governance. - Ensure operational directorate engagement and ownership. This will require a formal communication links to be established via governance forums or the re-instated of directorate level clinical audit committees. - Establish clinical audit links within CSCG to Standards and Guidelines, Patient Safety Meetings and Serious Adverse Incidents and across organisational directorates and to quality improvement priorities and QI support. - Promote connections to the audit divisions and activities of other corporate directorates e.g. nursing and finance to maximise efficiencies and share audit findings, intelligence and learning. . - Overseeing strengthening assurance processes and reporting to appropriate fora. - Development of the clinical audit improvement programme
Clinical Audit Manager (New post)	7	The Clinical Audit Manager is responsible for: - The day-to-day operational matters in relation to delivery of the Clinical Audit Programme and line management of the Trust's team of Clinical Audit Facilitators. - The performance reporting of the clinical audit function - Trust's requirements as NCEPOD local reporter - Developing the clinical audit training plan and resource library
Senior Clinical Audit facilitator (Training & Facilitation) (New Post) (Funding Phase 2 CSCG Paper Sept 2020)	6	The Senior facilitator is responsible for working closely with the clinical audit manager in the management and delivery of the clinical audit function throughout the Trust. - Project manage specific aspects of the Trust's prioritised work programme and have lead responsibility for the monitoring and progression of same. - Participate in the monitoring and reporting on the work plan for the clinical audit functions. - Provide advice, guidance and facilitation to multidisciplinary teams undertaking audit projects in respect of project design and the development of project techniques. - Manage the allocation of clinical audit facilitation staff to individual audit projects. - Plan and oversee the delivery of the Trust clinical audit training programme. - Responsible for the maintenance of the clinical audit programme management

Clinical Audit Facilitator Phased (3 new posts) (Funding Phase 2 CSCG Paper Sept 2020)	5	Clinical Audit Facilitators will: - Assist clinical staff with the completion of audit paperwork and information governance requirements - Register the project on the trust clinical audit database - Reach agreement with the specialty audit convener and the audit project lead as to the level of support that the facilitator can provide to the project – the decision will take account of Divisional and Trust priorities This advice and support may include the following: a) Appropriate methodology for the proposed project b) Literature searching and developing measurable clinical standards c) Design of audit tools d) Choosing sample size e) Organising availability of clinical case-notes f) Extraction of data from hospital information systems (where available) g) Data analysis and reporting h) Producing presentation materials - Monitor the progress of registered audits - Participate in and help organise meetings within the Division to allow presentation of audit proposals and results - Attend Divisional Governance/Quality meetings to enable the discussion and escalation of issues relating to clinical audit activity
Team Administrator (0.6 WTE) (New Post)	4	- To provide a comprehensive and supporting administrative function to the clinical audit team - Maintenance of the central clinical audit repository and reporting
Health Records Assistant (Equivalent Funding 0.5 WTE Post)	3	Equivalent funding within support services division to ensure year round access to adequate medical records resource. It is essential to facilitate audit programme submissions that chart / note retrieval is timely to enable clinician / professional reviewer access to charts and records.

12. Cost & Benefits of New Posts

New Posts for Enhanced Patient Safety Data & Improvement Team (CYE is the 2022/23 expected cost of Option 2, the preferred option)				
Post	**Band**	**Benefits**	**Current Effect (2022/23)**	**Full Year Cost**
Patient Safety Data and Improvement Manager (post approved Sept 2020)	8a	- Improving patient safety as a recommendation of the Inquiry into Hyponatreamia Related Deaths - Underpin Trust's strategic aims and objectives to promote a Trust safety culture that is progressive and values driven. - Responsible for leading the improvement and development of the Trust's Corporate Patient Safety Team a - Be a key support to the timely and effective provision and communication of a corporate safety analysis service.		
Patient Safety Strategy Manager (post approved Sept 2020)	7	- Implementation of the New SHSCT Patient Safety Strategy - Monitoring of the Patient Safety Strategy		
Patient Safety & Improvement Team Manager (with improvement project responsibilities	**7**	- Improved team working and motivation - Establishment and implementation of robust operational policies and procedures - Development of clear roles, responsibilities and functions within the team currently required - Provide work plans and training plans for members of staff and a robust induction plan not available at present		
Clinical Patient Safety Co-ordinator	**5**	- Increased support for Patient Safety Assurance Manager to enable further analysis of trends and improvement initiatives. - Increased availability for COVID19 reporting		
Patient Safety Facilitators - 2.00 WTE	**5**	- Increased facilitation and support to existing and new M&M meetings - Increased availability for COVID19 reporting		
Patient Safety Support - 1.53 WTE	**4**	- Provide support to Patient Safety Facilitators relating to their M&M function.		
Total – at 2021/22 rates prior to Pay Award				
3% Allowance for 2021/22 pay award				
Total – after allowance for 2021/22 Pay Award				

Irrelevant information redacted by the USI

Clinical Audit Team				
Post	**Band**	**Benefits**	Current Year Effect (2022/23)	Full Year Cost
Clinical Audit Assurance & Improvement Manager	**8a**	Strengthened assurance of clinical audit function as part of board assurance framework	50,301	67,068
Clinical Audit Manager	**7**	Audit function and team performance management	48,083	64,110
Senior Clinical Audit Facilitator (Training & Facilitation)	**6**	Training programme design and delivery. Project management of prioritised audit programmes	40,802	54,402
Clinical Audit Facilitator 3.00 WTE	**5**	Improved support directly to clinical leads in the delivery of audit programmes	0	131,166
Team Administrator 0.60 WTE	**4**	Delivery of a robust administrative system to support the team objectives and maintenance of central repository.	0	20,545
Health Records Support 0.50 WTE	**3**	Essential component in the design and delivery of clinical audit programmes is timely access to records	11,181	14,908
Total – at 2021/22 rates prior to Pay Award			**£150,367**	**£352,199**
3% Allowance for 2021/22 pay award			*4,511*	*10,566*
Total – after allowance for 2021/22 Pay Award			**£154,878**	**£362,765**

13. Options Summary

Option 1 – Do Nothing – No Investment in Additional Resourcing

Option 2 – Phased approach to investment and additional funding over 2 years

- A number of staff in each team will not be appointed until 01 April 2023 - Year 1 (2023/24)
- As all the identified additional staff have not yet been appointed all of the year 0 staff are assumed to be in place from June 2022 with 9 months Current Year Effect

Option 3 - Funding for resourcing is agreed as proposed (not phased)

- As all the identified additional staff have not yet been appointed so all are assumed to be in place from June 2022 with 9 months Current Year Effect

SECTION 14: MONETARY COSTS AND BENEFITS OF OPTIONS

Option 1: Status Quo	**Year 0 22/23 £ 000**	**Year 1 23/24 £ 000**	**Year 2 24/25 £ 000**	**Year 3 25/26 £ 000**	**Year 4 26/27 £ 000**	**Year 5 27/28 £ 000**	**Totals £ 000**
Capital Costs							
Capital Cost							
(a) Total Capital Cost	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Revenue Costs							
Baseline Costs	7,253.8	7,253.8	7,253.8	7,253.8	7,253.8	7,253.8	43,522.8
(b) Total Revenue Cost	**7,253.8**	**7,253.8**	**7,253.8**	**7,253.8**	**7,253.8**	**7,253.8**	**43,522.8**
(c) Total Cost = (a) + (b)	**7,253.8**	**7,253.8**	**7,253.8**	**7,253.8**	**7,253.8**	**7,253.8**	**43,522.8**
(d) Disc Factor @ 3.5%pa	*1.0000*	*0.9662*	*0.9335*	*0.9019*	*0.8714*	*0.8420*	
(e) NPC = (c) x (d)	**7,253.8**	**7,008.6**	**6,771.4**	**6,542.2**	**6,321.0**	**6,107.7**	**40,004.7**

COST ASSUMPTIONS:

Financial Assumptions:

1. Year 0 is 2022/23 Financial Year.
2. The baseline for this Service is the 2021/22 recurring revenue budget for the HR Directorate (CH4000) of the SHSCT, increased by 3% for inflation.
3. No other revenue or capital costs are associated with this option
4. A discount factor @3.5% pa has been applied to calculate the NPC.
5. All figures have been rounded to thousands and shown to one decimal place.
6. Total Net Present Cost (NPC) equates to £40,004.7k for this option.

Option 2: Phased approach to investment and additional funding over 2 years	**Year 0 22/23 £ 000**	**Year 1 23/24 £ 000**	**Year 2 24/25 £ 000**	**Year 3 25/26 £ 000**	**Year 4 26/27 £ 000**	**Year 5 27/28 £ 000**	**Totals £ 000**
Capital Costs							
(a) Total Capital Cost	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Revenue Costs							
Baseline Costs	7,253.8	7,253.8	7,253.8	7,253.8	7,253.8	7,253.8	43,522.8
New Posts for Enhanced Patient Safety Data & Improvement Team	212.1	378.8	378.8	378.8	378.8	378.8	2,106.1
New Posts for Clinical Audit Team	150.4	352.2	352.2	352.2	352.2	352.2	1,911.4
(b) Total Revenue Cost	**7,616.3**	**7,984.8**	**7,984.8**	**7,984.8**	**7,984.8**	**7,984.8**	**47,540.3**
(c) Total Cost = (a) + (b)	**7,616.3**	**7,984.8**	**7,984.8**	**7,984.8**	**7,984.8**	**7,984.8**	**47,540.3**
(d) Disc Factor @ 3.5%pa	*1.0000*	*0.9662*	*0.9335*	*0.9019*	*0.8714*	*0.8420*	
(e) NPC = (c) x (d)	**7,616.3**	**7,714.9**	**7,453.8**	**7,201.5**	**6,958.0**	**6,723.2**	**43,667.7**

COST ASSUMPTIONS:

Financial Assumptions:

1. Year 0 is 2022/23 Financial Year.
2. The baseline for this Service is the 2021/22 recurring revenue budget for the HR Directorate (CH4000) of the SHSCT, increased by 3% for inflation.
3. The cost of the staff identified in section 3 is per HSCB Costings 2021/22, Version 1
4. The staff costs include Employee related G&S but exclude any provision for Unsocial Hours or Excess Travel or Annual Leave/Sickness cover.
5. As all the identified additional staff have not yet been appointed all of the year 0 staff are assumed to be in place from June 2022 with 9 months Current Year Effect. The Year 1 staff are assumed to have a £Nil current year effect and a 12 month full year effect from 2023/24.
6. There are no Capital costs in this option.
7. We applied a discount factor @3.5% pa to calculate the NPC.
8. All figures are rounded to thousands and shown to one decimal place.
9. Total Net Present Cost (NPC) equates to £43,667.7k for this option
10. The additional Current Year cost of this option will be £362,418 or £373,291 after a 3% allowance for a 2021/22 Pay Award