final pathway to diagnosis code. This information will later be joined to the start point derived at the beginning of the algorithm.

The code creates a variable ('IPOP_Merged') which merges an Inpatient or Outpatient identifier with the final referral/admission source to form one third of the final pathway code.

Next the code creates a Pathway Grouping which will form the last third of the final pathway to diagnosis code. This grouping is based on the presence of inpatient and/or outpatient activity in the 6 months prior to the date of diagnosis. The pathway groups, A-E, have been detailed above.

With the three elements of the final pathway code now calculated ('Diagnosis_path', 'Pathway_Grouping' and 'IPOP_Merged_Source') the code concatenates this information into a single variable (route_code).

The code next aggregates these codes into 8 categories that can be used for analysis. The code uses a lookup file (RTD_Source_to_Route_Lookup) to carry out this aggregation. Details on the mapping of these categories have been included above.

If any cases have not been assigned they should be checked manually to determine which portion of the code contains an error.

10. Check for Screening Data

Screening information for NI cases is being collected from two sources – the outpatient hospital activity file and the NICR extract. This is different to PHE.

The majority of the screen flags come from the NICR who have validated cases directly with the breast, cervical and colorectal screening services. There are also a number of extra cases picked up through the outpatient activity file. These cases should primarily be cases referred in from Action Cancer (breast cancer only). There is no equivalent to these cases in England but they are being counted for NI as they constitute a valid route to diagnosis.

The code looks for any cases where the 'Screen' variable on the NICR extract that are classified as 'screen detected' and flags them.

11. Check for Suspect Red Flag Data

This code is used to identify cases which have been in receipt of a red flag cancer referral. For the PHE research this pathway was known as the Two Week Wait (TWW) pathway, reflecting the English target. For NI all red flags have been matched, including consultant upgrades and 'other'. The other group may include cases coming from other consultants or the likes of Action Cancer.

The code matches the NICR tumour level data to the Cancer Patient Pathway System data and identifies red flag referrals where there the date of decision to treat within 62 days prior to or 31 days after the date of diagnosis. These patients are flagged as red flag referrals.

The 62/31 day thresholds around these dates could potentially be revised in future iterations of the Northern Ireland analysis to better fit average waiting times in the Northern Ireland health care system.

12. Derive Final Route

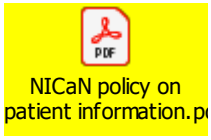
The final step carried out here is to override and previously defined routes with the screening and red flag referral information.

The code then produces a table to show the number of cases for each pathway for the year in question.

Once a year has been done, rename the table at with the year appended onto the end. Repeat the above steps for each year being analysed.

Finally, run the code entitled **'final working dataset creation',** this will combine all the individual years into one dataset called **'finalworkingroutes'.** The code then takes the original NIRC extract and appends the final route code and aggregated pathway category on. This is saved as **'COMPLETED_DATASET';** it is this file that the next stage of analysis will be run from.

Appendix 10- This is the regional policy outlining the information that must be given to patients on diagnosis



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Implementation	All Trusts	
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People receive health and social care services, directly related to their cancer investigations, diagnosis or otherwise, in various settings and from a wide range of HSC staff. Staff could be asked directly for cancer-related information or could identify a need for cancer-related information in their patient/client.

In this Guidance, 'information' means both clinical and non-clinical information. It is used to describe 'permanent' information for example, leaflets, booklets, web-based material, and audio-visual material.

This Guidance should be read and implemented in conjunction with the Trust policy on informed consent.

3. Aims/objectives

- To improve patient safety and patient/carer experience
- To help HSC Trusts achieve and evidence their delivery of patient information-related elements of patient safety alerts e.g. National Patient Safety Agency (NPSA)
- To help HSC Trusts achieve and evidence their delivery of the patient information standard in the Service Framework for Cancer Prevention, Treatment and Care
- To help HSC Trusts achieve and evidence their delivery of the patient information-related measures in Peer Review
- To help Service managers understand their responsibility in supporting the implementation of generic cancer information packs
- To help staff understand their responsibilities to provide information to people affected by cancer
- To help staff use generic information packs as a tool to do so.

4. Roles and responsibilities:

4a. HSC Trust leads for cancer patient information
Each HSC Trust has nominated a lead for cancer patient information.

The main role of the Cancer Information Lead is to provide advice to Trust managers on the implementation of network-agreed generic information packs in the Trust.

The role crosses several boundaries, notably between specialist and non-specialist cancer services, and between primary, secondary and tertiary care. The Cancer Information Lead is a resource and guide who communicates with those who have service responsibility to people affected by cancer.

Each Trust's Cancer Information Lead nomination is outlined in Appendix 2.

4b. NICaN role for Patient Information
The NICaN role for patient Information is the coordination of the work of groups developing generic information packs and support to the work of Trust Cancer Information Leads.

4c. Staff providing specialist and non-specialist cancer care
The main roles of staff relevant to this Guidance are to provide appropriate information to patients in line with cancer information pathways and to record such provision as evidence for audit.

5. Context
Patients and carers cannot express preferences about care and make choices on involvement in decision making unless they have access to appropriate and timely information. Furthermore informed consent for investigations or treatment for example cannot be obtained if patients do not have the appropriate information.

The DHSSPS report on its Regional Audit of Consent in 2007 states that,

"Seeking consent is a process of providing information, discussion and decision making. Consent for a (procedure or) treatment must be based on the patient having the information they need to make a valid decision. They can be given the information to read, and have time to discuss it with their family, carers or healthcare professionals before giving consent to the treatment.

As patients and staff move between different Health & Social Care (HSC) organisations throughout Northern Ireland it is important that the information used across the HSC is standardised".

Staff must adhere to their Trust's policy on seeking informed consent and should consult NICaN to see if regional information for investigations or treatment has been agreed.

Many patients report that they receive inadequate information from health and social care professionals. The Northern Ireland Cancer Patient Experience Survey, 2015 showed that only 64%

of patients reported having received information on the type of cancer they had at diagnosis comparted to 72% in England. It also showed that only 65% of patients reported having received information on the type of operation they were having compared to 76% in England (i).

Information materials of high quality should be available in places where patients can access them readily, with patients being offered them at key stages in the patient pathway (ii).

While good face to face communication skills are vital, patients also need access to other sources of information. Studies have shown that some patients only remember one tenth of what they were told during a consultation. Face to face communication needs to be backed up with high quality, accurate information that the patient can return to in their own time (iii).

Surveys have consistently shown nine out of ten people diagnosed with cancer want to receive information about their disease, its diagnosis, treatment options, side effects, and clinical outcome. It can enable them to feel informed and subsequently empowered to make their own choices, rather than having these imposed on them.

Studies have revealed that patients who are well-informed, experience less anxiety, and are more likely to cope with their illness than those who are ill-informed or uninformed (iv, v, vi).

There is evidence that leaflets specific to a condition are read by patients (vii) and evidence that patients receiving written information are more satisfied with the information they are given (viii).

Cancer has become a chronic disease that people live with for a number of years. Many of these people have an on-going need for care, rehabilitation, information and support. This might include information about the long-term side-effects of treatment and other 'survivorship issues' that can help an individual regain a sense of normality in their lives e.g. sexuality, fertility, financial issues, employment, and sources of support such as counselling and support groups.

The Service Framework for Cancer Prevention, Treatment and Care (DHSSPS, 2010)(ix) includes standards that aim to improve the patient experience. It builds on several other regional policy documents that address patient information, including Cancer Services: Investing in the future (Campbell Report, 1996)(x) and The Cancer Control Programme (DHSSPS 2006) (xi).

This Framework is currently under review however Health and Social Care (HSC) Trusts are still required to actively monitor performance against framework standards. This includes a specific standard on the provision of information.

> All people affected by cancer should be offered good information to support them throughout their cancer journey. This information should be tailored to their needs both in content and the way in which it is given (DHSSPS, 2010).

In recent years, there has been development work undertaken by Cancer Services within Northern Ireland to regionally agree high quality information for people affected by cancer. This guidance aims to help HSC staff understand how they can improve patient experience through making use of such work.

Section 2: Generic Information Packs

6. What is a generic information pack?

A generic information pack is an agreed core set of information given at or close to diagnosis of cancer. The current pack contains:

1. The Cancer Guide (Macmillan)
2. Information for you booklet (NICAN)
3. Benefits advice service leaflet (Macmillan CAB)
4. Living with and beyond cancer, survivorship website flyer (NICAN)
5. Macmillan support and information centre/service information (Local Trust)

The information resources have been identified as offering clear, accurate and well written information likely to be relevant to everyone diagnosed with cancer. This core generic pack can be added to throughout the cancer journey, to reflect the information needs of individuals e.g. Cancer Specific or treatment information, advice on talking to children etc.

Staff with any queries about tumour-specific information should direct them to Trust specialist staff for those cancer types in the first instance. The Cancer Information Manager/ Health and Wellbeing Coordinator within each trust may also be able to help (see Appendix 3 for list of managers).

7. Where can staff find information packs?

Generic information packs are available from Cancer Information Managers / Health and Wellbeing Coordinators or Clinical Nurse Specialists within each trust.

(See Appendix 3 for list of cancer information managers/health and wellbeing coordinators)

Section 3: Providing information

8. The interaction between information provider and recipient

There are a number of steps involved in a basic interaction between an information provider and the patient/carer. This includes selecting or sourcing information in alternative formats as needed.

These steps are outlined in Appendix 1.

See section 9 below for reference to complex interactions.

9. Skills development in information provision

Communication is a core competency within the Knowledge and Skills Framework (KSF). Each staff member's training needs on information provision, particularly complex interactions, should be assessed and addressed at their KSF appraisal.

10. Recording information provision

It is important that the Trust is able to evidence that information has been offered.

All staff providing information should record that the generic information pack has been offered and should file this in the patient's/client's case note. This could be achieved by using the keyworker sticker for example. Cancer Information Leads or Information Mangers within each trust should be contacted to determine the documentation method agreed locally.

Section 4: Monitoring and review

11. Monitoring:

The Trust will regularly and robustly monitor their implementation of this Guidance.

12. Review:

This Guidance will be reviewed in June 2019

References

i. Northern Ireland Cancer Patient Experience Survey, 2015
ii. Improving Supportive and Palliative Care for Adults with Cancer, National Institute for Clinical Excellence, 2004
iii. NHS Cancer Plan, 2000
iv. The Quality of Life. Fallowfield L. London Human Horizons Series Souvenir Press 1990
v. Information needs of cancer patients in the west of Scotland Meredith C, Symonds P, Webster L, Lamont D, Pyper E, Gillis CR, Fallowfield L. BMJ 1996 313 724-726
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vii. Edwards, M. (1990) "Satisfying Patients' Needs for Surgical Information". British Journal of Surgery vol. 77. pp 463-5
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Appendices

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(Based on Macmillan Cancer Support, Managing Cancer Information Materials 3rd edition)

Appendix 2 - Cancer Information Leads as at January 2017

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Beginning	1.Be approachable 2.Use open body language and eye contact 3.Listen to the person's concerns 4.Try not to interrupt, but be ready to speak when they are finished
Explore the content of the enquiry	1.Use open questions to tease out information needs 2.Consider topics included on the information pathway 3.The person's real issue of concern may not always be their opening question 4.Establish any information they have previously received on the topic 5.Reflect back what they have said
Clarify and summarise	1.Clarify the question to ensure you have interpreted their needs correctly 2.Describe and agree together what they need 3.If there are a range of issues, consider prioritising some– do this with the person and check that they are happy to do so
Guide enquirer through range of options appropriate to them and their query These options may be you providing information yourself, or you signposting them somewhere else	1. Consider resources listed in the information pathway. -Published leaflets -Non-print resources, e.g. CD -Guided internet search -Listening support -Counselling -Signposting to specialist services 2. Consider the person's information capacity. Do they need information in another language, an 'alternative format' or at a higher/lower literacy level? Remember you may have a statutory duty here (you can ask your Equality Manager for more information about this) 3.Go through the benefits and limitations of the options 4.Do not overwhelm the person 5.Agree and provide the information materials 6. If you don't know the answer to their question, signpost the person to an appropriate source. Do not risk giving wrong information 7.Offer the person written details of any websites or organisations and any resources you do not have to hand
Identify how to end and clarify enquirer's choices	1. Consider putting a timeframe on the end of the enquiry, e.g. "During the next five minutes or so, we'll go through what we've just discussed, and then I'll leave you to look through the information". 2.Check you have answered their question(s) 3.Confirm options and close the enquiry, e.g. "I think I have given you all of the information you have asked for, but let me know if there is anything else you need" 4.Ensure the person knows how they can get more information 5.Record the information you offered and whether the person took it up

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Appendix 4: NICaN Service Improvement Lead for Patient Information (Oct 14- ? 15)

Organisation	Name	Designation
NICaN	Edel Aughey	Service Improvement Lead for Information (Jan 15- Oct 15)

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

POST: Divisional Medical Director - Integrated Maternity and Women's Health (Fixed Term Post 3 Years)

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Care

ACCOUNTABLE TO: Medical Director

COMMITMENT: 3 PAs

LOCATION: Trustwide

Context:

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

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

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

Job Purpose:

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

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

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.

- To medically lead on all aspects of patient safety.
- To lead on all aspects of medical professional and clinical and social care governance including:

• Professional Medical Governance – Staffing and Staff Management – Professional Performance Management – Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Coronial Matters • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control) • Medications management	• Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Medical Education in conjunction with DivMD/ Dir Med Ed • Medical Workforce development • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement • Medical leadership in delivery of MCA and Safeguarding

Specific Divisional Responsibilities

- To lead on the development and ongoing management of a comprehensive clinical governance dashboard of IMWH services that includes a full range of dynamic patient safety data.
- To develop and lead medical professional development and leadership initiatives within IMWH.

Leadership Responsibilities

- To provide assurance on the quality of the professional, clinical and patient safety / Multi-Disciplinary Team systems, processes and meetings within the division.
- To promote quality improvement and to grow and embed a culture of Collective Leadership within the Division.
- To manage the clinical quality of care within the Division, promoting a climate of continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.
- To promote and strengthen links with primary care services including communications and development of service pathway improvements
- To develop and ensure guidelines and clinical pathways are maintained and embedded within clinical and social care governance structures and culture
- To be a leader in the alignment and commitment of developing a culture that delivers caring, compassionate, safe and continuously improving high quality health and social care.
- To be a leader in developing an inspiring vision that is put into practice at every level within the division, identify clear, aligned objectives for all teams, departments and staff, provide supportive enabling people management, develop high levels of staff engagement, support learning, innovation and quality improvement in the practice of all staff.
- To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full potential.

- To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:
  (a) delivery of safe, high quality and effective person-centred care
  (b) secures activity and performance
  (c) maintains ongoing financial viability
  (d) is aligned to corporate goals.

  The Divisional Medical Director with the assistant-director and professional leads will work in partnership to achieve the above objectives.
- To be a leader in the development of key quality and performance indicators for the Division and to ensure that effective performance management arrangements are in place.
- To ensure robust financial management of all medical staff across the Division
- To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
- To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.
- To model the HSC values.
- To act as an advocate for the Division.
- To represent the Division at the relevant senior Trust meetings.
- To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.
- To ensure that systems are in place so that all Health and Safety and other statutory requirements for patients, visitors, employees and contractors and the wider public are met.
- Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
- Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options
- To provide quarterly updates on the progress of aspects of professional and social care governance
- Perform any other duties that are consistent with the post

Appraisal and Revalidation

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

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

In conjunction with the Medical Director's Office to be involved in the oversight of Revalidation and Appraisal processes

Job Planning

- Provide leadership and support for Job planning process within the Directorate for Consultants, Associate Specialists and Specialty Doctors.

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

Implementation of HR policies for medical staff

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

Budgetary management

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

GENERAL REQUIREMENTS:

The post holder will be required to:

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

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

3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

4. Adhere at all times to all Trust policies including for example:

   - Smoke Free policy
   - IT Security Policy and Code of Conduct

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

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

7. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

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

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

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

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

SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE Divisional Medical Director

DIRECTORATE Surgery and Elective Care

Notes to applicants:

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

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

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

1. Applicants must be a permanent Consultant within the Southern Health and Social Care Trust.

2. Hold a medical qualification, GMC registration with License to Practice and specialist accreditation (CCT).

3. Experience of leadership within a team that led to successful service development and/or quality improvement.

4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

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

5. Excellent communication skills, both orally and in writing.

6. Be prepared to undertake clinical management and leadership development.

IMPORTANT NOTES REGARDING SELECTION PROCESS / INTERVIEW PREPARATION:

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

Prior to interview all shortlisted applicants will be offered the opportunity to meet with Dr Maria O'Kane, Medical Director to allow him to further discuss the role of Divisional Medical Director in the Trust. You can do this at any time during the application process or immediately

following shortlisting. To arrange a suitable appointment please contact Emma Campbell on Personal Information redacted by the USI.

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

Please note that interviews for this post will be held week commencing 3rd May 2021 (subject to change).

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

POST: Divisional Medical Director - Older Peoples Services (Fixed Term Post 3 Years)

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Care

ACCOUNTABLE TO: Medical Director

COMMITMENT: 3 PAs

LOCATION: Trustwide

Context:

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

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

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

Job Purpose:

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

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

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.

- To medically lead on all aspects of patient safety.
- To lead on all aspects of medical professional and clinical and social care governance including:

• Professional Medical Governance – Staffing and Staff Management – Professional Performance Management – Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Coronial Matters • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control) • Medications management	• Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Medical Education in conjunction with DivMD/ Dir Med Ed • Medical Workforce development • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement • Medical leadership in delivery of MCA and Safeguarding

Specific Divisional Responsibilities

- To lead on service improvements of older peoples services including stroke services to strengthen continuity of care between primary and secondary care services.
- To lead on the development, oversight and clinical management of specialist acute elderly care services

Leadership Responsibilities

- To provide assurance on the quality of the professional, clinical and patient safety / Multi-Disciplinary Team systems, processes and meetings within the division.
- To promote quality improvement and to grow and embed a culture of Collective Leadership within the Division.
- To manage the clinical quality of care within the Division, promoting a climate of continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.
- To promote and strengthen links with primary care services including communications and development of service pathway improvements
- To develop and ensure guidelines and clinical pathways are maintained and embedded within clinical and social care governance structures and culture
- To be a leader in the alignment and commitment of developing a culture that delivers caring, compassionate, safe and continuously improving high quality health and social care.
- To be a leader in developing an inspiring vision that is put into practice at every level within the division, identify clear, aligned objectives for all teams, departments and staff, provide supportive enabling people management, develop high levels of staff engagement, support learning, innovation and quality improvement in the practice of all staff.
- To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full potential.

- To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:
  (a) delivery of safe, high quality and effective person-centred care
  (b) secures activity and performance
  (c) maintains ongoing financial viability
  (d) is aligned to corporate goals.

  The Divisional Medical Director with the assistant-director and professional leads will work in partnership to achieve the above objectives.
- To be a leader in the development of key quality and performance indicators for the Division and to ensure that effective performance management arrangements are in place.
- To ensure robust financial management of all medical staff across the Division
- To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
- To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.
- To model the HSC values.
- To act as an advocate for the Division.
- To represent the Division at the relevant senior Trust meetings.
- To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.
- To ensure that systems are in place so that all Health and Safety and other statutory requirements for patients, visitors, employees and contractors and the wider public are met.
- Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
- Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options
- To provide quarterly updates on the progress of aspects of professional and social care governance
- Perform any other duties that are consistent with the post

Appraisal and Revalidation

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

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

In conjunction with the Medical Director's Office to be involved in the oversight of Revalidation and Appraisal processes

Job Planning

- Provide leadership and support for Job planning process within the Directorate for Consultants, Associate Specialists and Specialty Doctors.

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

Implementation of HR policies for medical staff

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

Budgetary management

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

GENERAL REQUIREMENTS:

The post holder will be required to:

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

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

3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

4. Adhere at all times to all Trust policies including for example:

   - Smoke Free policy
   - IT Security Policy and Code of Conduct

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

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

7. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

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

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

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

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

SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE Divisional Medical Director

DIRECTORATE Surgery and Elective Care

Notes to applicants:

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

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

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2. Hold a medical qualification, GMC registration with License to Practice and specialist accreditation (CCT).

3. Experience of leadership within a team that led to successful service development and/or quality improvement.

4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

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

5. Excellent communication skills, both orally and in writing.

6. Be prepared to undertake clinical management and leadership development.

IMPORTANT NOTES REGARDING SELECTION PROCESS / INTERVIEW PREPARATION:

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

Prior to interview all shortlisted applicants will be offered the opportunity to meet with Dr Maria O'Kane, Medical Director to allow him to further discuss the role of Divisional Medical Director in the Trust. You can do this at any time during the application process or immediately

following shortlisting. To arrange a suitable appointment please contact Emma Campbell on Personal Information redacted by the USI.

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

Please note that interviews for this post will be held week commencing 3rd May 2021 (subject to change).

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

POST: Divisional Medical Director – Surgery and Elective Care (Fixed Term Post 3 Years)

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Care

ACCOUNTABLE TO: Medical Director

COMMITMENT: 3 PAs

LOCATION: Trustwide

Context:

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

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

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

Job Purpose:

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

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

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.

- To medically lead on all aspects of patient safety.
- To lead on all aspects of medical professional and clinical and social care governance including:

• Professional Medical Governance – Staffing and Staff Management – Professional Performance Management – Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Coronial Matters • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control) • Medications management	• Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Medical Education in conjunction with DMD/ Dir Med Ed • Medical Workforce development • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement • Medical leadership in delivery of MCA and Safeguarding

Specific Divisional Responsibilities

- On behalf of the Medical Director represent the Trust in regional service development discussions including the development of regionalized surgical services
- Represent the Trust on the Surgical Regional Priority Operational Group

Leadership Responsibilities

- To provide assurance on the quality of the professional, clinical and patient safety / Multi-Disciplinary Team systems, processes and meetings within the division.
- To promote quality improvement and to grow and embed a culture of Collective Leadership within the Division.
- To manage the clinical quality of care within the Division, promoting a climate of continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.
- To promote and strengthen links with primary care services including communications and development of service pathway improvements
- To develop and ensure guidelines and clinical pathways are maintained and embedded within clinical and social care governance structures and culture
- To be a leader in the alignment and commitment of developing a culture that delivers caring, compassionate, safe and continuously improving high quality health and social care.
- To be a leader in developing an inspiring vision that is put into practice at every level within the division, identify clear, aligned objectives for all teams, departments and staff, provide supportive enabling people management, develop high levels of staff engagement, support learning, innovation and quality improvement in the practice of all staff.
- To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full potential.
- To strategically manage and develop the inter-relationships with primary care, the

HSCB, and other key stakeholders, in order to develop effective patient pathways.

- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:
  (a) delivery of safe, high quality and effective person-centred care
  (b) secures activity and performance
  (c) maintains ongoing financial viability
  (d) is aligned to corporate goals.

  The Divisional Medical Director with the assistant-director and professional leads will work in partnership to achieve the above objectives.
- To be a leader in the development of key quality and performance indicators for the Division and to ensure that effective performance management arrangements are in place.
- To ensure robust financial management of all medical staff across the Division
- To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
- To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.
- To model the HSC values.
- To act as an advocate for the Division.
- To represent the Division at the relevant senior Trust meetings.
- To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.
- To ensure that systems are in place so that all Health and Safety and other statutory requirements for patients, visitors, employees and contractors and the wider public are met.
- Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
- Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options
- To provide quarterly updates on the progress of aspects of professional and social care governance
- Perform any other duties that are consistent with the post

Appraisal and Revalidation

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

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

In conjunction with the Medical Director's Office to be involved in the oversight of Revalidation and Appraisal processes

Job Planning

- Provide leadership and support for Job planning process within the Directorate for Consultants, Associate Specialists and Specialty Doctors.
- Co-ordinate the implementation of Job Planning within Job Planning guidelines.

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

Implementation of HR policies for medical staff

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

Budgetary management

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

GENERAL REQUIREMENTS:

The post holder will be required to:

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

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

3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

4. Adhere at all times to all Trust policies including for example:

   - Smoke Free policy
   - IT Security Policy and Code of Conduct

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

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

7. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

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

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

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

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

SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE Divisional Medical Director

DIRECTORATE Surgery and Elective Care

Notes to applicants:

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

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

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2. Hold a medical qualification, GMC registration with License to Practice and specialist accreditation (CCT).

3. Experience of leadership within a team that led to successful service development and/or quality improvement.

4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

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

5. Excellent communication skills, both orally and in writing.

6. Be prepared to undertake clinical management and leadership development.

IMPORTANT NOTES REGARDING SELECTION PROCESS / INTERVIEW PREPARATION:

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

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

Personal Information redacted by the USI .

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

Please note that interviews for this post will be held week commencing 3rd May 2021 (subject to change).

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

POST: Divisional Medical Director - Emergency Medicine and Unscheduled Care (Fixed Term Post 3 Years)

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Care

ACCOUNTABLE TO: Medical Director

COMMITMENT: 3 PAs

LOCATION: Trustwide

Context:

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

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

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

Job Purpose:

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

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

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.
- To medically lead on all aspects of patient safety.
- To lead on all aspects of medical professional and clinical and social care governance including:

• Professional Medical Governance –Staffing and Staff Management –Professional Performance Management –Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Coronial Matters • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control) • Medications management	• Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Medical Education in conjunction with DivMD/ Dir Med Ed • Medical Workforce development • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement • Medical leadership in delivery of MCA and Safeguarding

Specific Divisional Responsibilities

- To lead on the implementation and professional and clinical management of Trust enhanced Emergency and Urgent Care services including Direct Assessment Units, Acute Medical Unit, Ambulatory Units and Urgent Care Centres
- To work with DivMD, DMD and AMD colleagues to ensure that clinical pathways across urgent care, primary care and secondary care are developed, maintained and monitored to maximise patient safety at all stages of the patient journey.
- On behalf of the Trust Medical Director lead on relevant medical clinical and professional tasks relating to the Trust No More Silos project

Leadership Responsibilities

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

high levels of staff engagement, support learning, innovation and quality improvement in the practice of all staff.

- To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full potential.
- To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:

  (a) delivery of safe, high quality and effective person-centred care

  (b) secures activity and performance

  (c) maintains ongoing financial viability

  (d) is aligned to corporate goals.

  The Divisional Medical Director with the assistant-director and professional leads will work in partnership to achieve the above objectives.
- To be a leader in the development of key quality and performance indicators for the Division and to ensure that effective performance management arrangements are in place.
- To ensure robust financial management of all medical staff across the Division
- To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
- To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.
- To model the HSC values.
- To act as an advocate for the Division.
- To represent the Division at the relevant senior Trust meetings.
- To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.
- To ensure that systems are in place so that all Health and Safety and other statutory requirements for patients, visitors, employees and contractors and the wider public are met.
- Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
- Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options
- To provide quarterly updates on the progress of aspects of professional and social care governance
- Perform any other duties that are consistent with the post

Appraisal and Revalidation

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

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

In conjunction with the Medical Director's Office to be involved in the oversight of

Revalidation and Appraisal processes

Job Planning

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

Implementation of HR policies for medical staff

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

Budgetary management

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

GENERAL REQUIREMENTS:

The post holder will be required to:

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

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

3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

4. Adhere at all times to all Trust policies including for example:

   - Smoke Free policy
   - IT Security Policy and Code of Conduct

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

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

7. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

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

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

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

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

SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE Divisional Medical Director

DIRECTORATE Surgery and Elective Care

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WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

HSC Southern Health and Social Care Trust

What is Clinical Governance

Clinical governance is the **system through which NHS organisations are accountable for continuously improving the quality of their services** and safeguarding high standards of care by creating an environment in which clinical excellence will flourish (Department of Health (UK), 2021)

HSC Southern Health and Social Care Trust

What is Medical Professional Governance

Where organisations create an environment which delivers effective clinical governance for doctors.

- Clinical excellence and the well-being of doctors are at the centre of the organisation's approach to deliver high-quality patient care.

Clinical governance processes for doctors are managed and monitored with a view to continuous improvement.

- Well-structured and governed systems with learning and continuous improvement at their heart promote confidence in patients and doctors.

Safeguards are in place to ensure clinical governance arrangements for doctors are fair and free from bias and discrimination.

- It is important patients, doctors, and other healthcare professionals have confidence that clinical governance arrangements for doctors are fair. Transparency of processes, including sharing of information and how decisions are made, play a key role in this.

Organisations deliver clinical governance processes required to support medical revalidation and the evaluation of doctors' fitness to practise.

- Organisations have a responsibility to ensure their clinical governance arrangements support the medical workforce to practise safely and meet their professional obligations, but also to identify and respond to concerns about doctors as they emerge

HSC Southern Health and Social Care Trust

What this Means for……

The Trust

- To put in place clinical governance systems which promote and protect the interests of patients.
- To create an environment which supports doctors in meeting their professional obligations.

Doctors

- To practise in accordance with the principles and values set out in Good Medical Practice and participate in revalidation.
- To participate in the systems and processes put in place by organisations to protect and improve patient care.

Regulators and quality improvement agencies

- To monitor, and where relevant, enforcing compliance with standards and regulations.
- To share information and intelligence in relation to patient-safety
- To promote a culture of continuous improvement and learning
- To act decisively to protect the public when risks to patient-care or well-being emerge.

HSC Southern Health and Social Care Trust

The Importance of Medical Leadership

'Being a good doctor means more than simply being a good clinician'

(GMC, Leadership and management for all doctors)

In day-to-day role doctors provide leadership to their colleagues and vision for the organisations in which they work and for the profession as a whole. This includes:

- Responsibilities relating to employment issues
- Teaching and training
- Planning, using and managing resources
- Raising and acting on concerns
- Helping to develop and improve services

HSC Southern Health and Social Care Trust

Areas of Development to Date

Revision of Medical Leadership Structures

- Introduction and Appointment of Deputy Medical Directors, Divisional Medical Directors and Clinical Directors
- Newly developed individual structured accountability framework for Divisional Medical Directors

Strengthening Appraisal and Revalidation

- Establishment of Medical Revalidation Oversight Group
- Development of Medical Appraisal Mentoring Scheme
- Additional Medical Appraisal and Revalidation Staffing

Improving Governance and Oversight of Medical Private Practice

- Enhanced Declaration of Private Practice
- Review of Private Practice Guidance -Revision of Change of Status form process
- Private Practice Structured Reflective Template (Whole Practice Appraisal)
- Private Practice Assurance Audits

HSC Southern Health and Social Care Trust

Revision of Medical Leadership Structures

Deputy Medical Directors

- Appointment of 3 new Deputy Medical Director Roles
  - Workforce
  - Quality, Safety and Clinical Governance
  - Appraisal and Revalidation

Divisional Medical Directors

- Revision and augmentation of the previously existing Associate Medical Director role
- New Divisional Medical Director posts created
  - Urology Improvement (Temporary)
  - Older Persons Services

Clinical Directors

- Revision and augmentation of the previously existing Clinical Director role
- New Clinical Director posts under development – new posts agreed for ED, MHLD, Cardiology, older persons and 2 posts for medicine

Strengthening Professional Governance Roles

- Planned introduction for the following
  - Medical Lead for Coroner Services
  - Medical Lead for Standards and Guidelines
  - Medical Lead for Litigation
  - Medical Lead for Locums
  - Medical Lead Complaints
  - Medical Lead Wellbeing

HSC Southern Health and Social Care Trust

Revision of Medical Leadership Structures

Divisional Medical Director Key Professional and Clinical Governance Duties

• Professional Medical Governance –Staffing and Staff Management –Professional Performance Management –Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Coronial Matters • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control) • Medications management	• Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Medical Education in conjunction with DMD/ Dir Med Ed • Medical Workforce development • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement • Medical leadership in delivery of MCA and Safeguarding

HSC Southern Health and Social Care Trust

Revision of Medical Leadership Structures

Monthly DivMD Accountability Meetings

Professional Governance

- Job Planning
- Medical Appraisal
- Revalidation
- Professional Performance Management
- Medical Workforce
- Doctors and Dentists Oversight

Clinical and Social Care Governance

- Adverse Incidents (Datix)
- Serious Adverse Incidents
- Litigation and Claims Management
- Coronial Matters
- Standards and Guidelines
- Complaints
- Morbidity and Mortality
- Clinical Audit and Quality Improvement
- Patient Safety

Other Relevant Areas

- Medical Education
- Research and Development

HSC Southern Health and Social Care Trust

What is Medical Appraisal

Medical appraisal is a process of facilitated self-review supported by information gathered from the full scope of a doctor's work.

It is a protected time, once a year, for each doctor to focus, with a trained colleague, on their scope of work. This includes:

- looking back at achievements and challenges and learning from experience, including reviewing the previous year's personal development plan objectives
- looking forwards to their aspirations, learning needs and the recording of new personal development plan objectives.

The appraisal process

- Medical appraisal is undertaken annually at a meeting between a doctor and a colleague who is trained as an appraiser. The appraiser is a trained and skilled individual whose skills and competencies are described in the document Quality Assurance of Medical Appraisers (NHS Revalidation Support Team, 2013)
- There are three stages in the medical appraisal process:
  - Inputs to appraisal, including a record of the doctor's scope and nature of work and relevant supporting information
  - The confidential appraisal discussion
  - Outputs of appraisal, including the doctor's personal development plan and a summary of the appraiser discussion and the appraiser's statements.

HSC Southern Health and Social Care Trust

What is Medical Revalidation

Medical Revalidation is a Quality Assurance Process

Revalidation is an evaluation of a doctors fitness to practise.	**Supports doctors in regularly reflecting on how they can develop or improve their practice**	**Gives patients confidence doctors are up to date with their practice**	**Promotes improved quality of care by driving improvements in clinical governance.**	**Every licensed doctor who practises medicine in the UK must revalidate to show they are up to date and fit to practise.**

Trust Revalidation Oversight Meeting	
Doctors Registration details	Involved in MHPS Investigation
Previous Revalidation form	Engaged with NHS Resolution
GMC Connection & History	Involved in GMC Investigation
5 Appraisals (6 if rescheduled by GMC Covid 19 year)	Involved in medicolegal case
4-5 years of complaints/incidents	Involved in Coroner's inquest or report
Significant Events	CD additional information (DMD should liaise with CD for update before meeting)
Patient Feedback Report	Governance – Concerns/issues
Colleague Feedback Report	M&M & Patient Safety Meeting attendance (last 5 years)
Private Practice	Review of issues which impact upon delivery of patient care if recorded by Doctor (last 5 years)
Letters of Good Standing	

HSC Southern Health and Social Care Trust

Medical Appraisal Mentoring Scheme

In order to support medical appraisers in completing this role a Trust medical appraisal mentoring scheme has been developed. The mentoring scheme will allow appraisers new to the role to avail of support, knowledge and experience of established mentors and offer a practical approach to appraiser training and skills development that is beneficial, enjoyable and suited to training needs. Appraisers who complete the mentoring scheme will receive a certificate of completion which can be used as evidence of medical leadership development.

The purpose of the scheme will be to:

- Support induction of staff into the role of medical appraiser
- Foster a spirit of collaboration and knowledge sharing
- Develop skills to enhance their role as medical appraiser
- Provide opportunity for staff to seek support in relation to issues raised in appraisal
- Enable staff to realise career development plans
- Provide staff an opportunity to develop their medical leadership skills

HSC Southern Health and Social Care Trust

Medical Appraisal and Revalidation Augmentation

Additional Medical Subject Matter Experts

Administrative and Systems Support

Southern Health and Social Care Trust

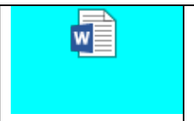
2020 SAI RECOMMENDATION ACTION PLAN INCORPORATING THE 2016 RECOMMENDATIONS WHERE APPLICABLE

Please Note This Is a Draft Action Plan and Will Change Throughout The Process

RAG Rated Scale for Actions		RAG & Number of Rec's in Each		Colour Code Of Recommendations	
	Newly Identified Action to Progress		0		2020
	Process in progress/ updates to follow		4		
	Process complete and recommendation implemented		7		

Rec 2020	From SAI Report	How This Will Be Achieved?	Action Owner	What Are The Key Outputs?	How Will This Be Measured?	Progress	Actions Outstanding/ Owners	Limiting Factors/ Essential Requirements	Supporting Guidance/ Policy	Timescale As Per SAI Overarching Report	Time scale	RAG
1	The Southern Health and Social Care Trust must provide high quality urological cancer care for all patients.	1. Data Mapping Process exercise completed by QI team from point of GP presentation to discharge. External independent team also completing data Map Process for another group	Internal QI Team and External MSD company overseen by Mary & Sarah	Mapping Process for Benign Pathway completed by internal QI team. Cancer pathway data map completed by external team Supported by the key elements of Clinical Governance	1. Process map will identify areas of good practice/ experience for each pathway 2. Action Plan will allow for focused QI	<u>May 2022</u> 1. Internal Data Map Process commenced. We have baseline data for the elements within the map. Review from referral, to triage, diagnostics and treatment. This will be supported by the best practice guidelines/ policies and procedures for each stage. 2. Care Opinion Team collaborating with Internal QI team to incorporate patient feedback process throughout the data map process, This will be the first time a full patient journey has had an ongoing feedback process. 3. MSD Company will be completing Date Map of the GI Pathway for comparison. This is being completed with the Belfast Trust also so we are benchmarking regionally as well as having another cancer pathway for comparison. 4. Both processes will allow us to compare what each has gathered and incorporate into collective action plan for addressing. 5. The Data Map of the Urology Pathway is also being supported by the Questionnaire/ QI Project currently in final stages of draft with our service user representatives.	<u>May 2022</u> 1. Internal and external data mapping process and reports/ action plans -owned by Internal QI team and MSD overseen by Cancer Services Improvement Lead & HOS's	- External Data Map is being completed in conjunction with BHSCT.	Appendix 1 Data Map Process.docx Governance.docx Urology Pathway Amended Urology	Immediate and On-Going	Internal process timescale likely to be June 22 due to complexity of numerous pathways . Updates will be provided. The External Data Map with Belfast Trust	
	What does this Mean?											
	1. Cancer care for all patients will be delivered based on: - Collective Multidisciplinary Team	2. Baseline Assessment of all Cancer MDT	MDT Leads & Chairs, Dr Tariq	Baseline of all MDT established and MDT chairs aware of the required standard of MDT performance as detailed in Clinical Guidelines/ Policies.	1.Following baseline assessments, action plans to be devised which incorporates overarching	<u>May 2022</u> 1. MDT baseline assessments complete across all Tumour sites 2. Action Plans for each MDT devised based on the findings of the assessment. All MDT's have action plans with "common" areas to address as well as specifics for each. Monthly	<u>May 2022</u> 1. Ongoing monthly update of Action Plan with MDT Leads. Will feed into this SAI action plan and will demonstrate	1. MDT Leads of All Tumour Sites Support, Leadership and Guidance to Implement	Appendix 3	Immediate and On-Going	Aim to have Principals/ Min Data Set embedded by end Jan 2022 (Achieved)	

	meetings. Following best practice guidelines for MDT process. -Robust support systems and processes for all patients and relatives from diagnosis, treatment planning, treatment delivery to completion and future follow up.			All MDTS will have standardised approach matching the NICAN guidance which is recognised as the standard we must achieve.	areas of QI as well as specific action plans to address specific QI within each cancer site. 2. Minimum Data Set standardised across all MDT with specific additions to reflect each tumour site. Audit to be devised/ time frame agreed for assessing completion of Minimum Data Set	meeting with MDT Leads with Cancer Services Improvement Lead to review and update action plan. This then feeds into the Task & Finish Super Group. All MDT's have engaged fully and are proactively working to achieve recommendations. Limitations recognised in the ability to audit all elements which is reflected below. 3. Principals document created based on the NCAT framework to be used to support the function of the MDT. This Principals document has been accepted by all MDT Leads. 4. MDT Proforma for each MDT required based on the Principals document. This is now operational within Urology and is in progress of being rolled out across all other tumour sites. This proforma allows for auditing of the MDT process and assurance that guidelines are followed. Urology audit of MDT proforma for April/ May produced results of 100%. 5. Cancer Service Improvement Lead & Head of Service for Clinical Assurance are meeting with each MDT Lead to review the outstanding actions and ensure all fully appraised of the requirements & timescales. ENT & Urology Completed. Awaiting confirmation from other MDT's of dates but aiming May to have this all completed. 6. Task & Finish Supergroup meetings well represented across all tumour sites and lots of participation and engagement. 6. All CNS are fully involved in the SAI action plan and requirements for the MDT function specific to their role.	progress with regards to the MDT Process. Will be shared at the HSCB Fortnightly meetings and Monthly Service User group meeting. 2. England Model of Referral and Triage being obtained to review criteria etc. This will be shared regionally as will require review of the GP/ Trust prior agreement regarding referrals. 3. Urology service trailed e-referral process approx. 10 years ago which did not proceed as barriers with GP requirement to input more detail into referral/ have mandatory fields. Process will be reviewed and revisited. 4. Continued roll out of revised MDT Proformas to all tumour sites. Lung pending as next. - Owned by MDT Leads & Chairs, Dr Tariq and Cancer Services Improvement Leads/ HOS/AD	the Recommendation to their MDT's 2. GP practice/ compliance with referral criteria. 3. Resource within Corporate Audit Team with particular focus on Cancer.	Appendix 4 Appendix 5 Action Appendix 6 MDT Appendix 7		Meeting with all MDT's for final timescales to be completed by May 22 MDT's specific proformas in roll out. Lung currently in progress and remaining will roll out over next few months. Potential end July 22.	
		3. Feedback from Patients from a variety of sources including: -Complaints	Mary, Sarah, Governance/ Patient Experienc	Feedback structures in place to allow ongoing collection of patient experience from a variety of sources.	1. Review of the historical feedback and establish what were the themes and	<u>May 2022</u> 1. Themes in the CPES feedback identified to structure the new template for gathering feedback. CNS Meeting in Jan to review the CPES survey. Due to unexpected sickness and service	<u>May 2022</u> 1. Ongoing with regards to service user/ QI team project. Meetings	1.Sickness amongst Urology CNS team has postponed the review of	Appendix 8 CPES	Immediate and On-Going	Aim to have feedback templates devised by end April 2022.	

		-Datix -Care Opinion -10,000 Voices -Patient Surveys	e Team & CNS	Standardised processes across all Cancer sites that compliments the feedback/ patient surveys completed by the Cancer Network. Internal and external feedback to be shared widely amongst teams so that all can learn from feedback to drive change/ improvement	what was implemented to drive change from these. 2.Service User Group to advise on a survey template we could use to collect fresh feedback	pressures in Urology CNS team this has been postponed until staff return. Will remain on agenda. 2. Service User project for Questionnaire supported by Marian Thompson from PPI has been progressing. We are now at final draft of the questionnaire which is now shared with our CNS in Urology. This focuses on the Diagnosis Clinic and the knowledge of the journey ahead the patient has. Elements being worked on currently: - scoping of pilot patients - review of relative/ supportive person questionnaire to compliment the patient questionnaire - QI team providing guidance and support for access to different formats for eg different languages/ large text - aide memoir in draft for the CNS to reference when using the questionnaire -We have already identified lots of areas we can branch into following this piece of work & the next phase of questionnaires including review/ revision of the patient info documentation for eg based on the feedback we receive. 3. Another service being introduced is the Peer Support Facilitator through Macmillan whereby patients who have been through a cancer diagnosis offer support to our patients & are planning to assist in gathering of patient experiences. This is being trialled with 30 patients initially, and pending feedback will be rolled out to other cancer/ tumour sites. 4. Care Opinion focused feedback project in Thorndale. Kiosk into waiting area and CNS & Medical Staff received Care Opinion refresher and responder training in first weeks of Feb 2022. Next Care Opinion Team meeting 27.4.22 where we will review: -link on e HNA system so when patients are emailed their information and access to their care plan they will have direct link to Care Opinion - Development of QR code specific for Patient Information Packs.	fortnightly currently. 2. Awaiting the final elements of the Care Opinion process (QR Code etc) and will have these operational as soon as possible following the training for CNS and Medical Staff. 3. CNS team review of CPES feedback and refresh of CPES survey for staff. - Owned by Mary, Sarah, Governance/ Patient Experience Team & CNS	the CPES survey	 		Start feedback exercise May 2022. 10,000 voice/ Care Opinion will be ongoing process. Commenced Feb 22.	

Rec 2020	From SAI Report	How This Will Be Achieved?	Action Owner	What Are The Key Outputs?	How Will This Be Measured?	Progress	Actions Outstanding/ Owners	Limiting Factors/ Essential Requirements	Supporting Guidance/ Policy	Timescale As Per SAI Overarching Report	Time scale	RAG
2	All patients receiving care from the SHSCT Urology Cancer Services should be appropriately supported and informed about their cancer care. This should meet the standards set out in Regional and National Guidance and meet the expectation of Cancer Peer Review. **What Does This Mean?**	1. Information Pathway. Review of: - information given to patients -Timing of Information given - Recording of Information given - Audit of Information Given - Past patient feedback on Information. Including sources, access, content etc	Mary, Clair & Sarah and CNS Service Users for Survey	Information provided to patients is: -specific to their diagnosis -given at the right time -easily accessible -easy to understand - details support to patients/ families -Patient records reflect the information given - supports the Clinical Guidelines/ Policies	1. Clinical Guidance/ Policy review of Information patients should receive 2. Review of current process of patients receiving information and accessibility to Information 3. What Information is available currently 4. Audit of patient records with diagnosis regarding information given. -is it clearly recorded -does it detail what was given -was the information refreshed during patients journey 5. New patient survey specific to information based on the requirements in guidance/ policy.	<u>May 2022</u> 1. Review of the NICAN policy regarding information that must be given to patients completed. The Principals Document contains and references the completion of the Information tracking form. 2. Cancer Leads and Lead Nurses for CNS are working through assessment of completion of the paper "Information Tracker Form". This has been raised regionally and will be on next agenda for discussion to have CAPPS system enabled to record this rather that a paper form which can/ does go missing. As we are moving towards paperless recording this will require regional discussion and planning. Last review of this was 2015. We have reviewed what we do in Trust and established that either the form is completed or it is recorded in the free text options on CAPPS with the majority using the paper form. 3. We have agreed to standardise our process in Trust whilst waiting regional steer. All CNS informed of need to ensure paper checklist of information completed and added to records in interim. Once completed CAPPS field for "information given" to be completed to allow audit to be completed of this. Information Team have been informed and we will audit this is 3 months to ascertain compliance. The aim is to have a dedicated "Information" Tab on CAPPS which details ongoing information given throughout the patient journey. This has been discussed extensively at the CAPPS User Group Meeting & regional recognition that CaPPS system needs refreshing. This process will allow for auditing of the system to ascertain compliance. 4. Service User project for Questionnaire supported by Marian Thompson from PPI has been progressing. We are now at final draft of the questionnaire which is now shared with our CNS in Urology. This focuses on the Diagnosis Clinic and	<u>May 2022</u> 1. Ongoing with regards to service user/ QI team project. Meetings weekly currently. 2. Regional work required for the amendments needs on CAPPS system. -Owned by Mary, Clair & Sarah and CNS - Service Users for Survey -MDT Administrator - Regional Input - Lead Nurse Cancer Services	1. Regional Revision of "Information Tracking" Recording 2. Regional Revision of CAPPS System	Appendix 10 NCAT	Immediate and On-Going	Aim End April/ May 2022 to have baseline assessment / audit completed. Will also be ongoing as we gather feedback and review processes	

						the knowledge of the journey ahead the patient has. Elements being worked on currently: - scoping of pilot patients - review of relative/ supportive person questionnaire to compliment the patient questionnaire - QI team providing guidance and support for access to different formats for eg different languages/ large text - aide memoir being created for the CNS when using the questionnaire -We have already identified lots of areas we can branch into following this piece of work & the next phase of questionnaires. This includes potential review of what information is given to patients & the development of patient held MDT records for their entire cancer treatment pathway. 5. Audit process has commenced by the Lead Nurse for Cancer Services on the CNS Proforma. This is the start point of audit following standardising the internal processes in the absence of regional updates with regards to recording of information given to patients (amongst other elements). This has been completed in Urology to date and other CNS in other Tumour sites in progress. Report will be discussed with CNS and action plans devised to address areas for improvement.					
	All patients have access to information about their diagnosis , treatment options and treatment pathway. - Information to be given verbally and supported by written - Options discussed by MDT must be available to the patient -Informed consent	2. Staff have advanced communication skills training and are up to date with requirements	MDM Leads/ Line Managers of Cancer Specialities	1. Staff who are directly involved in communicating with patients with a cancer/ potential cancer diagnosis are trained and skilled to deliver difficult information throughout the patients journey. 2. Staff from all levels are trained including: -Consultants -All levels of Doctors -CNS -MDM Chairs -Any staff that may be in contact. 2. Resource available for access	1. Baseline % of staff trained in each staff group 2. Review of volume and type of training available 3. Review if guidance on requirements to refresh training 4. Action plan for addressing training and communication with line managers to address	<u>May 2022</u> 1. Update from PHA that regionally looking at virtual model to deliver training. This is used in England now. At this stage no further update from Region. 2. Trust has agreed to resource this training in absence of regional training package. This is pending at the minute. Funding requested and awaiting confirmation. 3. Established approx. 16-18 staff across all tumour sites requires this training and will also need to allow capacity within training model for Palliative Care Team to avail also. 4. When Cancer Services Improvement Lead and Head of Service for Clinical Assurance when meeting with MDT leads to review the action plans- advised that MDT	<u>May 2022</u> 1. Awaiting regional plan 2. Training requested and awaiting commencement 3. Once above confirmed need to establish how we can maximise training attendance, with reduced workforce and service pressures. -Owned by Trust for Funding options	1. Funding Resource 2. Capacity to Facilitate Training in Restrictions 3. Maintaining Service with Reduced Workforce & Need to Complete Training & Maximise the Available Training		Immediate and On-Going	Awaiting commencement timescale of training package	

	-Clear documentation of information given and discussions/ patients preference.			to advanced communication skills 3. Refresher training programme to support updates in guidance /policy 4. Staff awareness and responsibility to be skilled in communication.		attendees to identify their training needs and escalate to line managers. 5. CNS Forum established starting in June which will focus on the training needs as well as the communication pathways required for CNS role. This includes easy access and signposting to MDT, building relationships and identifying links to allow the CNS to fully support the patient with all elements of their cancer pathway. The first meeting in June will focus on these relationships and creating a "sign post" resource of key contacts for the CNS to easily reference. Review of the support available to CNS to access skills and peer support also on agenda. Deirdre McKenna has been engaged to provide support for communication training and building relationships. The Bereavement Team is also supporting Advanced Comms training which extends to not only CNS but will focus on all levels of staff at ward level from ED to Discharge including Domestics, Health Care Assistants, Nurses, Secretaries, Doctors etc. Recognised that communication pertaining to Cancer, prognosis and treatment is happening in acute wards and ED departments not just in outpatients and it is vital we build communication skills in all teams. The bereavement team are also focusing on basic communication including the telephone calls to NOK, ensuring families know where their relative is and ensuring communication amongst teams reflects the awareness of the situation.	-Staff who require training and Line managers				
		3. Key Workers allocated at diagnosis	MDT Leads, MDT Coordinator & CNS and line managers & Regional Work	1. Patients are aligned to a Keyworker/ Nominated CNS on diagnosis 2. Keyworker/ Nominated CNS allocation recorded at MDM 3. Key Worker/ Nominated CNS makes contact with	1. Process review of allocations of Keyworker/ Nominated CNS are across all tumour sites. 2. What HNA clinics are in place across all CNS specialities	<u>May 2022</u> 1. MDM process currently does not include the physical allocation of the Keyworker/ Nominated CNS. Included in the MDT Principals document which is now operational. This also needs revised regionally. CNS have had oversight of the Principals Document and are aware of its contents. See below recommendations for process update. As part of the monthly MDT action plan update & the individual meetings with the MDT leads by	<u>May 2022</u> 1. Review of Breaking Bad News Clinics- Region to steer based on feedback from other Trusts. 2. CNS Database should capture HNA activity this will be fully functional when	1. Regional Revision of CAPPS MDT Section to allow recording of Key Worker at MDT	Appendix 11 CNS Proformas - Link.html	Immediate and On-Going	This is regional work also. The review of current processes in Trust completed by end Feb 2022.	

				the patient within an agreed timeframe 4. Patients with a cancer diagnosis have an HNA appointment (electronic HNA and Face to Face) allocated within an agreed timeframe 5. HNA clinics in place across all tumour sites with CNS 6. Breaking Bad News Clinics follow Guideline Structure of Breaking Bad News Clinics. 7. Patients are informed of recommendations from the MDT, treatment options and records the patients preference/ choice.	3. Recording of Keyworker/ Nominated CNS in patient records- what is the practice now? 4. How many Breaking Bad News Clinics are embedded in specialties and what is the structure in line with the guidance	Cancer Services Improvement Lead & Head of Service for Clinical Assurance this is reinforced with everyone the importance of this allocation. The default Keyworker is the CNS. 2. Regional work required for recording of key worker on CaPPS to be an essential field. MDT Administrator & Project Officer raised CaPPS user group meeting on 26.1.22. Group agreed this needs to be a set requirement on system, however the system currently does not allow for fields to be made mandatory in the MDM section due to issues with saving the document. Agreement this requires addition of a tick box and free text box to the MDM section to allow input of keyworker name at MDM meeting. The Trust has decided to use the free text box now to record the keyworker and we can begin to audit this. 3. Review of how diagnosis are delivered. Also known as “Breaking Bad News”. Established no standardised practice in Trust or Region. Use of “red flag” clinics, protected review slots, meetings in Consultants Office or ward attendance are all noted to be ways this can be done. Internal meeting with Booking Teams to discuss the need for dedicated codes to allow this activity to be audited and to ensure these types of reviews are well known by the teams to ensure planning and presence from essential team members to inform and support the patient. Internally we have discussed how this needs to be and agreed this needs to be a code aligned to a patient rather than an entire clinic code. Brought back to regional group and advised we must get a steer from all Trusts to ensure the process is consistent across the region. All Trusts have been asked to advise on their processes and work required will be discussed following this. Regionally they feel it is important to maximise the role of the Keyworker firstly across all Trusts. The Trust is now as a pilot, we are setting up a nurse-led clinic for UGI patients who have just had their diagnosis – the	all CNS are using the electronic format to allow data to be pulled easily off for audit purpose. 3. Process Map/ Patient feedback will identify the best time for the HNA clinics based on patient feedback. -Owned by MD, AD, HOS and CNS & Region. 4. Contacted Bereavement Team to identify ward staff to be part of a group focusing on communication skills development- awaiting response. 5. Clinical Education Centre contact to ascertain what is available as an “essential” core skill for all levels of staff to develop communications skills- awaiting response.		Appendix 23 HNA.docx		Regional input is ongoing.	

						clinicians will refer all patients to the clinic after they give results. We are keen to ensure a robust process so that the CNS's are able to identify and follow-up with all newly diagnosed patients. Breaking Bad News also not contained within an outpatient setting, feedback on ward based news breaking has raised the need for ward staff to be skilled in this. 4. HNA workshop organised for CNS with Governance, Quality, Patient Safety and Patient Experience Teams present. Focusing on embedding HNA into CNS job plans and devising audit tools to allow systemic audit of the process (including patient feedback) and benchmarking (based on KPI's). Work now regionally focused on agreed KPI framework and benchmarking across all Trusts. 5. HNA clinics. Rolling out electronic HNA across all CNS. All CNS have now been trained across all tumour sites. H&N and Urology CNS are operational, Colorectal and Breast CNS are next. Currently all CNS are completing HNA but aim is to move to electronic format. CNS Database will capture all this activity. 6. CNS Proforma now on Sharepoint. Once completed this goes straight to support worker and uploaded onto CNS database which will now allow ability to audit. As discussed above the audits of CNS proforma has commenced. This is our new baseline following standardisation of the process internally in absence of the regional update required.					
		4. KPI Audit Framework for CNS	Mary , Clair, Sarah, CNS, Governance Team & Regional	1. Regional development of an audit tool for submission of data against the KPI's of CNS to ascertain the level of performance and compliance to the regional KPIs for CNS 2. Robust & regular process in keeping with other KPI's within Trust for eg NQI's	1. HNA workshop is also to establish how the KPI audit will look: -what are key indicators - how will they be audited -how many to audit -how will report look - what will be the outcomes	<u>May 2022</u> 1. Workshop in March (detailed above) focused on the KPI Audits for CNS. 2. Regional work required. The Trust will feed into the regional group with regards to our work on this. 3. Establishing where the KPI's would sit internally as not in line with NQI's. This is going to be work in progress as some Cancer CNS do not sit under Cancer Services and are line managed by Surgical Directorate. Need to review once the process of KPI collection is devised to ensure robust Governance around this.	<u>May 2022</u> 1. Regional involvement and development required for benchmarking and standardisation of KPI framework. - Owned by CNS, Governance Teams and Region 2. Audit process commenced on CNS Proforma.	1. Regional division of KPI model based on our work. Will inevitably be a process and involvement engagement and comment from other Trusts/ tumour sites to ensure this		Immediate and On-Going	June 2022 Ongoing as this involves regional work .	

				3. Action plan devised to address audit results and system of review to ensure actioned with CNS. 4. Supported by NIPEC Job Planning Guidance for Cancer Nurse Specialists. KPI's to reflect domains within this. 5. Policies & Procedures for Cancer Nurse Lead Activity/ Clinics		5. CNS in Urology have reviewed, revised and developed Nurse lead Policies reflective of the most up to date regional and national guidance. These are now supporting them in their Nurse Lead Activity as detailed in their individual job plans. Have been processed through the internal nursing governance process for sign off by the Executive Director of Nursing. As a result of this piece of work we are developing a "tracking system" for nurse lead policy sign off to ensure timely, traceable and issues actioned promptly to ensure practice supported by most up to date clinical guidelines. 6. CNS Proforma now on Sharepoint. Once completed this goes straight to support worker and uploaded onto CNS database which will now allow ability to audit. Audits commenced on the completion of this proforma. 7. CaPPS development for recording of KPIS for CNS. Regional development for this. 8. CNS Forum now in place starting June 2022. This will be an opportunity to support, review and develop practice.	Require more resources to fully embed.	meets the needs of all.				
		5.Resource and Skill Set of CNS within each Tumour site	Each HOS within each cancer speciality/ Lead Nurses/ Cancer Leads & Regional Work	1. Funded CNS posts and % of unfilled posts across tumour sites. 2. Regional comparison of % unfilled posts across tumour sites 3. Training required and Recruitment of CNS	1. Overall Trust position of CNS. Funded/ SIP/ Vacancies 2. Regional position of above 3. MDT Coordinators funded/ SIP/ Vacancies 4. Demand and Capacity Assessment	<u>May 2022</u> 1. MDT Administrator and Projects Manager recruited and started 1st Week of Jan 2022. Already recognised we will likely require more of these roles and will require additional funding. Very involved in implementation of SAI recommendations and support MDT's. Also is our link to regional meetings to share the work ongoing and actions required outside of the Trust. 2. MDT Administrator and Projects Manager has oversight of the use of the Principals Document and is developing an audit framework for assurance of the MDT function. 3. Internal staff census complete for CNS. This is regionally focused also. Health Minister request the demand for CNS by mid Jan in order to proceed with sign off of the Cancer Strategy. Report in draft format awaiting sign off by DOH and will steer how the future planning of the	<u>May 2022</u> 1. Awaiting DOH to respond to the demand/ capacity submitted by Trust and update on the requirements for planning for meeting the Cancer Strategy. - Owned by DOH 2. Discussion with Cancer Service Improvement Lead, HOS and CNS to review current gaps in CNS access to MDT. (Pending this week). Process map and further discussion & review of the HNA process.	1. Investment Into the Administrator Roles which will come from the Region 2. Regional Cancer Strategy Sign Off and the Resource requirement needed to enable Trust & all Trusts to achieve. Will involve a lot of service modelling and predictions of demand/ capacity and	Strategy.docx	Immediate and On-Going	Internal analysis of workforce in CNS completed by End Dec 2021 Regional data still awaited.	

						workforce will look. Regional work being lead by PHA. Recognised deficit in the CNS workforce in Trust and regionally. Trust submitted what we require now to meet demand and predicted demand for 10 years. 4. CNS 5 year work plan devised. DOH modelling process ongoing in line with Cancer Strategy and development of nurses to become CNS/ Succession Planning. Regional process driven by the Health Board. 6. Review of the resources and accessibility of MDT to CNS to allow timely and holistic approach to HNA assessments. (newly raised deficit). Review of the MDT involvement in the HNA process and how this is structured to ensure patients' needs are met.	3. Mapping of Cancer Strategy into the SAI recommendations . 	associated resources.				
Rec 2020	**From SAI Report**	**How This Will Be Achieved?**	**Action Owner**	**What Are The Key Outputs?**	**How Will This Be Measured?**	**Progress**	**Actions Outstanding/ Owners**	**Limiting Factors/ Essential Requirements**	**Supporting Guidance/ Policy**	**Timescale As Per SAI Overarching Report**	**Time scale**	**RAG**
3	The SHSCT must promote and encourage a culture that allows all staff to raise concerns openly **What Does That mean?**	1. Trust and Regional Guidelines and Policies -Whistle Blowing Policy - DOH Your Right to Raise a Concern Guide -Nursing and Midwifery Accountability and Assurance Framework - Working Well Together Policy	Ronan/ Sarah & Vivienne Toal & direct line managers for filtering to teams	1. All staff levels awareness of their responsibility to raise concerns. Processes detailed in Accountability and Assurance Framework for escalation and responsibility. 2. Directorates and Trust responsibility to respond to concerns and ensure escalation ,investigation and recording in line with policy 3. Communication strategy for disseminating information. 4. Learning from previous Inquiries for eg Muckamore	1. "Audit, Review and Refresh" section 41 within the DOH Guidance. Establish the systems and processes we have in place internally. 2. Challenge of measuring compliance with the policies- review of historical concerns and how they were managed? 3. Cyclical Global Email to entire Trust Staff Base	<u>May 2022</u> 1. Whistle Blowing is incorporated into Induction of all staff levels. Part of the Nursing and Midwifery Corporate Welcome. HR reports made available the total number of the Whistle Blowing incidents within the Trust. Report demonstrates limited use of Whistle Blowing process- themes are predominately raised by staff about working conditions. 2. Leadership walkarounds from Lead Nurses/ HOS/ ADS (Operational and Corporate) in progress. Allows staff to become familiar with management structure and supports staff to feel comfortable in approaching and potentially raising concerns. 3. Review of learning from other Public Inquiries for Eg Muckamore 4. Contacted Comms Team 19.1.22 to get cyclical global email for Whistleblowing circulated to all staff and desktop notification on raising concerns. 5. CNS forum will be an opportunity for peer support and supervision. This will allow CNS to feel able to raise concerns with peers and on up the structure to ensure the standard	<u>May 2022</u> 1. Complete at this stage		Appendix 13 Appendix 17 N&M	Immediate and On-Going	End Feb 2022	

					expected is reflected across all cancer sites.						
	All Staff members firstly are aware of their duty to patient safety to raise a concern, even if they are unsure if it is an actual concern. -Staff to feel respected and supported to raise concerns - Line mangers to ensure if concerns raised about cancer care in which the patient is being managed within for eg a surgical speciality under a surgical team then the cancer team is informed of the concern raised.	2.NMC & GMC Registration and requirements to Revalidate & Assurance of Safe to Practice. Duty of Candour as stipulated in Code of Conduct	Line Managers, Revalidation Teams & Individual Staff on a Professional Register	1. All registrants of both medical and nursing professions Revalidate in line with the professional body they are aligned to. 2. Revalidation process encompasses the 4 fundamental aspects of a nurses responsibilities within their Code of Conduct - Prioritise People -Promote Professionalism -Practice Effectively -Preserve Safety 3. Staff aware of the Duty of Candour (Nursing and Medical)	1. Revalidation team for nursing staff. Monthly emails to staff and line managers to ensure prompt submission of documents/ fees to ensure no lapse in status on register. Revalidation every 3 years which is signed off by a line manager whereby the Nurse must demonstrate how they meet the 4 principals of the code. Uploaded to NMC personal record and NMC validate. 2. Escalation Process for staff who have lapsed on Revalidation 3. Medical staff follow the same process within the Trust.	<u>May 2022</u> 1. Communication strategy already in place to ensure Revalidation requirements are met in time. 2. NMC has process of validation where records can be asked for to assess. 3. Sharepoint resource for support for the Revalidation process and access to Code of Conduct.	<u>May 2022</u> 1. Complete at this stage		Appendix 14 Appendix 15 Appendix 16 Code Appendix 18 NMC Appendix 19 GMC	Immediate and On-Going	Fully Compliant 17.12.21	
		3. Information that supports the raising of concerns and management of concerns within the Organisation	Governance Teams	1. Evidence to support that concerns are being raised 2. Evidence to support that concerns are registered 3. Evidence to support concerns are actioned,	1.Datix review relating to concerns 2. Complaints review relating to concerns - what process was followed 3. Evidence of sharing Datix incidents and complaints	<u>May 2022</u> 1. Review of incidents within the Trust raised regarding concerns of Treatment. Currently the National Incident Reporting system (DATIX) does not allow for categorising "concern". Of the report run from Jan 2019 to Dec 2021 themes that could include a concern were: -Diagnosis-Wrong (8 reports) -Failure to Note Relevant Info In A Patients Record (61 reports)	<u>May 2022</u> 1. Discussion with Governance Team regarding the process/ coding of concerns. Initial discussion regarding coding and now to identify how to disseminate	1. National Incident Reporting System Limitations on Coding 2. Induction Training to include Datix Completion		Immediate and On-Going	Aim end of Feb 2022 to have data on incidents and complaints relating to a concern. Expect the analysis and generating	

				addressed and closed. 4. Evidence to support investigated concerns have been shared for wider learning. 5. Robust structures across all teams and specialities for discussion of concerns. Including meeting structures/ agendas/ forums	relating to concerns. 4. Review of the structures in place within Cancer and Benign teams which allow for raising, discussion and recording of concerns.	-Failure to Discontinue Treatment (10 reports) -Failure/ Delay to Order Correct Tests/ Images (125 reports) -Inadequate Investigation/ Inadequate Assessment (7 reports) - Treatment/ Procedure Not Clinically Indicated (13 reports) -Treatment/ Procedure Inappropriate/ Wrong (38 reports) Of note there has been more reporting since 2019 and steady increase year on year. Reflective of staffs awareness to raise concerns and confidence to report. Discussed with Governance Team. Datix can code concerns but staff awareness of this is limited. Shared with Lead Nurses for sharing at Sisters Meeting to disseminate to teams regarding use of Datix for reporting concerns.	learning and enhance staffs awareness of how to code concern correctly and for managers to address a raised concern. 2. Discuss with HR regarding process/ volume/ outcome of concerns raised -Owned by Sarah				outcome report will take further time. Aim April 2022	

Rec 2020	From SAI Report	How This Will Be Achieved?	Action Owner	What Are The Key Outputs?	How Will This Be Measured?	Progress	Actions Outstanding/ Owners	Limiting Factors/ Essential Requirements	Supporting Guidance/ Policy	Timescale As Per SAI Overarching Report	Time scale	RAG
4	The Trust must ensure that patients are discussed appropriately at MDM and by the appropriate professionals.	1. All MDT meetings follow the Guidance from National Cancer Action Team (NCAT) and meetings formatted in accordance with this framework as recognised as best practice regionally.	MDT Leads ,Cancer Leads and Regional MDT	1. MDT meetings are structured in accordance to the NCAT tool. Meeting agendas follow the essential elements within the NCAT Tool. 2. Quoracy at MDT for specialities is not recorded in Policy and is not agreed regionally at a set %. 3. Clear ownership of implementing MDT recommendations is discussed and accurately recorded. 4. Recording of variances in actions from the recommendation of the MDT is clear and demonstrates rationale for this. 5. Patients that require discussion at MDT are referred in correctly and the MDT process allows for patients with positive pathology to be identified and discussed as soon as possible ensuring prompt implementation of the recommended care plan. 6. MDT Coordinator to oversee the MDT and ensure process follows the NCAT framework	1. Baseline assessment of MDT Meetings across all tumour sites - identify themes/ gaps -action plan to address deficits -acknowledge resource issues - current practice of recording discussion/ variances/ change to plans 2. MDT Coordinator clear role and responsibility for MDT process can be subject to audit/peer review and demonstrate compliance/ action plan to address	<u>May 2022</u> 1. MDT baseline assessments complete across all Tumour sites 2. Action Plans for each MDT devised based on the findings of the assessment. All MDT's have action plans with "common" areas to address as well as specifics for each. Monthly meeting with MDT Leads with Cancer Services Improvement Lead to review and update action plan. This then feeds into the Task & Finish Super Group. 3. Principals document created based on the NCAT framework to be used to support the function of the MDT. This Principals document has been accepted by all MDT Leads. 4. MDT Proforma for each MDT required based on the Principals document. This is now operational within Urology and is in progress of being rolled out across all other tumour sites. This proforma allows for auditing of the MDT process and assurance that guidelines are followed. 5. Cancer Service Improvement Lead & Head of Service for Clinical Assurance are meeting with each MDT Lead to review the outstanding actions and ensure all fully appraised of the requirements & timescales. ENT & Urology, Lung & Gynae Completed. Awaiting confirmation from other MDT's of dates but aiming May to have this all completed. 6. Task & Finish Supergroup meetings well represented across all tumour sites and lots of participation and engagement. 7. All CNS are fully involved in the SAI action plan. 8. Established recording of attendance at MDT which is reported monthly and shared with MDT Leads. Can establish quoracy from these and identify issues early and address. Report for Jan pending and will continue on a monthly basis with oversight by MDT Leads.	<u>May 2022</u> 1. Ongoing monthly updates with Mary, MDT Leads, HOS and AD supported by MDT administrator and regional input	1. MDT Leads of All Tumour Sites Support, Leadership and Guidance to Implement the Recommendation to their MDT's	Appendix 20 Guidance Link.docx	3 months and on-going - Commencing May 2021	Ongoing. MDT leads to update group in May 2022 with regards to action plan update. As MDT Administrator in post as of Jan this will be ongoing.	
	What Does That Mean?											

						9. Audit requirement detailed in the Principals document are no beginning to be rolled out across all MDTS. These require additional support from the Corporate Audit Team which is currently recruiting additional support.					
	MDT Chairs and those required to attend MDT will have: - Job descriptions reflect the requirement of the MDT chair and MDT Leads supported by NCAT framework. - Job plans reflect the prep time and time to attend MDT - MDT will be represented according to recognised required quoracy. - Clear accountability & responsibility of MDT participants for action of recommendations and recording of action owners at MDT. - Process for re-referral for re-disussion at MDT is based on NCAT guidelines	2. MDT Chairs & essential professionals eg CNS will have Job Planned sessions for MDT role. This is reflected also in Job Description	Dr Tariq, Stephen Wallace & Line Managers for CNS	1. Job plans of MDT chairs and CNS reflect the required attendance at MDT 2. Job descriptions clearly detail roles and responsibilities for the Chair in keeping with the Effective MDT principals.	1. Baseline review of all MDM chairs job plans - who has it/ who doesn't have it job planned in weekly/ monthly activity. -how does MDT chair record this in their activity? Recognising that this is inconsistent regionally. 2. Standardised MDT Job Description detailing the requirements in line with the Effective MDT Principals. Will also allow for specifics to be incorporated for each tumour site.	<u>May 2022</u> 1. JD for Urology MDT had been finalised and agreed with the Chair and the Div MD. JD explains very clearly who is responsible for the operational element and who is responsible for the clinical elements of the particular Cancer MDT. Essential element needed is for audit function as it is impossible to support Governance requirements at a basic level. However at last T&F group meeting the MDT Chairs raised some queries which has resulted in the JD going back to draft and further consultation with the chairs is required. 2. Job planning for MDT Leads ongoing across all tumour sites. 3. MDT to have 95% attendance at each meeting (across all those representing from all specialities) . Individuals to have 66% across the year at MDT, but to have clear actions to ensure replacement representation is secured if they cannot attend. 4. MDT Administrator and Projects Officer auditing attendance for the MDT. From this quoracy at each MDT can be established. These are being completed monthly and will allow gaps to be identified at an early stage. 5. Elements of job planning included in the MDT action plans which are in progress. 6. Process for re-referral for MDT discussion and other scenarios is still being discussed with MDT Leads supported by the Principals Document. The new auditor posts will support this by identifying patients who have not followed MDT recommendations, deviated from plan or where to come back to MDT and have not. 7. Trust SMT recognised deficit in our Clinical Audit Team. Planned investment into this in phased	<u>May 2022</u> 1. MDT recognised in CNS Job Planning Guidelines and will be an element incorporated into the KPI audit template being discussed and devised at March 22 workshop. 2. Regional review of MDT processes and quoracy 3. Need resource for Auditing Team recruited to -Owned by CNS , Line managers and Governance Teams -regional input also 4. Concerns over recruitment and retention of MDT Leads as the overall accountability falling to one person- MDT leads cannot facilitate this and feel it is devolving Corporate responsibility. A clinician cannot check another clinicans work. Issue with personal accountability and professionalism.	1. Job Description Needs to Be Standardised Regionally 2. Resource for MDT Audit & Administration Roles	CNS.docx	3 months and on-going - Commencing May 2021	Job Description will be a regional change and may take time. Provisionally aim March 2022 Baseline review of levels of Job planning for CNS to be completed Jan 2022. (Complete)	

						approach with priority into Cancer MDT. 9. All CNS have job plans in place. All have job planned time to attend MDT. All job plans being reviewed by Cancer Improvement Leads.					
Rec 2020	**From SAI Report**	**How This Will Be Achieved?**	**Action Owner**	**What Are The Key Outputs?**	**How Will This Be Measured?**	**Progress**	**Actions Outstanding/ Owners**	**Limiting Factors/ Essential Requirements**	**Supporting Guidance/ Policy**	**Timescale As Per SAI Overarching Report**	**Time scale**	**RAG**
5	The Southern Health and Social Care Trust must ensure that MDM meetings are resourced to provide appropriate tracking of patients and to confirm agreed recommendations / actions are completed **What Does This Mean?**	1. Compliance with regional tracking requirements. Currently 31 & 62 day tracking is the only requirement in accordance with CaPPS	Operational Service Leads and Cancer Leads	1. All patients with Cancer diagnosis are recorded in CaPPS system 2. Patients are tracked 31 & 62 days 3. Regionally no Trust tracks beyond 62 days. If this changes this will be a collaborative regional piece of work and will require: -funding -resources including staff, training and IT system update to support.	1. Data of number of patients tracked at 31 & 62 days (%)	<u>May 22</u> 1. X2 additional trackers now in post which has resulted in a fully resourced team focused on this process. 2. Recognition if region decides to track beyond the 31 & 62 days there will be need for additional resources and needs to be a regional policy/ procedure change 3. Discussion with Lead Cancer Commissioner regarding the ask of the Trust to track beyond the regional requirements. Advised this must be a regional position and not only within one Trust. Met this week regarding the Tracking process and the plans for enhancing the role. Identified there needs to be 100% increase in resource in all Trusts to meet the demand. It will be phased approach across the region looking at treatment tracking and tracking of secondary cancer diagnosis. Commissioner is escalating to HSCB that this request for the Trust alone is not appropriate or feasible. Awaiting response. Noted that the process would need to begin with extending the 62 day tracking to the end of treatment and will lead to subsequent diagnosis tracking. 4. Trust has submitted what we need for now and projections for tracking in 10 years. 5. Current re-establishment of Waiting Time Guidance Review Group. These guidelines are from 2008 and need work to update in line with England current guidance. This will look at subsequent treatment for 2nd diagnosis etc. First meeting next month.	<u>May 22</u> 1. Requirement fully met to date 2. Awaiting regional updates and actions -Owned by Region and internally OSL's, Cancer Service Improvement Lead	1. Extensive Regional Review of Tracking Guidelines & Associated Systems Update/ Infrastructure and Staffing Resource	Appendix 23 CaPPS.pdf	3 months - Commencing May 2021	Completed & Fully compliant as of 6.12.21	

	MDT Coordinator role to encompass auditing of the pathway. To include mechanisms in place to ensure no patients are inadvertently missed from MDT. This includes use of laboratory systems which enables weekly reports to be generated and made available at MDT. The CNS in keyworker role to also have responsibility to ensure tracking is complete. . It is essential that current limited clinical resource is focused on patient care		MDT Leads, Clinicians, CNS & MDT Coordinator	1. All patients with positive pathology results are identified and referred to MDT promptly. 2. Robust systems to enable alerts/ cross checking and sign off of pathology results for patients on tracking	1. Review processes currently in place to alert key staff of positive Pathology results 2. Review process from positive pathology to discussion at MDT including: -who chases results -when are results checked -are results signed off on Lab system -who signs off results -who notifies MDT Lead -what is time frame from positive result and discussion at MDT	<u>May 22</u> 1. Trust is first in region that allows Pathology report to be generated detailing all results to allow these to be cross referenced with patients on Tracking 2. This will steer improvement in the processes going to be reviewed and allow this to be drafted into a guideline/ roles and responsibilities of CNS/ MDT Coordinator potentially/ MDT 3. Report is now available and the MDT Administrator is currently working MDT Leads to develop Standard operating procedure for use at the MDT meetings. 4. Its purpose is a safeguard that all patients with a positive pathology are discussed at an MDT.	<u>May 22</u> 1. The development of SOP and ensure governance framework to support this. -Owned by AD of Radiology and Laboratory and MDT Coordinator		Have we any supporting documentation about the new Pathology process?	3 months - Commencing May 2021	As this will be a change that will impact the regional MDT this may take some time to embed and develop guidelines for this process. Ongoing.	

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6	The Southern Health and Social Care Trust must ensure that there is an appropriate Governance Structure supporting cancer care based on patient need, patient experience and patient outcomes.	1. This overlaps with Rec #2. Feedback from Patients from a variety of sources including: -Complaints -Datix -Care Opinion -10,000 Voices -Patient Surveys	Mary, Sarah, Governance/ Patient Experience Team & CNS	Feedback structures in place to allow ongoing collection of patient experience from a variety of sources. Standardised processes across all Cancer sites that compliments the feedback/ patient surveys completed by the Cancer Network. Internal and external feedback to be shared widely amongst teams so that all can learn from feedback to drive change/ improvement	1. Review of the historical feedback and establish what were the themes and what was implemented to drive change from these. 2.Service User Group to advise on a survey template we could use to collect fresh feedback	<u>May 2022</u> 1. Review of the NICAN policy regarding information that must be given to patients completed. The Principals Document contains and references the completion of the Information tracking form. 2. Cancer Leads and Lead Nurses for CNS are working through assessment of completion of the paper "Information Tracker Form". This has been raised regionally and will be on next agenda for discussion to have CAPPS system enabled to record this rather that a paper form which can/ does go missing. As we are moving towards paperless recording this will require regional discussion and planning. Last review of this was 2015. We have reviewed what we do in Trust and established that either the form is completed or it is recorded in the free text options on CAPPS with the majority using the paper form. 3. We have agreed to standardise our process in Trust whilst waiting regional steer. All CNS informed of need to ensure paper checklist of information completed and added to records in interim. Once completed CAPPS field for "information given" to be completed to allow audit to be completed of this. Information Team have been informed and we will audit this is 3 months to ascertain compliance. The aim is to have a dedicated "Information" Tab on CAPPS which details ongoing information given throughout the patient journey. This has been discussed extensively at the CAPPS User Group Meeting & regional recognition that CaPPS system needs refreshing. This process will allow for auditing of the system to ascertain compliance. 4. Service User project for Questionnaire supported by Marian Thompson from PPI has been progressing. We are now at final draft of the questionnaire which is now shared with our CNS in Urology. This	<u>May 2022</u> 1. Ongoing with regards to service user/ QI team project. Meetings weekly currently. 2. Regional work required for the amendments needs on CAPPS system. -Owned by Mary, Clair & Sarah and CNS - Service Users for Survey -MDT Administrator - Regional Input	1. Regional Revision of "Information Tracking" Recording 2. Regional Revision of CAPPS System	Appendix 10 NCAT	Immediate and On-Going	Aim End April/ May 2022 to have baseline assessment / audit completed. Will also be ongoing as we gather feedback and review processes	
	What Does This Mean?											

						focuses on the Diagnosis Clinic and the knowledge of the journey ahead the patient has. Elements being worked on currently: - scoping of pilot patients - review of relative/ supportive person questionnaire to compliment the patient questionnaire - QI team providing guidance and support for access to different formats for eg different languages/ large text - aide memoir being created for the CNS when using the questionnaire -We have already identified lots of areas we can branch into following this piece of work & the next phase of questionnaires. This includes potential review of what information is given to patients & the development of patient held MDT records for their entire cancer treatment pathway. 5. Audit process has commenced by the Lead Nurse for Cancer Services on the CNS Proforma. This is the start point of audit following standardising the internal processes in the absence of regional updates with regards to recording of information given to patients (amongst other elements). This has been completed in Urology to date and other CNS in other Tumour sites in progress. Report will be discussed with CNS and action plans devised to address areas for improvement.					
	This will be achieved by - Developing a proactive governance structure based on comprehensive ongoing Quality Assurance Audits of care pathways and patient experience for all. It should be proactive and supported by adequate resources.This should have	2. This overlaps with Rec #2. Key Workers allocated at diagnosis	MDT Leads, MDT Coordinator & CNS	1. Patients are aligned to a Keyworker/ Nominated CNS on diagnosis 2. Keyworker/ Nominated CNS allocation recorded at MDM 3. Key Worker/ Nominated CNS makes contact with the patient within an agreed timeframe 4. Patients with a cancer diagnosis have an HNA appointment (electronic HNA and Face to Face)	1. Process review of allocations of Keyworker/ Nominated CNS are across all tumour sites. 2. What HNA clinics are in place across all CNS specialities 3. Recording of Keyworker/ Nominated CNS in patient records- what is the practice now?	<u>May 2022</u> 1. MDM process currently does not include the physical allocation of the Keyworker/ Nominated CNS. Included in the MDT Principals document which is now operational. This also needs revised regionally. CNS have had oversight of the Principals Document and are aware of its contents. See below recommendations for process update. As part of the monthly MDT action plan update & the individual meetings with the MDT leads by Cancer Services Improvement Lead & Head of Service for Clinical Assurance this is reinforced with everyone the importance of this allocation. The default Keyworker is the CNS.	<u>May 2022</u> 1. Review of Breaking Bad News Clinics- Region to steer based on feedback from other Trusts. 2. CNS Database should capture HNA activity this will be fully functional when all CNS are using the electronic format to allow data to be pulled easily off for audit purpose.	1. Regional Revision of CAPPS MDT Section to allow recording of Key Worker at MDT	Appendix 11 CNS Proformas - Link.html Appendix 23 HNA.docx	Immediate and On-Going	This is regional work also. The review of current processes in Trust completed by end Feb 2022. Regional input is ongoing.	

	an exception reporting process with discussion and potential escalation of deficits. It must be multidisciplinary to reflect the nature of cancer and work with other directorates.			allocated within an agreed timeframe 5. HNA clinics in place across all tumour sites with CNS 6. Breaking Bad News Clinics follow Guideline Structure of Breaking Bad News Clinics.	4. How many Breaking Bad News Clinics are embedded in specialties and what is the structure in line with the guidance	2. Regional work required for recording of key worker on CaPPS to be an essential field. MDT Administrator & Project Officer raised CaPPS user group meeting on 26.1.22. Group agreed this needs to be a set requirement on system, however the system currently does not allow for fields to be made mandatory in the MDM section due to issues with saving the document. Agreement this requires addition of a tick box and free text box to the MDM section to allow input of keyworker name at MDM meeting. The Trust has decided to use the free text box now to record the keyworker and we can begin to audit this. 3. Review of how diagnosis are delivered. Also known as “Breaking Bad News”. Established no standardised practice in Trust or Region. Use of “red flag” clinics, protected review slots, meetings in Consultants Office or ward attendance are all noted to be ways this can be done. Internal meeting with Booking Teams to discuss the need for dedicated codes to allow this activity to be audited and to ensure these types of reviews are well known by the teams to ensure planning and presence from essential team members to inform and support the patient. Internally we have discussed how this needs to be and agreed this needs to be a code aligned to a patient rather than an entire clinic code. Brought back to regional group and advised we must get a steer from all Trusts to ensure the process is consistent across the region. All Trusts have been asked to advise on their processes and work required will be discussed following this. Regionally they feel it is important to maximise the role of the Keyworker firstly across all Trusts. The Trust is now as a pilot, we are setting up a nurse-led clinic for UGI patients who have just had their diagnosis – the clinicians will refer all patients to the clinic after they give results. We are keen to ensure a robust process so that the CNS’s are able to identify and follow-up with all newly diagnosed patients. Breaking Bad News also not	3. Process Map/ Patient feedback will identify the best time for the HNA clinics based on patient feedback. -Owned by MD, AD, HOS and CNS & Region.					

						contained within an outpatient setting, feedback on ward based news breaking has raised the need for ward staff to be skilled in this. 4. HNA workshop organised for CNS with Governance, Quality, Patient Safety and Patient Experience Teams present. Focusing on embedding HNA into CNS job plans and devising audit tools to allow systemic audit of the process (including patient feedback) and benchmarking (based on KPI's). Work now regionally focused on agreed KPI framework and benchmarking across all Trusts. 5. HNA clinics. Rolling out electronic HNA across all CNS. All CNS have now been trained across all tumour sites. H&N and Urology CNS are operational, Colorectal and Breast CNS are next. Currently all CNS are completing HNA but aim is to move to electronic format. CNS Database will capture all this activity. 6. CNS Proforma now on Sharepoint. Once completed this goes straight to support worker and uploaded onto CNS database which will now allow ability to audit. As discussed above the audits of CNS proforma has commenced. This is our new baseline following standardisation of the process internally in absence of the regional update required.					

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7	The role of the Chair of the MDT should be described in a Job Description, funded appropriately and have an enhanced role in Multidisciplinary Care Governance. **What Does This Mean?**	1 This overlaps with Rec #4. MDT Chairs will have Job Planned sessions for MDT role. This is reflected also in Job Description	Dr Tariq, Stephen Wallace & Line Managers for CNS	1. Job plans of MDT chairs reflect the required attendance at MDT 2. Job descriptions clearly detail roles and responsibilities for the Chair in keeping with the Effective MDT principals.	1. Baseline review of all MDM chairs job plans - who has it/ who doesn't have it job planned in weekly/ monthly activity. -how does MDT chair record this in their activity? Recognising that this is	<u>May 2022</u> 1. JD for Urology MDT had been finalised and agreed with the Chair and the Div MD. JD explains very clearly who is responsible for the operational element and who is responsible for the clinical elements of the particular Cancer MDT. Essential element needed is for audit function as it is impossible to support Governance requirements at a basic level. However at last T&F group meeting the MDT Chairs raised some queries which has resulted in the JD going back to draft and further consultation with the chairs is required.	<u>May 2022</u> 1. Ongoing monthly updates with Mary, MDT Leads, HOS and AD supported by MDT administrator and regional input	1. MDT Leads of All Tumour Sites Support, Leadership and Guidance to Implement the Recommendation to their MDT's	Appendix 20 Guidance Link.docx	3 months and on-going - Commencing May 2021	Ongoing. MDT leads to update group in May 2022 with regards to action plan update. As MDT Administrator in post as of Jan this will be ongoing.	

	Not specifically set out in the recommendation of the overarching report				inconsistent regionally. 2. Standardised MDT Job Description detailing the requirements in line with the Effective MDT Principals. Will also allow for specifics to be incorporated for each tumour site.	2. Job planning for MDT Leads ongoing across all tumour sites. 3. MDT to have 95% attendance at each meeting (across all those representing from all specialities) . Individuals to have 66% across the year at MDT, but to have clear actions to ensure replacement representation is secured if they cannot attend. 4. MDT Administrator and Projects Officer auditing attendance for the MDT. From this quoracy at each MDT can be established. These are being completed monthly and will allow gaps to be identified at an early stage. 5. Elements of job planning included in the MDT action plans which are in progress. 6. Process for re-referral for MDT discussion and other scenarios is still being discussed with MDT Leads supported by the Principals Document. The new auditor posts will support this by identifying patients who have not followed MDT recommendations, deviated from plan or where to come back to MDT and have not. 7. Trust SMT recognised deficit in our Clinical Audit Team. Planned investment into this in phased approach with priority into Cancer MDT. 9. All CNS have job plans in place. All have job planned time to attend MDT. All job plans being reviewed by Cancer Improvement Leads.						

Rec 2020	From SAI Report	How This Will Be Achieved?	Action Owner	What Are The Key Outputs?	How Will This Be Measured?	Progress	Actions Outstanding/ Owners	Limiting Factors/ Essential Requirements	Supporting Guidance/ Policy	Timescale As Per SAI Overarching Report	Time scale	RAG
8	All patients should receive cancer care based on accepted best care Guidelines (NICAN Regional Guidance, NICE Guidance, Improving	1. This overlaps with Rec #2. Information Pathway. Review of: - information given to patients -Timing of Information given - Recording of Information given - Audit of Information Given	Mary, Clair & Sarah and CNS Service Users for Survey	Information provided to patients is: -specific to their diagnosis -given at the right time -easily accessible -easy to understand - details support to patients/ families -Patient records reflect the information given	1. Clinical Guidance/ Policy review of Information patients should receive 2. Review of current process of patients receiving information and	<u>May 2022</u> 1. Review of the NICAN policy regarding information that must be given to patients completed. The Principals Document contains and references the completion of the Information tracking form. 2. Cancer Leads and Lead Nurses for CNS are working through assessment of completion of the paper "Information Tracker Form". This has been raised regionally and will be on next agenda for discussion to have CAPPS system enabled to record this	<u>May 2022</u> 1. Ongoing with regards to service user/ QI team project. Meetings weekly currently. 2. Regional work required for the amendments needs on CAPPS system. -Owned by Mary, Clair & Sarah and CNS	1. Regional Revision of "Information Tracking" Recording 2. Regional Revision of CAPPS System	Appendix 10 NCAT	Immediate and On-Going	Aim End April/ May 2022 to have baseline assessment / audit completed. Will also be ongoing as we gather feedback	

	Outcome Guidance).	- Past patient feedback on Information. Including sources, access, content etc		- supports the Clinical Guidelines/ Policies	accessibility to Information 3. What Information is available currently 4. Audit of patient records with diagnosis regarding information given. -is it clearly recorded -does it detail what was given -was the information refreshed during patients journey 5. New patient survey specific to information based on the requirements in guidance/ policy.	rather that a paper form which can/ does go missing. As we are moving towards paperless recording this will require regional discussion and planning. Last review of this was 2015. We have reviewed what we do in Trust and established that either the form is completed or it is recorded in the free text options on CAPPS with the majority using the paper form. 3. We have agreed to standardise our process in Trust whilst waiting regional steer. All CNS informed of need to ensure paper checklist of information completed and added to records in interim. Once completed CAPPS field for "information given" to be completed to allow audit to be completed of this. Information Team have been informed and we will audit this is 3 months to ascertain compliance. The aim is to have a dedicated "Information" Tab on CAPPS which details ongoing information given throughout the patient journey. This has been discussed extensively at the CAPPS User Group Meeting & regional recognition that CaPPS system needs refreshing. This process will allow for auditing of the system to ascertain compliance. 4. Service User project for Questionnaire supported by Marian Thompson from PPI has been progressing. We are now at final draft of the questionnaire which is now shared with our CNS in Urology. This focuses on the Diagnosis Clinic and the knowledge of the journey ahead the patient has. Elements being worked on currently: - scoping of pilot patients - review of relative/ supportive person questionnaire to compliment the patient questionnaire - QI team providing guidance and support for access to different formats for eg different languages/ large text - aide memoir being created for the CNS when using the questionnaire -We have already identified lots of areas we can branch into following this piece of work & the next phase of questionnaires. This includes potential review of what information is given to patients & the development of patient	- Service Users for Survey -MDT Administrator - Regional Input				and review processes	

						held MDT records for their entire cancer treatment pathway. 5. Audit process has commenced by the Lead Nurse for Cancer Services on the CNS Proforma. This is the start point of audit following standardising the internal processes in the absence of regional updates with regards to recording of information given to patients (amongst other elements). This has been completed in Urology to date and other CNS in other Tumour sites in progress. Report will be discussed with CNS and action plans devised to address areas for improvement.						
	How This Will Achieved From SAI Report This will be achieved by - Ensuring the multi-disciplinary team meeting is the primary forum in which the relative merits of all appropriate treatment options for the management of their disease can be discussed. As such, a clinician should either defer to the opinion of his / her peers or justify any variation through the patient's documented informed consent.	3. This overlaps with Rec #2. Key Workers allocated at diagnosis	MDT Leads, MDT Coordinator & CNS	1. Patients are aligned to a Keyworker/ Nominated CNS on diagnosis 2. Keyworker/ Nominated CNS allocation recorded at MDM 3. Key Worker/ Nominated CNS makes contact with the patient within an agreed timeframe 4. Patients with a cancer diagnosis have an HNA appointment (electronic HNA and Face to Face) allocated within an agreed timeframe 5. HNA clinics in place across all tumour sites with CNS 6. Breaking Bad News Clinics follow Guideline Structure of Breaking Bad News Clinics. 7. Patients are informed of recommendations from the MDT, treatment options and records the patients preference/ choice.	1. Process review of allocations of Keyworker/ Nominated CNS are across all tumour sites. 2. What HNA clinics are in place across all CNS specialities 3. Recording of Keyworker/ Nominated CNS in patient records- what is the practice now? 4. How many Breaking Bad News Clinics are embedded in specialties and what is the structure in line with the guidance	<u>May 22</u> 1. MDM process currently does not include the physical allocation of the Keyworker/ Nominated CNS. Included in the MDT Principals document this is out for consultation. This needs revised regionally. CNS have had oversight of the Principals Document and are aware of its contents. 2. Breaking Bad News Guidance. PHA note this needs reviewed (last in 2003). This may change for region but this is our baseline to benchmark against now. 3. 18.1.22 HNA workshop originally organised for CNS with Governance, Quality, Patient Safety and Patient Experience Teams present. Focusing on embedding HNA into CNS job plans and devising audit tools to allow systemic audit of the process (including patient feedback) and benchmarking (based on KPI's). HNA Workshop has been rescheduled until the 21st March. This is due to pressures in the service and team sickness resulting in essential staff being absent from process. Team also requested this be face to face workshop to maximise the session. Agenda discussed for workshop and agreed already. 4. Regional work required for recording of key worker on CAPPS. MDT Administrator & Project Officer raised CAPPS user group meeting on 26.1.22. Group agreed this needs to be a set requirement on system, however the system currently does not allow for fields to be made	<u>May 22</u> 1. Review of Breaking Bad News Clinics- add hoc. Some formalised some not. Unclear how they are recorded/ activity not captured. Dr Tariq and Consultants delivering bad news to discuss how we collect this info. 2. CNS Database should capture HNA activity this will be fully functional when all CNS are using the electronic format to allow data to be pulled easily off for audit purpose. 3. Process Map/ Patient feedback will identify the best time for the HNA clinics based on patient feedback. -Owned by MD, AD, HOS and CNS	1. Regional Revision of "Information Tracking" Recording 2. Regional Revision of CAPPS System	See Recommendation #2 Supporting Documents	Immediate and On-Going - Commencing May 2021	This is regional work also. Aim to have review of current processes in Trust completed by end March 2022.	

						mandatory in the MDM section due to issues with saving the document. Discussions to add a tick box and free text box to the MDM section to allow input of keyworker name at MDM . Cancer Lead setting up working group to review this. 5. HNA clinics. Rolling out electronic HNA across all CNS. All CNS have now been trained across all tumour sites. H&N and Urology CNS are operational, Colorectal and Breast CNS are next. Currently all CNS are completing HNA but aim is to move to electronic format. CNS Database will capture all this activity.						
Rec 2020	**From SAI Report**	**How This Will Be Achieved?**	**Action Owner**	**What Are The Key Outputs?**	**How Will This Be Measured?**	**Progress**	**Actions Outstanding/ Owners**	**Limiting Factors/ Essential Requirements**	**Supporting Guidance/ Policy**	**Timescale As Per SAI Overarching Report**	**Time scale**	**RAG**
9	The roles of the Clinical Lead Cancer Services and Associate Medical Director Cancer Services should be reviewed. The SHSCT must consider how these roles can redress Governance and Quality Assurance deficits identified within the report.	1. Job Descriptions to reflect the requirements for robust Governance and Quality Assurance processes for Cancer Services Leads, AMD's and Divisional Medical Directors	Medical Directors Office, MDT Leads	1. Consistent and Standardised requirement within Job Descriptions across Leads, Directors and Associate Medical Directors.	1. Clinical Director Job Description 2. Divisional Directorate Medical Director. New Title and Job Descriptions completed for both 2. Attendance/ Representation at Interface Meetings 3. Communication channels between divisional director and Cancer Lead when there are clinical concerns.	<u>May 22</u> 1. Revised Job Descriptions have been have been agreed. 2. This will be a regional piece of work also as all Trusts need to reflect the same. Highlighted at Board meeting on 6.1.22	<u>May 22</u> 1. Awaiting comments. Based on this revised JD, this will shape job plans etc Recognition the JD's need to reflect the specific governance requirements within each. Further discussions pending. -Owned by Dr Tariq, MD and MDT Leads		DivMD JD IMWH (FINAL).docx DivMD JD OPCC(FINAL).docx DivMD JD SEC (FINAL).docx DivMD JD EDUCC(FINAL).docx	*Not specifically set out in the recommendation of the overarching report*	As this will also involve some regional input this is likely going to be ongoing and end time scale is unable to be established currently.	
	What Does This Mean? Not specifically set out in the	2. Each of the above will have full oversight of the requirements of the SAI	Medical Directors Office, MDT	1. Governance structures are clear, consistent and robust across		<u>May 22</u> 1. All MDT Chairs invited to the Monthly Group Meetings and all fully appraised that the recommendations extend across all tumour sites	<u>May 22</u> 1. Ongoing Monthly updates with MDT Leads, Cancer Services		Medical	*Not specifically set out in the recommend*	All MDT Chairs fully aware of the recommend	

	recommendation of the overarching report	implementation action plan	Leads & Dr Tariq	Cancer and Non Cancer		therefore support from each is essential. Good support from December and Feb meeting across all sites. 2. Updated action plan for MDT provided monthly which is detailed in Recommendation #1 3. Update provided by Medical Director 28.2.22 (see associated powerpoint) detailing the work completed in medical leadership, appraisal and revalidation and Governance including Private Patients.	Improvement lead and MD and Dr Tariq -owned by the above			*ation of the overarching report*	ations and actions/ engagement required	
Rec 2020	**From SAI Report**	**How This Will Be Achieved?**	**Action Owner**	**What Are The Key Outputs?**	**How Will This Be Measured?**	**Progress**	**Actions Outstanding/ Owners**	**Limiting Factors/ Essential Requirements**	**Supporting Guidance/ Policy**	**Timescale As Per SAI Overarching Report**	**Time scale**	**RAG**
10	The families working as "Experts by Experience" have agreed to support implementation of the recommendations by receiving updates on assurances at 3, 6 and 12 monthly intervals. **How This Will Achieved From SAI Report** Not specifically set out in the recommendation of the overarching report	Having patients and carers/ relatives involved in the implementation of the recommendation . Ensuring their contributions are evident throughout in helping shape and direct changes and maximising the patient centred focus	Task & Finish Group	1. Patients involved in the SAI's are provided with written updates on the progression of the action plan and meeting the requirements of the recommendations at 3, 6 and 9 month intervals. 2. Patient and Relative representation is essential and action plan must demonstrate the input and oversight provided by them in achieving the recommendations. 3. Patient and Relative input into the actions	1. Letters sent to relevant patients/ families at agreed time (Sept 21/ Jan 22 and May 22) 2. Action Plan reflects the patients/ relatives involvement in helping structure the actions needed to meet the requirements.	<u>May 22</u> 1. Letter 1 was completed and sent in Sept 21. 2. Second letter sent Jan 22. This includes an update of the work so far on the SAI recommendation actions. Letter reviewed and approved by MMcC and sent to Chief Executive Office 20.1.22 Approved content and Letters sent. Following feedback from the service users on Letter 2 Update, the Trust has decided to re-issue this incorporating the feedback. 3. Established "service user" group with engagement and support from them into helping steer direction and ensuring a patient centred approach to all actions.	<u>May 22</u> 1. Next update pending May 22 -owned by HOS for Clinical Assurance and Chief Executive	1. Legal Services Team are currently reviewing a redraft and associated apology letter		*Not specifically set out in the recommendation of the overarching report*	Ongoing and will conclude and be achieved at the end of the timeframe given.	

Rec 2020	From SAI Report	How This Will Be Achieved?	Action Owner	What Are The Key Outputs?	How Will This Be Measured?	Progress	Actions Outstanding/ Owners	Limiting Factors/ Essential Requirements	Supporting Guidance/ Policy	Timescale As Per SAI Overarching Report	Time scale	RAG
11	The Southern Health and Social Care Trust should consider if assurance mechanisms detailed above, should be applied to patients or a subset of patients retrospectively.	1. Following completion of recommendations 1-10 the aspects of improvement identified are to be applied to any service/ team/ speciality outside of Cancer Care	All Teams	1. Generating Quality improvement opportunities across the Trust and Regionally to improve standards and patient care and experience	1. Based on outcomes of current QI work specific to Cancer Care	May 22 1. This will be an ongoing process as when we complete an element that would be of benefit to another service/ team we will share the learning and drive change forward.	May 22 1. Ongoing as process continues -owned by all members of the SAI recommendation/ Steering groups and the Trust			Not specifically set out in the recommendation of the overarching report	Ongoing and will be likely at end of process where we sum up everything we have achieved	
	What Does This Mean Not specifically set out in the recommendation of the overarching report	2.Is there a need to review records beyond 2019-2020?	PI Team, RCS and Trust	1. Identifying potential further patients who have been on potentially incorrect management plans/ had deficits in care etc	1. Based on independent review of 100 records prior to 2019-2020 timeframe to establish level of risk	May 22 1. The decision to complete a Lookback of more patients beyond the 2019/2020 cohort will be based on the independent records review being completed by the Royal College of Surgeons (RCS) on 100 charts. At this time we don't have any further steer on this and await the outcomes. 2. Guidance has been issued to extend Lookback to 5 years	May 22 -Owned by RCS and Trust/ Public Inquiry Team			Not specifically set out in the recommendation of the overarching report	The extension of the Lookback has been extended for 5 years. The current 18 month cohort is to be completed first before progressing to the new cohorts.	

URO-ONCOLOGY IMPROVEMENTS JUNE 2022 MR BARRY CONWAY

Update is as follows:

Key issues raised in the Dermot Hughes report relating to Cancer MDTs were:

- Not all patients with a cancer diagnosis were brought by Mr O Brien for discussion at the Urology Cancer Multidisciplinary Team (MDT) meeting

- Not all patient with a cancer diagnosis brought by Mr O Brien to the Urology Cancer MDT were allocated a Cancer Nurse Specialist (CNS) as the key worker

- Having presented and agreed a specific plan for cancer patients at the MDT, Mr O Brien deviated from the agreed plan in the delivery of cancer care for his patients

My own reflection / learning:

- There was no commissioned post to oversee the effectiveness of each of the MDTs (Cancer MDT Administrator)

- There were no monthly reports in place to show how each MDTs was working – including information on quoracy. This information was contained within an Annual Report for each MDT

- There was no clinical audit support in place to check that actions agreed at MDT where implemented

- There was no way of recording that the key worker have been allocated for each patient at MDT

- There was no way of checking if a Cancer Nurse Specialist was involved with each patient and that information was shared with each patient in terms of their cancer diagnosis, their treatment plan and support available

- Information from the pathology department, including cancers confirmed through laboratory tests, was not being cross referenced back to cases presented to each cancer MDT

Actions taken / or ongoing:

- New resources are being put in place at financial risk to support the Cancer MDTs and to provide monthly monitoring by way of assurance.

- A Cancer MDT Administrator commenced in January 2022. This is the first post of this kind in NI as far as I'm aware. Angela Muldrew is the postholder

- A Cancer MDT Clinical Auditor and Information Officer is to be appointed at financial risk. This is a Band 5 post. This post is to be advertised soon and we will try and fill this post as soon as possible – could be September 2022 realistically for this.

- We have moved to appoint an Interim Lead Nurse for Cancer Services. Nicola Shannon is the postholder. This post is not commissioned. I have taken the opportunity to establish this post using slippage on Delivery Care funding. In my opinion, we need to move as soon as possible to appoint a permanent lead Nurse for Cancer Services. This Lead nurse will have responsibility for nursing staff in the Mandeville Unit, all the Cancer Nurse Specialists (across all Acute Divisions) and the Haematology ward which moved to my Division from Medicine & Unscheduled Care from 1 April 2022.

New monthly reports are being established as follows:

- Attendance / quoracy

- Audits to confirm that actions agreed by the MDT were implemented (this is currently being done for Urology only – a new post is to be trawled which will support this audit process for all 8 Cancer MDTs)

- Confirmation that a key worker had been identified and documented

- Confirmation that the Cancer Nurse Specialist (CNS) was involved with patients with a confirmed cancer

- Establishing a cross check mechanism with the Cellular Pathology Laboratory in Craigavon Area Hospital to ensure that, patients with a laboratory confirmed cancer, were brought to the MDT by their consultant for discussion

Ongoing improvement work following completion of the NCAT baseline audits from all Cancer MDTs (including Urology)

- Baseline audits completed with each Cancer MDT between June and August 2021

- An MDT Improvement Plan was devised

- A key part of the improvement plan was a new MDT Principles Document which describes how the MDT will function in line with best practice. Some of the new principles now included are:
    - Each MDT will use a proforma to capture data for each case to be discussed
    - Each patient will have a key worker allocated and it is agreed this will be the Cancer Nurse Specialist

- The key worker information will be recorded on the Cancer Patient Pathway System (CAPPS) and will be audited monthly

All the above work is underway through the Cancer and Clinical Services Division. We report on progress on this work through the Task and Finish Group that was established to deliver against the 11 recommendations in the Dermot Hughes report.

Southern Health and Social Care Trust

Quality Care - for you, with you

Briefing Paper

From: Margaret O'Hagan

To: Dr Maria O'Kane

Date: 9 June 2022

Subject: Proposed update to Urology Lookback Review structure, processes and accountability

Action Required: For consideration and agreement

Purpose

1. The purpose of this paper is to clearly articulate a proposed update to the structure and process for the ongoing Southern Trust Urology Lookback Review.

Background

2. On 31st July 2020 the Southern Trust contacted the Department to report an Early Alert concerning the clinical practice of a urology consultant, Mr Aidan O'Brien. The Trust informed the Department that on the 7th June 2020 it became aware of potential concerns regarding delays in the treatment of patients who were under the care of the consultant urologist had been employed by the Trust from 6 July 1992 until his retirement on 17 July 2020.

3. At that time, the Trust set about reviewing the treatment and care of patients over an 18-month period from January 2019 to June 2020. This came recognised as formal Lookback Review in July 2021 when the Trust received the updated guidance on for implementing a Lookback Review process[1].

4. On a related note, on 24 November 2020, the Health Minister announced to the Assembly his intent to set up a statutory public inquiry under the Inquiries Act 2005 into the Urology Service in the Southern Health and Social Care Trust. This Inquiry commenced on 6 September 2021 and is chaired by Ms Christine Smith QC.

5. Until very recently responsibility for coordinating the review of patients, which later became the Lookback Review, fell to one person. Up to October 2021, that person was the urology service manager. This manager moved to a different job within the Trust's Public Inquiry team and was replaced by a newly appointed

[1] https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-reg-guide-lookback-reveiw.pdf

"Head of Service – Clinical Assurance" in November 2021. The setting up and managing of the review / Lookback of these urology patients has created a very considerable workload for both these individuals.

6. Within the current Lookback Review process, there has been a number of errors mostly relating to the quality of the communication with patients. This was investigated and there were many findings including weaknesses in the operational and governance arrangements of the Urology Lookback Review process.

7. One of the recommendations was to review the operational and governance arrangements within the Acute Directorate as well as corporate levels, to strengthen reporting, oversight and accountability for the Lookback Review. Any new structure and process should be closely aligned to the DoH policy and guidance for *"Implementing a Lookback Review Process"* (2021).

Current Situation

8. There is currently only one formal internal group related to the Lookback Review called the ***Internal Urology Oversight Steering Group***. This is chaired by the Director of Acute Services and has membership from within the directorate, as well as corporate membership including the Medical Director, Deputy Medical Director and Assistant Director for the Public Inquiry.

9. There is no formal sub-groups with specific terms of reference, reporting to the Trust's Internal Urology Oversight Steering Group. All the work required for the Lookback is undertaken by the Head of Service – Clinical Assurance and she presents this to the Internal Urology Oversight Group by way of update.

10. There is a group of medical staff who meet to decide if gaps in patients' care meet the threshold of a Structured Clinical Record Review (SCRR). This group does not appear to have a terms of reference and the Internal Urology Oversight Steering Group receives the update of the outcomes of this group from the Head of Service – Clinical Assurance.

11. Trust's Internal Urology Oversight Steering Group is scheduled to meet for 30 minutes every 2-weeks. Because there is no subgroups undertaking the work of the Lookback Review, this meeting deals with operational as well as strategic issues. This is a busy meeting and there is insufficient time to debate and discuss aspects of the lookback that may requires more oversight, attention to detail, consideration, decision-making, scrutiny, etc. There is also no level above to escalate issues, decisions, etc. if required.

12. It is not clear in the terms of reference what the Urology Oversight Steering Group's internal upward reporting and accountability line is although an update

is provided to the Governance Committee and to the confidential section of Trust Board. This is presented alongside an update on the Urology Public Inquiry.

13. It appears that the Trust's Internal Urology Oversight Steering Group is held to account by an external group call the ***Southern Trust Oversight Steering Group*** which is led by the Director of Commissioning of the previous HSCB now Strategic Planning and Performance Group (SPPG) in the DoH.

14. The terms of reference of this group has considerable overlap / duplication as those of the Trusts' Internal Urology Oversight Steering Group. Hence, it is difficult to distinguish between the two groups and determine exact role and function of each. However, the SPPG Southern Trust Oversight Steering Group has a wider membership that reflects what is recommended for a Trust Steering Group in the DoH policy on *Implementing a Lookback Review Process* (2021).

15. The SPPG Southern Trust Oversight Steering Group provides a report to the Department of Health's **Urology Assurance Group**, which is chaired by the Permanent Secretary.

16. Essentially, the Trust's internal Lookback Review operational and oversight process are not in line with the 2021 DoH policy and guidance for implementing a Lookback Review Process. This lack of structure and process creates weaknesses in both internal and external assurances.

Proposal

17. It is proposed that the internal operational and oversight of the Urology Lookback Review is revised and strengthened so that it lines up with the DoH policy on Implementing a Lookback Review Process. While the Lookback Review remains ongoing it must be very clearly reflected in Trust Governance Framework in terms of reporting and accountability internally to Senior Management Team and the Trust Board and externally to the Department of Health.

18. It is anticipated that the Lookback Review reporting and accountability process will dovetail into the Trust's Urology Public Inquiry Programme. However, it is important that the Lookback Review process and the Public Inquiry process are both clearly defined operationally and within the Trust's Governance Framework, as they are inter-related but distinct processes both presenting a challenge and creating risk to the organisation.

19. The proposed core structure, which will span the lifetime of the Lookback exercise, includes:

- **Trust Lookback Review (LBR) Steering Group** – Chaired by an Executive Director (suggested Medical Director) and co-chaired by Independent Advisor for Urology (when released from chairing operational team below).

  The Chair(s) from this group will update the Chief Executive and SMT and report to Governance Committee and Trust Board. Representatives from the group will sit on the Departmental Urology Assurance Group. The core membership of the LBR Steering Group should include for example:

  - Operational Director responsible for the urology service;
  - Divisional Medical Director for Urology Improvement;
  - Corporate Directors / Senior management reps form planning and performance (which will cover IT), finance, HR and the Public Inquiry Office;
  - Senior Management Rep from Corporate Risk / Governance;
  - Senior Communications Rep;
  - Chairs of sub groups;
  - External stakeholders such as representative from SPPG, PHA, RQIA;
  - Administration.

- **LBR Operational Team** – As per DOH guidance, this group should be commissioned by the Steering Group and chaired by Independent Advisor for Urology in the first instance – she will be replaced by either a newly established Assistant Director or the operational director responsible for urology services when the new acute directorate structure is implemented;

- **Clinical Reference Group** - Chaired by Deputy Medical Director incorporating SCRR screening and other clinically related actions;

- **Learning and Improvement Group** – Chaired by a Deputy Medical Director focusing on sharing learning from 2021 Urology SAI and implementing in real time other learning emerging while the Lookback Review is progressing.

- **Communication Group** – Chaired by a senior Communications Officer – it is proposed that this is a joint group incorporating the Trust's Public Inquiry communications work (see appendix 1).

20. It is also proposed to have a number of **Task and Finish (T&F) work streams** to progress with discreet pieces of work on behalf of the LBR Operational Team and / or Clinical Reference Group and / or Learning and Improvement Group and / or Communication Group. These will not span the life of the Urology Lookback rather they will be short-lived to deliver of specific work. Initial T&F work streams include:

i. Database development;
ii. Urology Lookback Phase 1 Outcomes Report;

iii. Use of IS - Operational plans and contracting;
iv. Finance – IPT, agreement on tracking Lookback spend including IS spend;
v. Extending the Lookback Review – options appraisal, risk stratification;
vi. Prepping media and other communications for phase two of the Lookback Review;
vii. Review of risk management, assurance framework and other governance related processes;
viii. Implementing 2021 SAI recommendations; (an existing group)
ix. Implementation of Action Plan from Letters Investigation;
x. Lookback Review SOPs.

21. All of the groups above will have clear terms of reference / work plans with actions logged and progressed to specific time lines.

22. This proposed Lookback structure and process now clearly maps across the stages of a Lookback Review reflected in the DoH guidance (see appendix 1 for detail).

23. As the current (first) phase of the Urology Lookback Review in already ongoing is at Stage 3 of the Lookback Guidance. When the next phase of the Lookback commences the Trust will step back to Stage 2 and progress from there. Therefore, the proposed structure is applicable now and will also be fit for purpose for the next phase of the Urology Lookback Review

24. Much of the work reflected in paragraph 20 above has commenced or is about to commence as time is of an essence to move this phase of the Lookback process towards closure and trigger the next phase.

25. The proposed structure with internal and external reporting / accountability, including the relationship of the Lookback Review to the Public Inquiry, is reflected in Appendix 1.

Next Steps

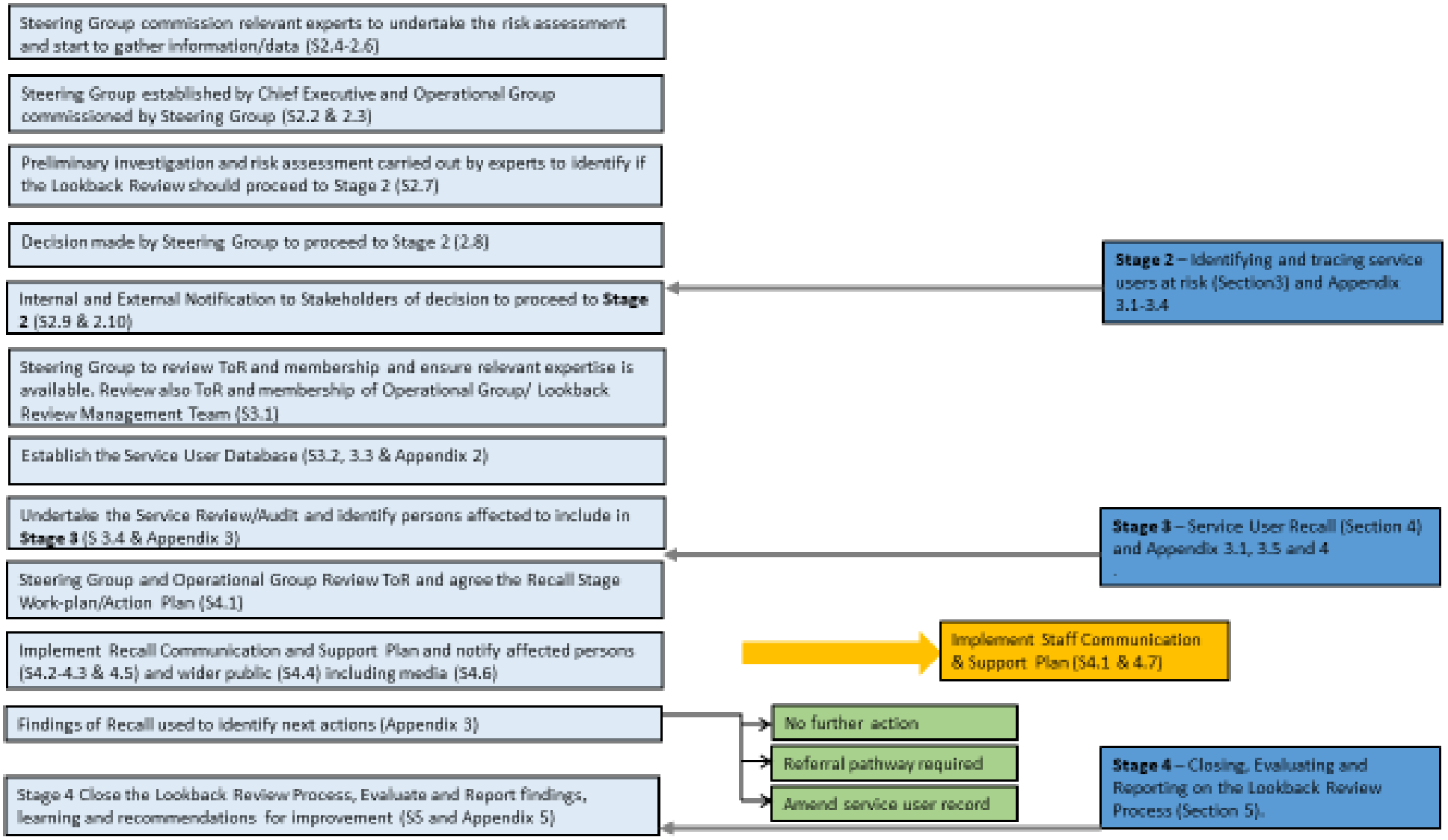
26. On the basis that this proposed Lookback Review structure and process is agreed a conversation needs to take place between the Trust and Departmental officials as in reality this new Trust structure removes the need to continue with the current SPPG Southern Trust Oversight Steering Group. In this arrangement, the Trust's Lookback Steering Group will report to the Department's Urology Assurance Group directly.

27. In the Trust new LBR structure and process, the oversight and challenge function of the commissioner and other stakeholders would remain by their membership on the Trust's Lookback Review Steering Group

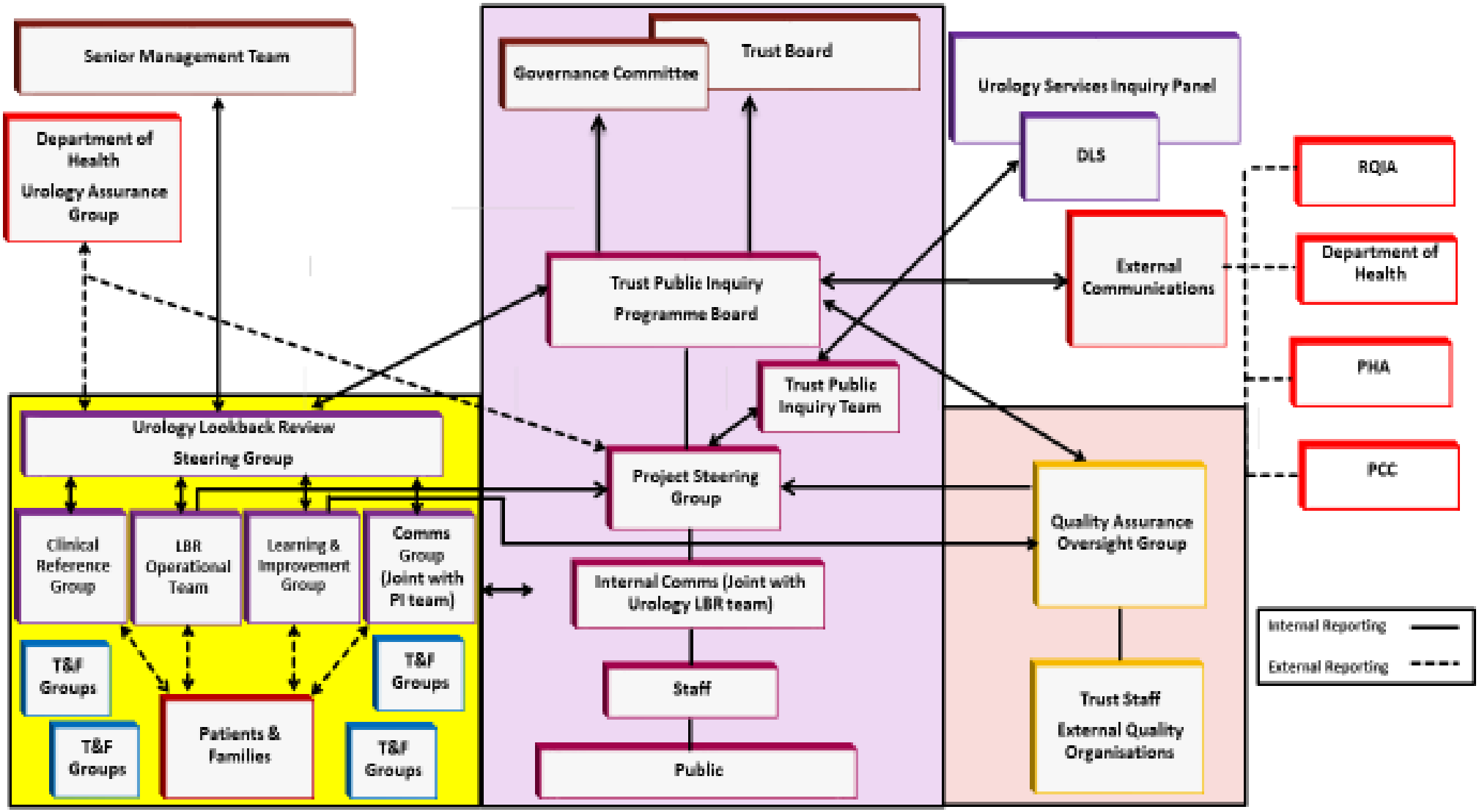
28. This move is timely as the original group was the HSCB reporting to the DOH however, as SPPG are now the lead, the Southern Trust Oversight Steering *Group* is an internal Departmental group reporting to the Permanent Secretary.

29. The Independent Advisor (MOH) will progress with establishing terms of reference, i.e. membership, outline work plans, draft agenda for all groups above with the view to implementing the meeting process within the new structure as soon as receiving agreement to proceed.

Proposed Lookback Review Mapped Across Stages in the DOH Lookback Guidance



Trust Public Inquiry Structure
(Incorporating the Urology Lookback Review)



Triangulating Your Data For A Rich Picture Of Safety

Welcome, the call will begin at 14:00

Agenda

- Welcome and introductions
- What do we mean by triangulation?
- Understanding different sources of safety data
- Tips for data triangulation
- Bringing it all together

What do we mean by triangulation?

What do we mean by triangulation?

- Different data sources for one specific measure / issue
- Different types of display of data for one measure
- Different measures related to one broader topic
- Different cuts of the data: by setting, specialty etc

Understanding different sources of safety data

	Research	Admin Data	Adverse Event	Safety Thermometer	Audit
Pressure Ulcers	**7 - 12%** prevalence (category II-IV)	**0.3%** prevalence (all categories)	**67,848** Reports each year (category III-IV)	**8.3%** prevalence (category II-IV)	Included in GTT as harm as a count (no prevalence data available)

		Incident Reporting 2012/2013				NHS Safety Thermometer 2012/13		
Admissions (inpatient spells)*	Shelford Group	No. of Incidents reported	Proportion of patients with a new pressure ulcer	Rate per 1000 patients	Cat 2 Included	Proportion of patients with a new pressure ulcer	Extrapolation of estimated annualalised burden	Extrapolation of estimated annualalised burden Cat 3-4 only
129,471	The Newcastle Upon Tyne Hospitals NHS Foundation Trust	800	0.6%	6.2	Yes	[illegible]	186	491
130,084	Sheffield Teaching Hospitals NHS Foundation Trust ***	243	0.2%	1.9	[illegible]	1.6%	2098	270
132,010	Central Manchester University Hospitals NHS Foundation Trust	842	0.6%	6.4	Yes	0.9%	1215	273
120,798	Oxford University Hospitals NHS Trust	[illegible]	0.2%	2.1	Yes	1.6%	1948	209
126,013	Imperial College Healthcare NHS Trust	22	0.0%	0.2	No	0.8%	1041	38
95,286	Cambridge University Hospitals NHS Foundation Trust	153	0.2%	1.6	Yes	0.6%	629	55
76,503	University College London Hospitals NHS Foundation Trust	222	0.3%	2.9	Yes	0.5%	428	142
99,491	Guy's and St Thomas' NHS Foundation Trust	80	0.1%	0.8	Yes	0.6%	613	68
95,589	King's College Hospital NHS Foundation Trust	147	0.2%	1.5	Yes	1.3%	1328	189
71,962	University Hospitals Birmingham NHS Foundation Trust **	501	0.7%	7.0	Yes and Grade 1	0.3%	266	**

'Which one is right?!

* Extrapolated figures based on full years HES (2011/12) admissions (inpatient spells) for Shelford group organisations and NHS ST national data for financial year 2012/13

** Issue with National Safety Thermometer data / validation process of HSCIC (only one data point showing)

*** Median taken from latest figure on Safety Thermometer Webtool

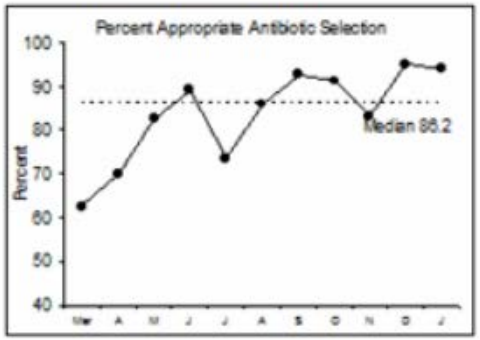
**** Community reporting of pressure ulcers is proportionally higher than Acute reporting (Acute 80 & Community 717)

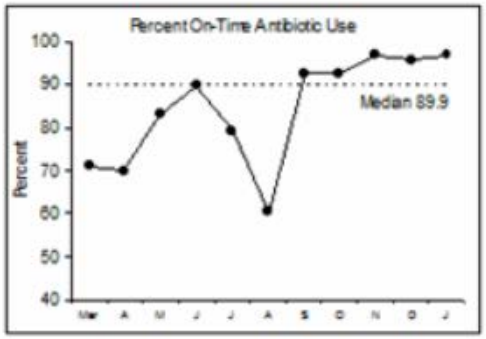
What can we learn from each data source?

Tips for data triangulation

1. Choose a small number of measures to use together

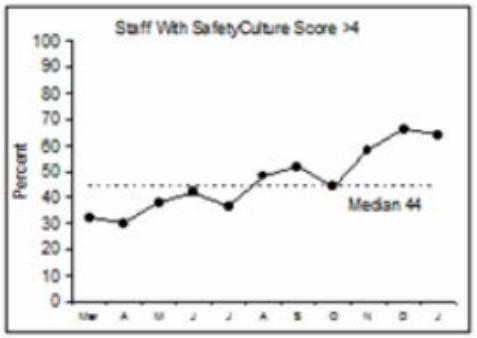
Process Measure

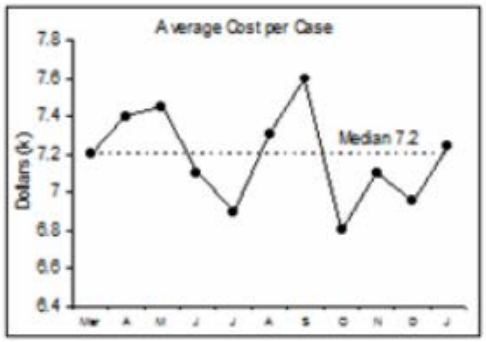




Process Measure

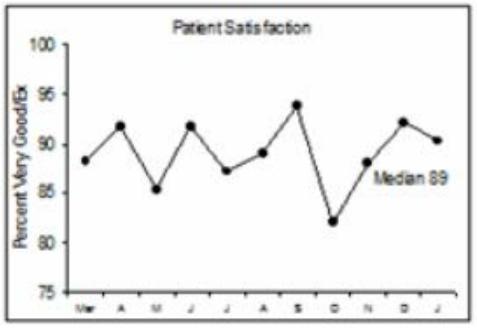
Process Measure

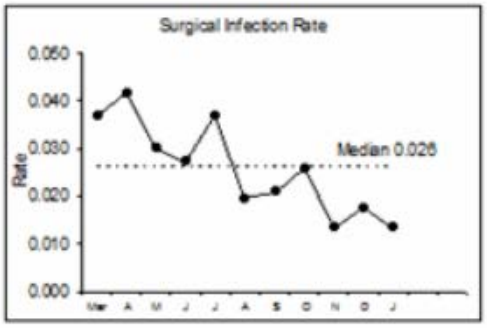




Balancing Measure

Balancing Measure





Outcome Measure

HC Data Guide, p 61-64

1. Choose a small number of measures to use together

Sutton CCG: Urgent and Emergency Care Dashboard

Select care/nursing home: Test Court Nursing Home

Test Court Nursing Home

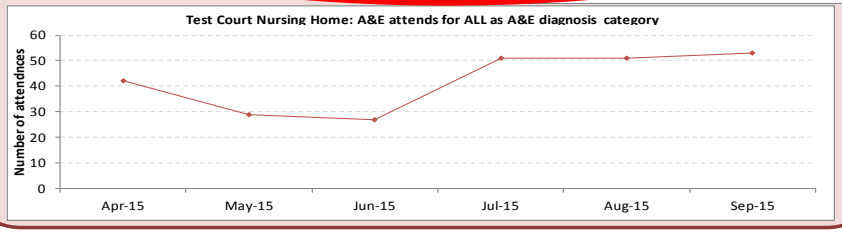
Address	16 Somewhere Square
Postcode	SM1 4LD
Type	Nursing
Dementia	No
Funding	Private
Beds	20
Occupancy rate	80.0%

CQC rating: Good

Safe	Effective	Caring	Responsible	Well led

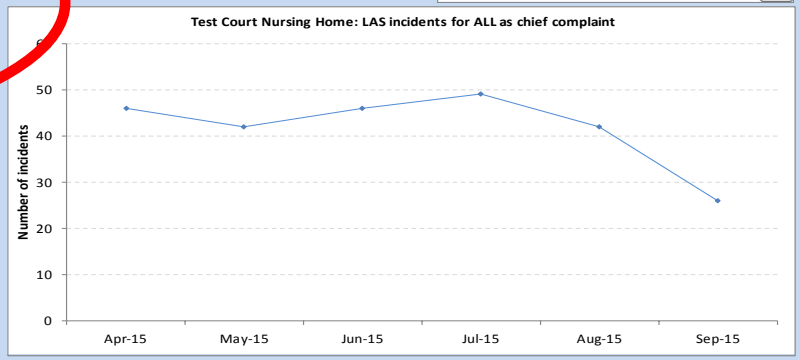
A&E attendances from care/nursing home locations

Select A&E diagnosis category: ALL



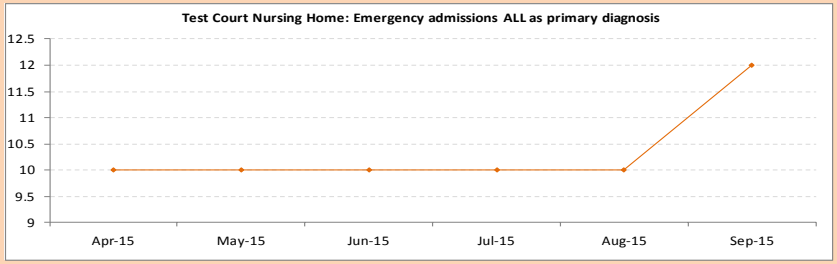
LAS incidents to care/nursing home locations

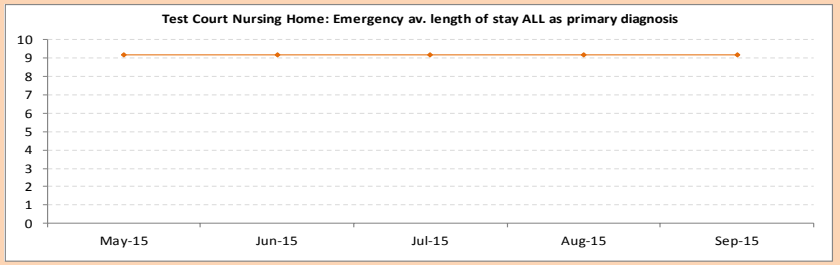
Select chief complaint: ALL

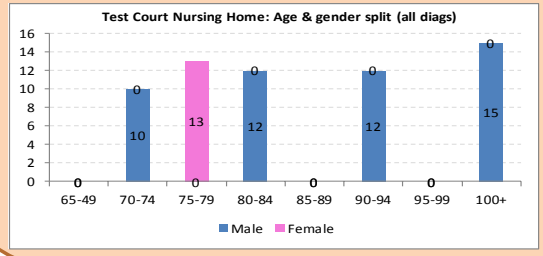


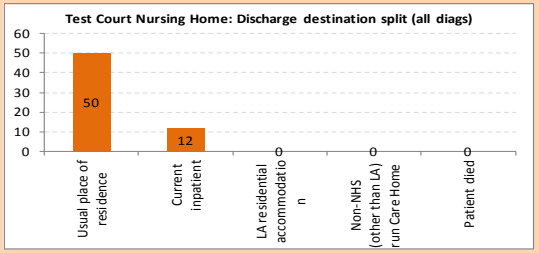
Emergency admissions from care/nursing home locations

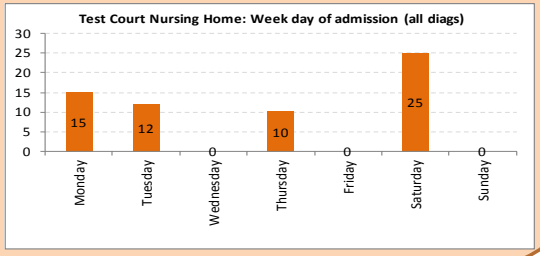
Select primary diagnosis: ALL











1. Choose a small number of measures to use together

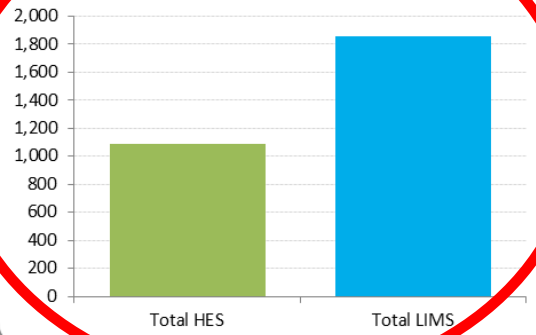
Acute Kidney Injury Outcome Measures

Data Source: HES Inpatient dataset 2013-2015, EQ Programme AKI data report (Clarity Informatics)

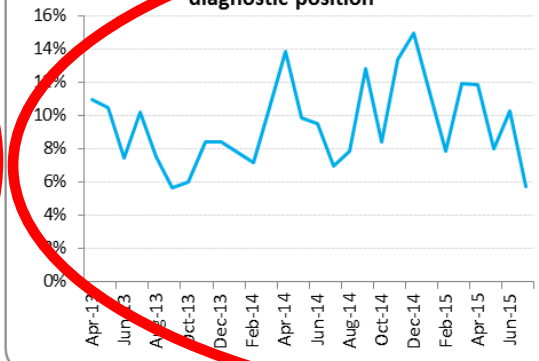
Quality Observatory

Select Trust from the drop-down box :

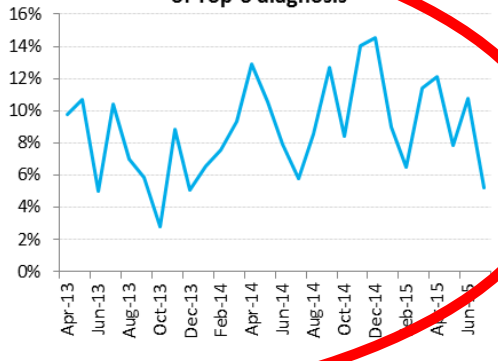
HES counts vs LIMs counts *(6 months t… June 2015)*



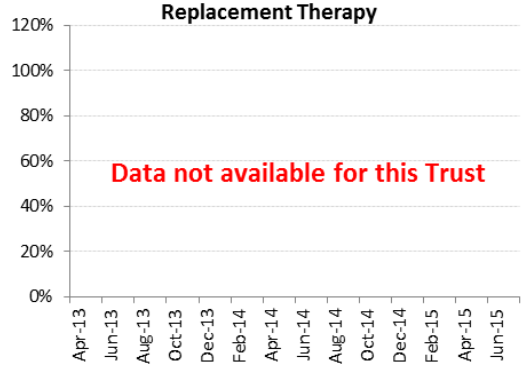
Inpatient mortality rate - AKI coded in any diagnostic position



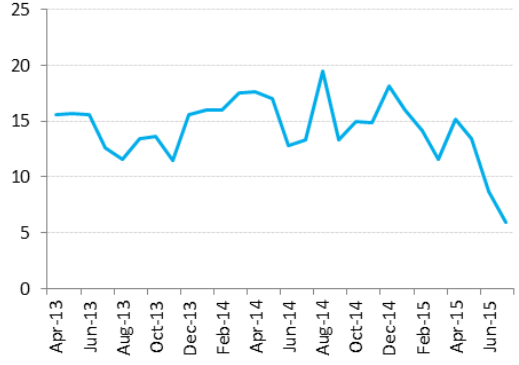
Inpatient mortality rate - AKI coded as one of Top 6 diagnosis



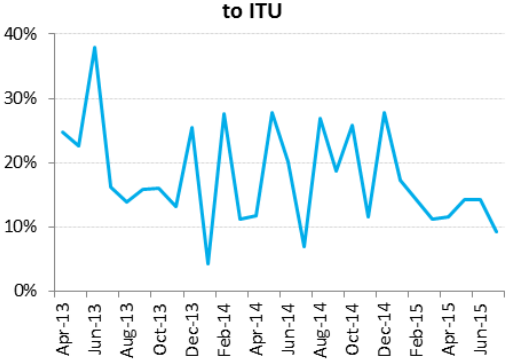
Rate of AKI admissions requiring Renal Replacement Therapy



Average length of stay for AKI admissions



Rate of AKI admissions requiring admission to ITU



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1. Choose a small number of measures to use together

Remember:

Ensure your measures are linked to your aim; be guided by what you need, not by what you can get

Have a mix of process, outcome and balancing measures; a family of measures

Wherever possible, look at measures on the same page

Think about patient centred measures and measures from different settings

2. Understand your different data sources

2. Understand your different data sources

Acute Kidney Injury Outcome Measures

Data Source: HES Inpatient dataset 2013-2015, EQ Programme AKI data report (Clarity Informatics)

Quality Observatory

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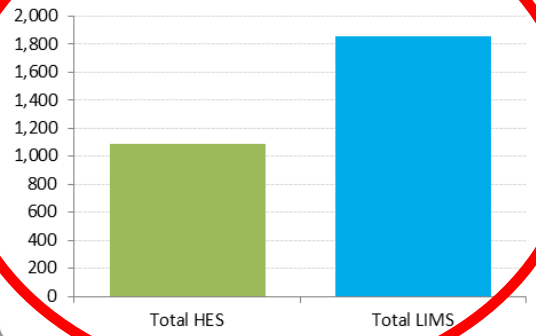
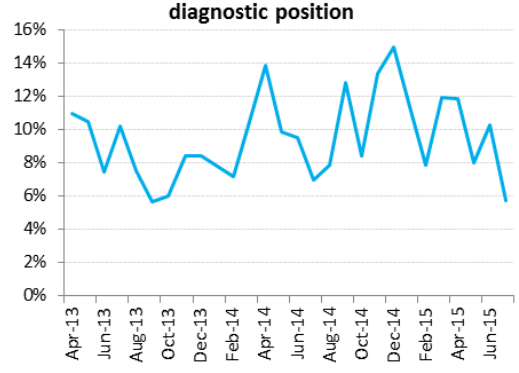
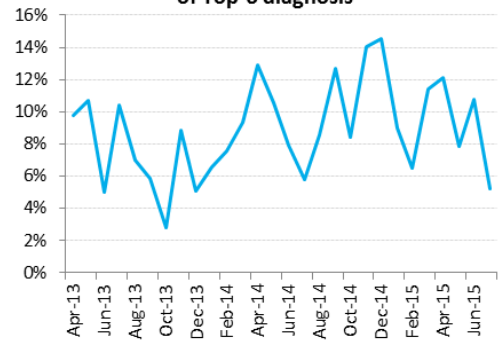


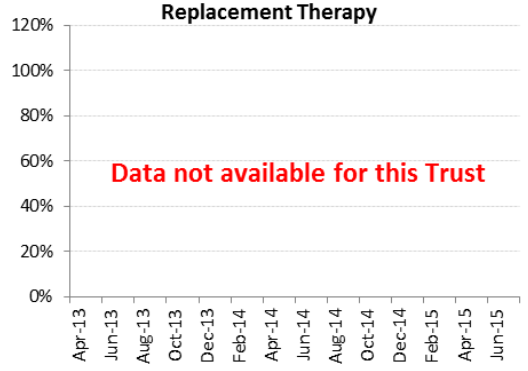
Inpatient mortality rate - AKI coded in any diagnostic position



Inpatient mortality rate - AKI coded as one of Top 6 diagnosis



Rate of AKI admissions requiring Renal Replacement Therapy



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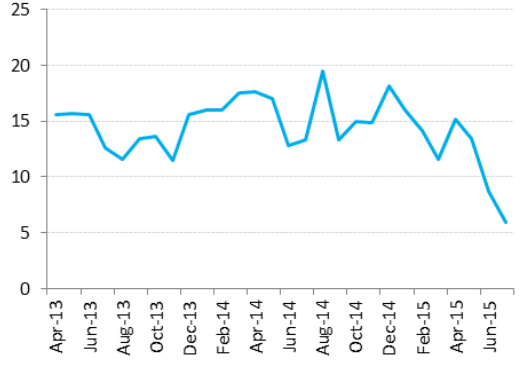
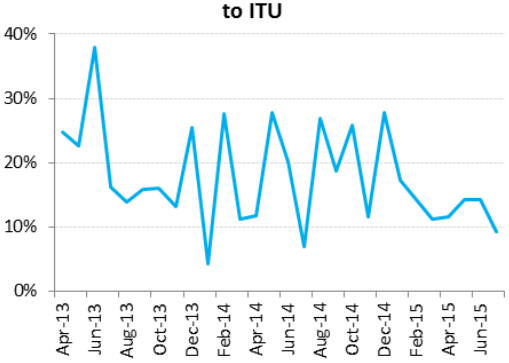


Rate of AKI admissions requiring admission to ITU



2. Understand your different data sources

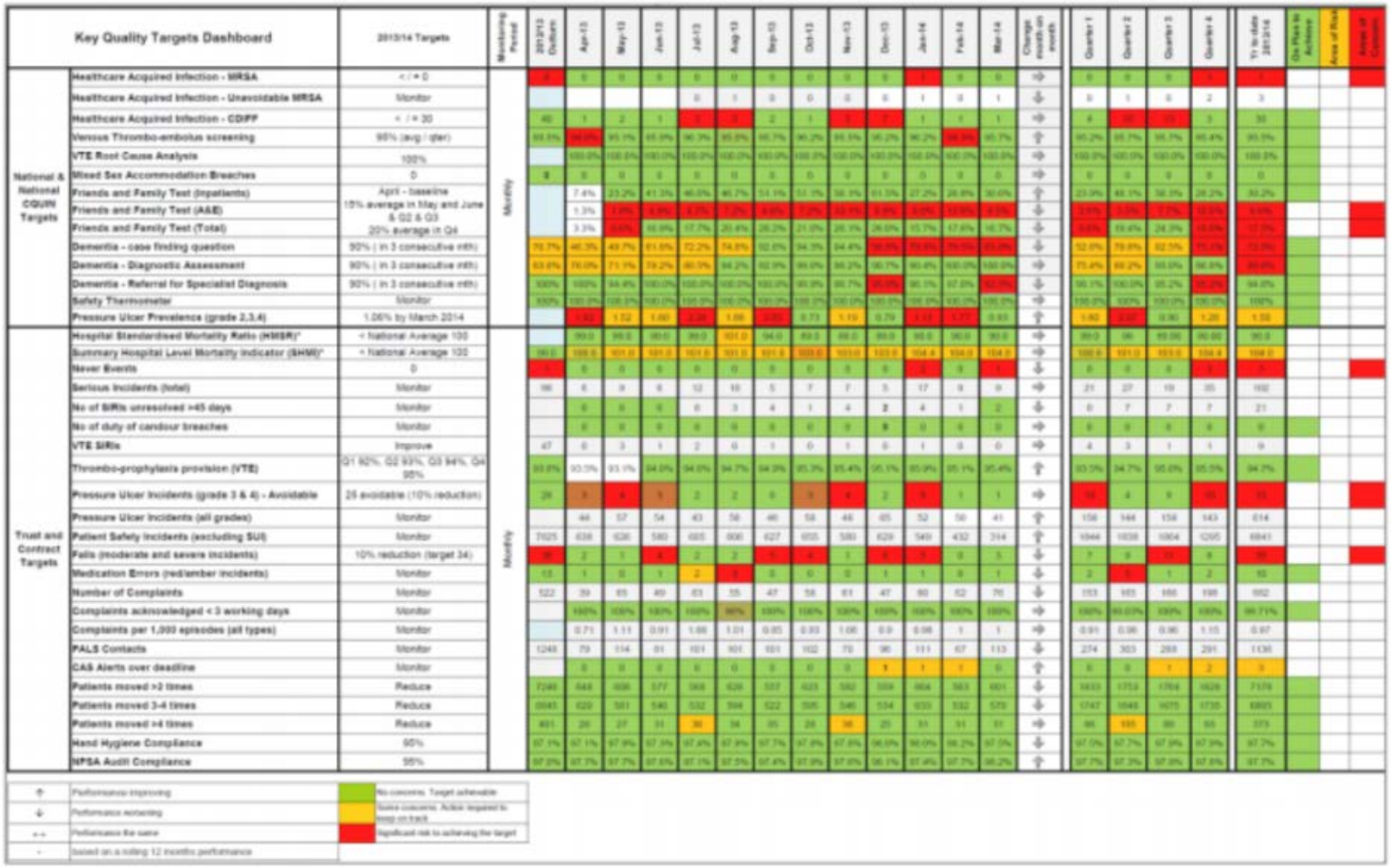
Remember:

Different data collections were designed for different purposes and should be viewed in an appropriate context

No data is ‘bad’ data, everything can provide useful knowledge

Multidisciplinary discussions of multiple datasets provides the best insight

3. Focus on trends over time and patterns in the data



Key Quality Targets Dashboard		2013/14 Targets	Monitoring Period	2012/13 Outturn	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Change Position from month	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Yr to date 2013/14	On Plan to Achieve	Area of Risk	Areas of Concern
National & National CQUIN Targets	Healthcare Acquired Infection - MRSA	< / = 0	Monthly	4	0	0	0	0	0	0	0	0	0	2	0	0	⇨	0	0	0	2	2			
	Healthcare Acquired Infection - Unavoidable MRSA	Monitor						0	1	0	0	0	0	1	0	1	⇩	0	1	0	2	3			
	Healthcare Acquired Infection - CDIFF	< / = 30		40	1	2	1	5	5	2	1	3	2	1	1	1	⇨	4	10	11	3	30			
	Venous Thrombo-embolus screening	95% (avg / qtr)		93.5%	94.0%	95.1%	95.9%	96.3%	95.8%	95.7%	96.2%	95.5%	96.2%	96.2%	94.9%	95.7%	⇧	95.2%	95.7%	95.5%	95.4%	95.5%			
	VTE Root Cause Analysis	100%			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	⇨	100.0%	100.0%	100.0%	100.0%	100.0%			
	Mixed Sex Accommodation Breaches	0		0	0	0	0	0	0	0	0	0	0	0	0	0	⇨	0	0	0	0	0			
	Friends and Family Test (Inpatients)	April - baseline 15% average in May and June & Q2 & Q3 20% average in Q4	Monthly		7.4%	23.2%	41.2%	46.0%	46.7%	51.1%	51.1%	56.9%	61.5%	27.2%	26.8%	30.6%	⇧	23.9%	49.1%	38.3%	28.2%	30.2%			
	Friends and Family Test (A&E)				1.3%	1.8%	4.8%	4.3%	7.2%	8.6%	7.2%	12.1%	8.8%	5.0%	11.0%	8.5%	⇩	2.5%	5.5%	7.2%	10.1%	6.4%			
	Friends and Family Test (Total)				3.3%	6.6%	16.9%	17.7%	20.4%	26.2%	21.0%	20.1%	26.0%	15.7%	17.6%	16.7%	⇩	8.6%	19.4%	24.5%	18.8%	17.5%			
	Dementia - case finding question	90% (in 3 consecutive mth)		76.7%	46.3%	49.7%	61.6%	72.2%	74.8%	82.6%	84.3%	84.4%	94.9%	89.8%	79.5%	83.8%	⇩	52.6%	79.8%	82.5%	77.1%	72.5%			
	Dementia - Diagnostic Assessment	90% (in 3 consecutive mth)		83.6%	76.0%	71.1%	79.2%	80.5%	84.2%	82.9%	86.0%	86.2%	90.7%	90.4%	100.0%	100.0%	⇨	75.4%	84.2%	95.6%	96.5%	89.4%			
	Dementia - Referral for Specialist Diagnosis	90% (in 3 consecutive mth)		100%	100%	94.4%	100.0%	100.0%	100.0%	100.0%	95.9%	96.7%	95.9%	96.3%	97.9%	92.5%	⇩	96.1%	100.0%	95.2%	92.3%	94.6%			
	Safety Thermometer	Monitor		100%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	⇨	100.0%	100%	100.0%	100.0%	100%			
	Pressure Ulcer Prevalence (grade 2,3,4)	1.06% by March 2014			1.82	1.52	1.60	2.00	1.66	0.83	0.73	1.10	0.79	1.13	1.11	0.93	⇧	1.60	2.00	0.90	1.20	1.38			
Trust and Contract Targets	Hospital Standardised Mortality Ratio (HSMR)*	< National Average 100	Monthly		99.0	96.0	98.0	99.0	101.0	94.0	93.0	98.0	99.0	98.0	96.0	99.0	⇨	99.0	98	99.00	98.00	98.0			
	Summary Hospital Level Mortality Indicator (SHMI)*	< National Average 100		99.0	100.6	101.0	101.0	101.0	101.0	101.0	100.0	101.0	103.0	104.0	104.0	104.0	⇨	100.6	101.0	103.0	104.4	104.0			
	Never Events	0		2	0	0	0	0	0	0	0	0	0	0	0	1	⇩	0	0	0	1	2			
	Serious Incidents (total)	Monitor		66	6	9	6	12	10	5	7	7	5	17	9	9	⇨	21	27	19	35	102			
	No of SIRIs unresolved >45 days	Monitor			0	0	0	0	3	4	1	4	2	4	1	2	⇩	0	7	7	7	21			
	No of duty of candour breaches	Monitor			0	0	0	0	0	0	0	0	0	0	0	0	⇨	0	0	0	0	0			
	VTE SIRIs	Improve		47	0	3	1	2	0	1	0	1	0	1	0	0	⇨	4	3	1	1	9			
	Thrombo-prophylaxis provision (VTE)	Q1 92%, Q2 93%, Q3 94%, Q4 95%		93.8%	93.5%	93.1%	94.0%	94.0%	94.7%	94.3%	95.3%	95.4%	95.1%	95.9%	95.1%	95.4%	⇧	93.5%	94.7%	95.6%	95.5%	94.7%			
	Pressure Ulcer Incidents (grade 3 & 4) - Avoidable	25 avoidable (10% reduction)		29	3	4	3	2	2	0	3	4	2	3	1	1	⇨	10	4	3	10	33			
	Pressure Ulcer Incidents (all grades)	Monitor			44	57	54	43	58	46	58	44	65	52	50	41	⇧	158	144	154	143	614			
	Patient Safety Incidents (excluding SUI)	Monitor		7025	638	626	580	605	606	627	655	580	629	549	432	314	⇧	1044	1038	1064	1295	4841			
	Falls (moderate and severe incidents)	10% reduction (target 34)		38	2	1	4	2	2	4	4	1	4	4	0	5	⇩	7	8	11	8	34			
	Medication Errors (red/amber incidents)	Monitor		13	1	0	1	2	0	0	0	0	1	1	0	1	⇩	2	0	1	2	10			
	Number of Complaints	Monitor		522	59	65	49	63	55	47	58	61	47	60	62	70	⇩	153	165	169	199	692			
	Complaints acknowledged < 3 working days	Monitor			100%	100%	100%	100%	96%	100%	100%	100%	100%	100%	100%	100%	⇨	100%	99.03%	100%	100%	99.71%			
	Complaints per 1,000 episodes (all types)	Monitor			0.71	1.11	0.91	1.66	1.01	0.85	0.83	1.06	0.9	0.98	1	1	⇨	0.91	0.96	0.96	1.15	0.97			
	PALS Contacts	Monitor		1248	79	114	81	101	101	101	102	70	96	111	67	113	⇩	274	303	269	291	1136			
	CAS Alerts over deadline	Monitor			0	0	0	0	0	0	0	0	1	1	1	0	⇧	0	0	1	2	3			
	Patients moved >2 times	Reduce		7240	644	608	577	568	628	537	623	582	559	564	563	601	⇩	1833	1713	1764	1828	7178			
	Patients moved 3-4 times	Reduce		3945	629	581	540	532	594	522	595	546	534	633	532	570	⇩	1747	1648	1675	1735	6805			
	Patients moved >4 times	Reduce		401	29	27	31	36	34	35	29	36	25	31	31	31	⇨	86	105	80	93	373			
	Hand Hygiene Compliance	90%		87.1%	87.1%	87.9%	87.3%	87.4%	87.9%	87.7%	87.4%	87.6%	86.0%	86.0%	88.2%	87.5%	⇩	87.5%	87.7%	87.9%	87.9%	87.7%			
	NPSA Audit Compliance	95%		97.5%	97.7%	97.7%	97.6%	97.1%	97.5%	97.4%	97.9%	97.6%	96.1%	97.4%	97.7%	96.2%	⇧	97.7%	97.3%	97.3%	97.6%	97.7%			

⇧	Performance improving	No concerns. Target achievable
⇩	Performance worsening	Some concerns. Action required to keep on track
⇨	Performance the same	Significant risk to achieving the target
-	based on a rolling 12 months performance	

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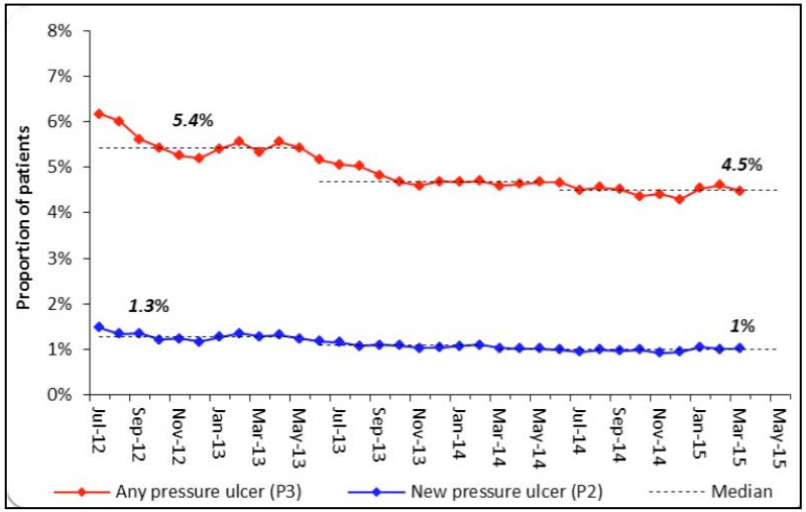
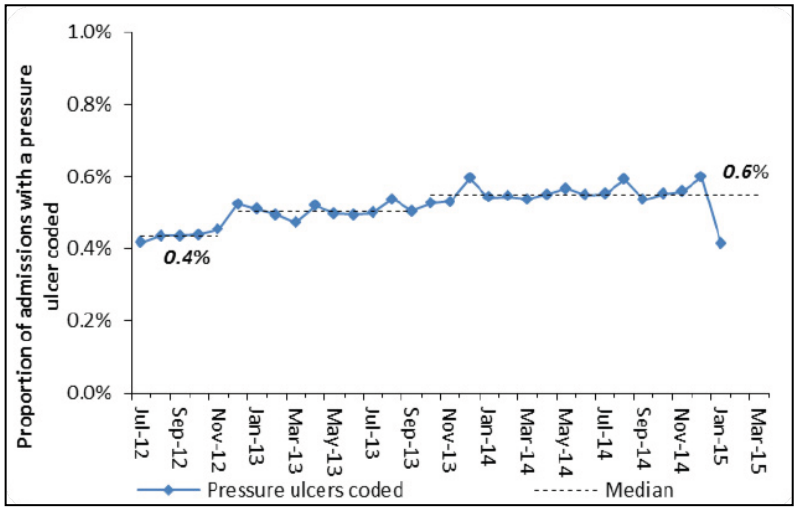
3. Focus on trends over time and patterns in the data

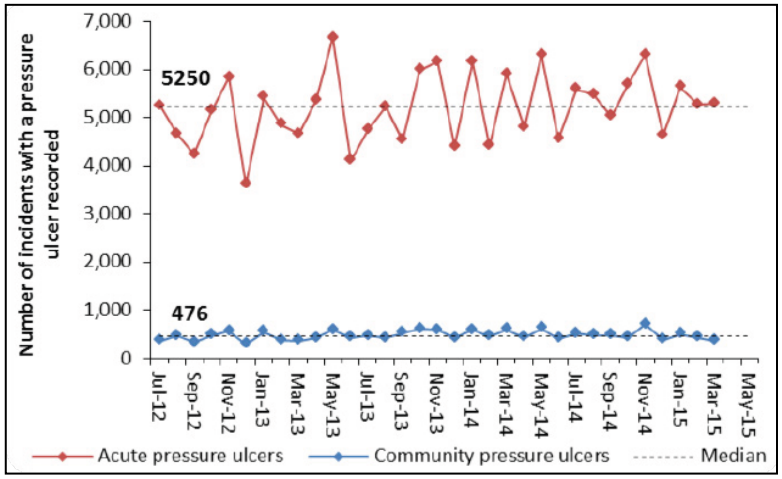
Safety Thermometer (improvement)



HES data (administrative)

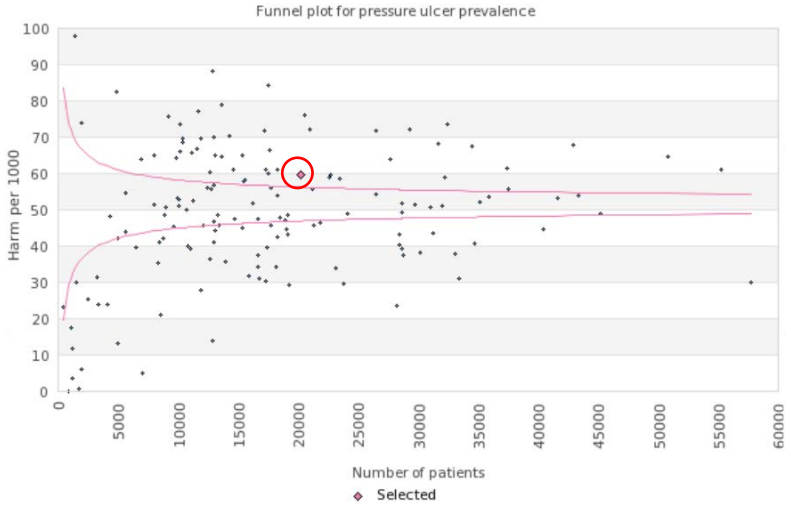


NRLS data (incident reporting)

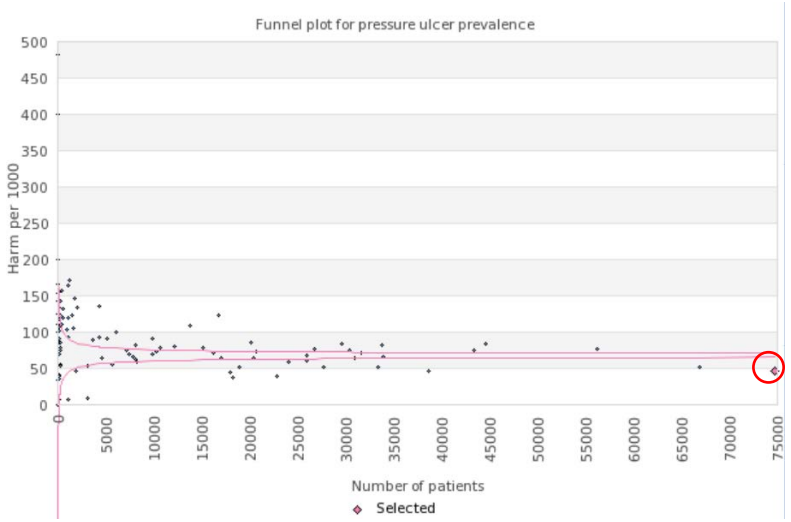


3. Focus on trends over time and patterns within the data

Acute Trust A



Community Trust B



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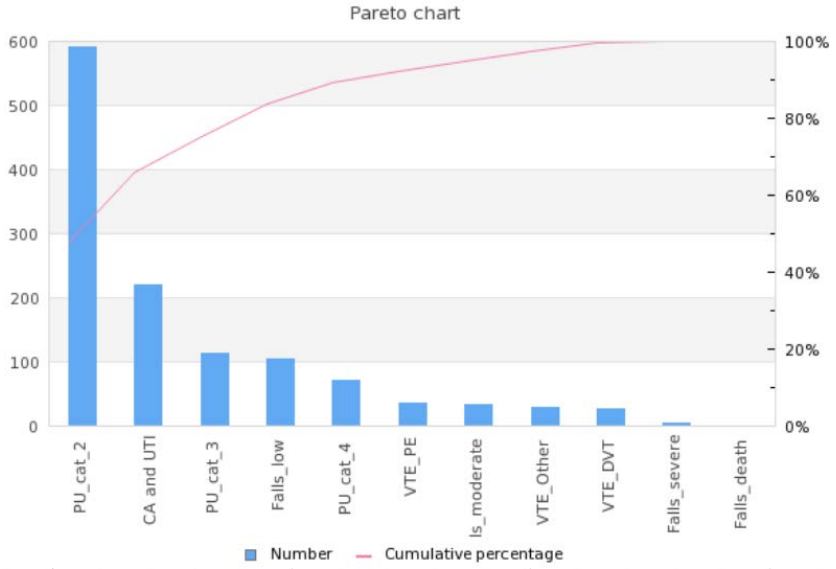

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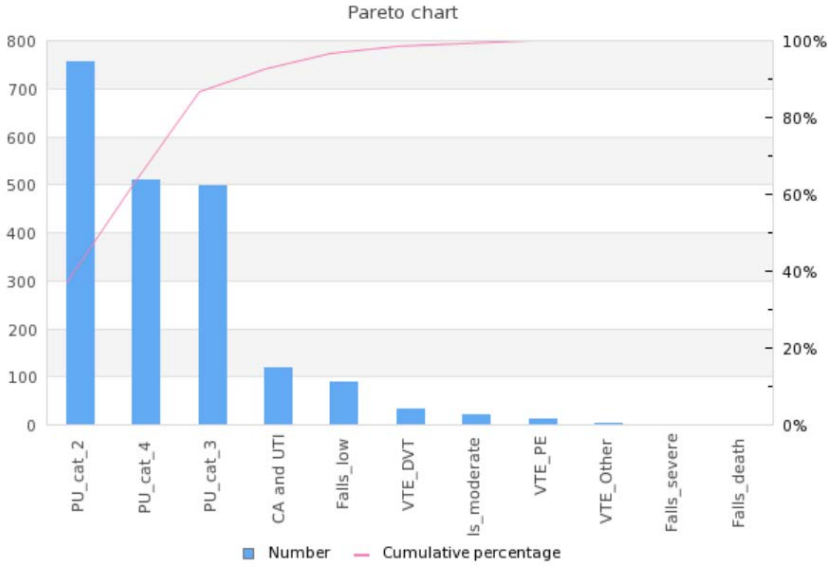


3. Focus on trends over time and patterns in the data

Remember:

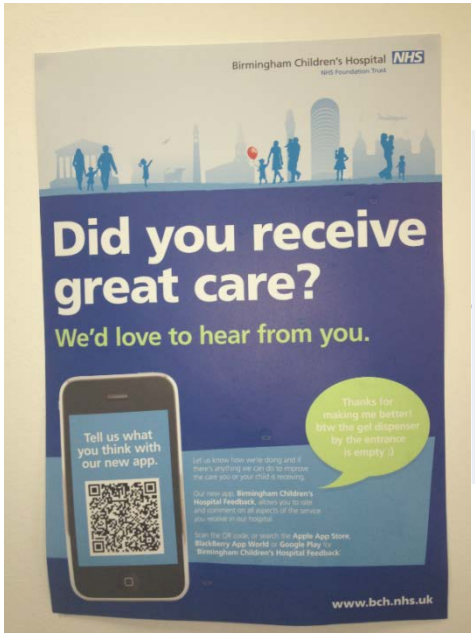
Worry less about absolute numbers and look at how trends are similar or differ

Think back to your understanding of data sources to help you understand differences or similarities when using them together

Look at the data from different ‘angles’ by using different plots or different cuts

We’re not doing research; don’t worry about ‘controlling’ the data

4. Use qualitative information as well as numbers



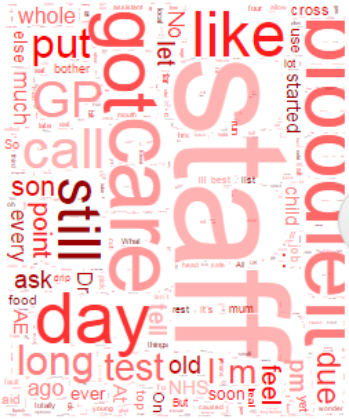
We would like you to think about your experience in the ward where you spent the most time during this stay.

How likely are you to recommend our ward to friends and family if they needed similar care or treatment?

- ☐ Extremely likely
- ☐ Likely
- ☐ Neither likely nor unlikely
- ☐ Unlikely
- ☐ Extremely unlikely
- ☐ Don't know

+ve text cloud

-ve text cloud



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4. Use qualitative information as well as numbers

Remember:

Data is most effective if you can tell a story with it

5. Be clear about what you want from the data and your expectations from the start

Incident reporting to be encouraged. Used as a measure of culture and expected to go up

Improve coding: this measure will go up

One audit to be undertaken at the beginning to identify focus areas

Sample used to reduce burden, won't give us in depth information but will be used to track improvement

5. Be clear about what you want from the data and your expectations from the start

Remember:

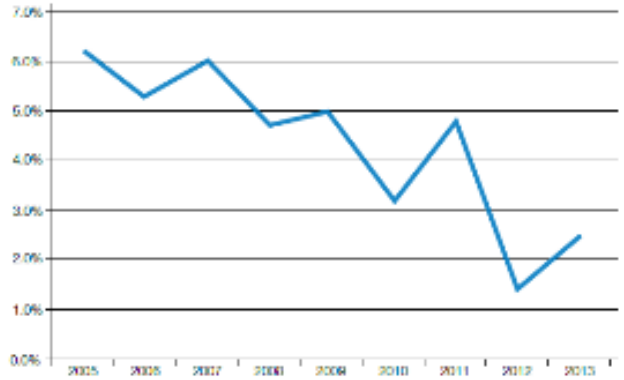
You know your system and processes best; work with your analysts to get a view of what you expect to happen, for example, at different times of the year, or in relation to specific improvement work

Each time you review refreshed data ask the question “is this what we expected to happen”

Think back to tip 1; by linking your measures to your goals you will be much more able to articulate your expectations

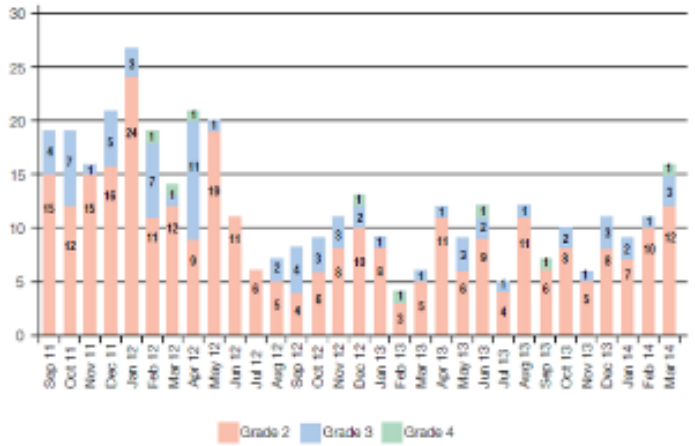
Bringing it all together

Acquired pressure ulcer prevalence 2005-2013



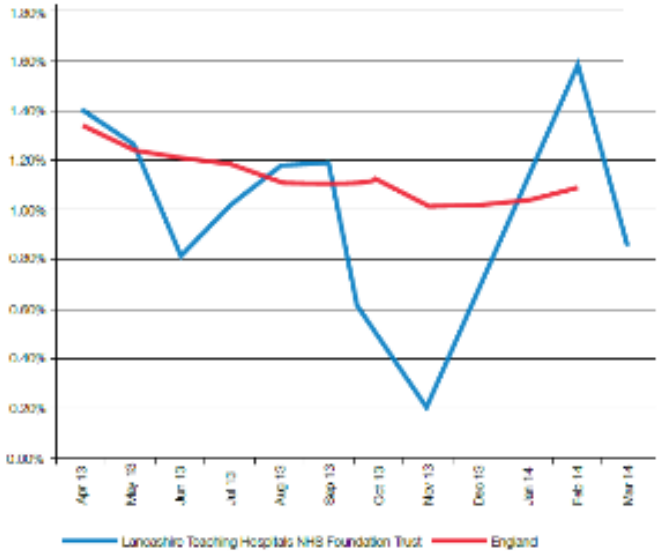
Source: Pressure Ulcer Prevalence Report LTH 2013 Arjo Huntleigh 2013

Avoidable Hospital aquired pressure ulcers by grade 2100-14



Source: Datix

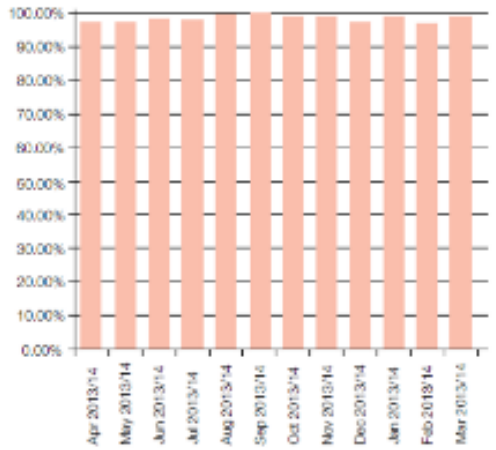
- Via the safety thermometer – a monthly point prevalence audit of all pressure ulcers, including hospital acquired ulcers. The results indicate a very low level of new pressure ulcers with performance better than the national average.



Source: NHS safety Thermometer

The Essentials of Care Audit Programme (ECAP) continues to focus attention on the importance of the tissue viability risk assessment and results show that 96.4% of patients have risk assessments for tissue viability completed within 6 hours of admission or transfer to a ward, representing a 0.4% improvement on 2012-13 performance.

ECAP performance - Tissue viability



Source: LTHTR ECAP programme

Thank You

Upcoming Calls

Developing a Measurement Strategy - 25th November 2015 - 2:00pm

Making Safety Visible: improving the measurement and monitoring of safety - 8th December 2015 - 11:00am

Making the most of your NHS Safety Thermometer data - 1st February 2016 - 11:00am

Measurement for boards: past, present and future - 22nd February 2016 - 11:00am

Urology Letters Investigation - Action Plan

No	Recommendation	Action(s)	Action Owner(s)	Comment / Update (include date)	Status	Due / BF'd	Date Closed
1	All of the letter templates should be reviewed and amended to include accurate information regarding the USI. These should be clear, concise and formatted appropriately	Update both versions of Letter A and B	Independent Advisor	Templates amended - old templates removed from active file from use	complete	NA	12/05/2022
2	An apology letter should be sent to every patient (or relative) who received a letter with incorrect information, highlighting the error and clarifying the accurate context. Each patient should ideally receive the same letter whether their original letter had clinical detail or not	Send Apology letters bespoking them according to the original sent and use to update on stage of Lookback Process where appropriate	Independent Advisor	18/5/22 - Apology Letter drafted and agreed for patients who received Letter A (alive & deceased) and Letter B (alive & deceased) and SCRR. Drafting, printing and forwarding to patients ongoing. **Update 30/5/22** Prioity of letters agreed with B letters and SCRR letter going before A letters	In progress	30/06/2022	
3	The patient information leaflets should be reviewed so there is no ambiguity in the reading. The appropriate leaflet should be included with the patient letter going forward	Update Patient Information Leaflet	Independent Advisor	Review ongoing	complete	31/05/2022	31/05/2022

4	Any outstanding and future letters to patients involved in the Lookback Review should be sent using the new template and new information leaflet	Draft SOP for sending letters to patients	Independent Advisor	SOP being drafted	In progress	31/05/2022	
5	Mr Patient 38 should receive a letter of apology from the Chief Executive. This letter should reference the investigation and its outcome and should also rectify the inaccuracies regarding the context of the USI	Complete Letter and send to patient	Chief Executive	Complete	Complete	N/A	16/05/2022
6	The acute management team should be augmented with a senior manager at Assistant Director level with full operational responsibility for all aspects of the Urology Lookback Review reporting, service improvement following previous SAIs and future outcomes of SCRR. This focus of this should also be on ensuring the governance of the Lookback is clear and robust.	Seek agreement for internal trawel for additional AD post. If authorised advertise accordingly	Director of Acute Services / Independent Advisor	18/05/22 In progress **Update 30/05/22** authoised by CX. JD to be drafted	In progress	16/06/2022	

7	There should be a review of the job description of the Acute Directorate Head of Service for Clinical Assurance to make it clear that this role pertains specifically to the urology service.	Review JD and agree scope and change title as required.	Director of Acute Services / Independent Advisor	Inprogress	In progress	16/06/2022	
8	The Trust should also consider resourcing dedicated admin to support the administrative processes associated with the Urology Lookback Review	Idenfty further admin support dedicated to LBR	Director of Acute Services	18/5/22 - Complete MS commenced on 16/5/22. **Update 31/5/22** Further support identified to join team	Complete		16/05/2022
9	Arrangements to support all the staff involved in the Lookback Review should be in place this should include 1:1 meetings, supervision etc	On going action	Independent Advisor	Will be ongoing	In progress	ongoing	
10	All staff new to the Urology Lookback team should be fully inducted and orientated to the background to the Lookback Review including all the associated systems and processes as well as receiving contextual information about the USI and how the Lookback review sits within that	On going action	Independent Advisor	Will be ongoing	In progress	ongoing	

11	Relocate staff (and locate new staff) undertaking work aligned to the Urology Lookback Review to promote concentration and reduce the risk of errors occurring.	1- Identify suitable accomadation for LBR team 2 - relocate accordingly	Independent Advisor	18/5/22 Room idenfiied being prepped for IT. **Update 30/5/22** - staff relocated	In progress		30/05/2022
12	Consideration should be given to separating the implementation of the Urology SAI recommendations from the Urology Lookback Review process at the Head of Service for Quality Assurance	Mainatin current situation as AD and Admin is agreed for LBR	Independent Advisor	Review when recommendation 8 complete **Update 30/5/22** - Keep two functions together now extra support is being added to the LBR process	Complete		30/05/2022
13	There should be a review of the Trusts Urology Lookback Review operational and governance arrangements within the Acute Directorate as well as corporate levels, to strengthen reporting, oversight and accountability.	Draft paper on way forward - map against DOH 2021 guideance	Independent Advisor	Paper being drafted for sharing with SMT	In progress	07/06/2022	
14	Standard Operating Procedures associated with the Lookback Review process drafted to add more clarity and structure to ensure everyone involved is aware of who does what and when.	Agree list of SOP and draft accordingly		SOPs being identified drafting / updating of those no inprogress	In progress		

15	There should be an audit / QA of the overall numbers of patients currently included in this phase of Urology Lookback Review process to assure the Chief Executive that the detail at this time is correct.		Independent Advisor	18/5/22 Methodogy to undertake this in process of being agreed **Update 30/5/22** - Letter and numbers being QAed at the same time as apology and update letters are being forwarded to patients	In progress	TBC	
16	The Medical Director and Operational Director should consider if all patients to date reviewed with the short Urology Patient Review Form should have the remaining 6 questions applied to their most recent clinical assessment		Medical Director / Director Acute Services	Agreed to exend to include extra 6 questions for "4" question patients	Complete		need to confirm date
17	There should be Trust decision, informed by senior clinical and managerial opinion and in conjunction with the DoH's Strategic Planning and Performance Group as to whether the Urology Lookback Review process should extend back to earlier years and agreement as risk stratification and the methodology to undertake this		Medical Director / Director Acute Services	18/5/22 Extended Lookback agreed. Methodolgy and extent still under considertion - this action is replicated in the LBR Steering Group actions so closed on here.	Moved to Steering Group		18/05/2022

18	The acute team undertaking the Lookback Review should participate in a learning process to inform an extension of the Lookback, to reflect on what went well, what did not, what should be replicated and what should be changed, to enable learning going forward.		Director of Acute Services / Independent Advisor	18/5/22 Learning ongoing. Zoom meeting to be arranged	In progress	TBC	
19	A robust action plan to implement the above recommendations should be developed and urgently commenced.		Independent Advisor	Complete	complete		18/05/2022

Southern Health and Social Care Trust

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UROLOGY LOOKBACK REVIEW

PATIENT LETTERS INVESTIGATION FINAL REPORT

31 May 2022

BACKGROUND

1. On 15 February 2022, Ms Christine A Smith QC, Chair of the Urology Services Inquiry (USI) wrote to Mr Shane Devlin, the then Chief Executive of the Southern Health and Social Care Trust (the Trust), advising that it had recently come to her attention that the Trust had issued letters to patients regarding the ongoing Urology Lookback Review exercise that contained inaccurate information pertaining to the USI. This letter resulted in a temporary suspension on issuing a number of outstanding patient letters regarding the Urology Lookback Review while the situation was reviewed and the inaccuracies corrected.

2. Further to this, on Thursday 24 March 2022, the Chief Executive's office in the Trust received a copy of correspondence dated 21 March 2022 from by a patient, Mr Patient 38 that had been sent to Chair of the USI. In his correspondence Mr Patient 38 informed Ms Smith that clinical information contained in a letter dated 31 December 2021 that he received from Shane Devlin regarding the Urology Lookback Review exercise was inaccurate.

3. This correspondence was passed to Dr Maria O'Kane, who was the acting Accounting Officer and Medical Director and Mrs Jane McKimm, Programme Director for Public Inquiry, for urgent attention. It was quickly verified by the consultant urologist who is currently responsible for Mr Patient 38's care that the clinical information in the Trust letter was indeed incorrect.

4. It was noted that Mr Patient 38's letter also included factual inaccuracies pertaining to the context of the USI referred to in para 1 above.

5. On Sunday 27 March 2022, Dr O'Kane requested that the situation with regard to the inaccuracies in letters informing patients about the Urology Inquiry and also the specific case of the incorrect clinical information in Mr Patient 38's letter be urgently investigated.

6. To that end, an independent investigation team was assembled and the Terms of Reference were agreed. The investigation commenced on 29 March 2022. A draft report was shared with Dr O'Kane on 9 May 2022. This version remained the working copy from which an action plan was developed, until it was shared with those who contributed to the investigation for factual accuracy checking.

7. The final version of this report and the action plan is dated 31 May 2022.

INVESTIGATION TEAM

8. The investigation team are:

- Margaret O'Hagan – Director of Surgery and Clinical Services, Northern Trust;
- Grace Hamilton – Assistant Director of Nursing - Safety, Quality and Patient Experience, Southern Trust.

TERMS OF REFERENCE

9. The terms of reference for the investigation were:

i. To review systems and processes (administrative and quality assurance) that were in place which resulted in letters forwarded to patients (or family of the deceased patients) containing contextual information about the Urology Service Inquiry that was factually incorrect;

ii. To quantify the number of patients (and / or relatives) who received letters referred to above broken down by each sub category, clearly identifying the number letters that contained specific clinical information and the number of letters that did not;

iii. To review the administrative and quality assurance process in place that resulted in patient Mr Patient 38 receiving correspondence containing information that was clinically inaccurate;

iv. Within the cohort of patients (or family of the deceased) who received correspondence containing specific clinical information, provide assurance that other patients / families in this group received accurate information;

v. Identify any learning for the organisation and make recommendations as to how a recurrence will be prevented in the future;

vi. Identify if a retrospective review of other aspects of the Urology Lookback process is required;

vii. Provide an urgent written report to Dr O'Kane.

METHODOLOGY

10. In order to complete the investigation to sufficient depth to deliver on the terms of reference, the investigation team applied a root cause analysis approach to identify:
    - The problems (the what?);
    - The contributory factors that led to the problems (the how?) taking into account the environmental and human factors; and
    - The fundamental issues/root cause (the why?) that need to be addressed.

11. In relation to the human factors referenced above, the investigation team considered these to be important as the staff dealing with this situation are human and as such, are fallible. Understanding human factors in an important feature in any learning organisation as it helps build better "defences" into systems and processes in order to prevent or reduce the likelihood of serious error resulting in harm to a patient by:

    - Allowing understanding why errors are made;
    - Improving safety culture within teams and the organisation;
    - Enhancing teamwork and communication;
    - Identify "what went wrong";
    - Helping predict "what could go wrong" in the future;
    - Improving the design of the work-related system/processes.

12. The investigation team reviewed documents and information from a number of sources. These were:

i.	Documents on USI website https://www.urologyservicesinquiry.org.uk/
ii.	"Regional Guidance for Implementing an Lookback Review Process" (DoH, 2021)
iii.	"A Practical Guide to Conducting Patient Service Reviews or Look Back Exercises" (DoH, 2007)
iv.	Source documents used to create the "parent" template that was used as the basis of patient letters i.e. the two statements from the Minister (November 2020 and August 2021) and the draft v2 of the Trust's Structured Clinical Record Review (SCRR) protocol
v.	The different letter templates for each category of patient regarding the Lookback which contained inaccuracies pertaining to the USI
vi.	Correspondence from the USI Chair dated 15 February in respect of the inaccuracies in the letter templates
vii.	The Trust's copy of letter from Mr Patient 38 to the USI Chair dated 21 March 2022
viii.	Patient information leaflets i.e. the "General Information Leaflet" and "SCRR Information Leaflet"

ix.	Urology Update Report for HSCB for a meeting on 30th March 2022
x.	Structure and processes used to deliver on the USI programme specifically the Terms of Reference for the Urology Oversight / Lookback Group
xi.	Urology Patient Review Form – "4 Questions" Urology Patient Review Form – "9 Questions"
xii.	Individual letters sent to all patients in the Structured Clinical Record Review (SCRR) category of the Lookback Review
xiii.	NIECR - reviewed in conjunction with xii above to check accuracy of letters containing information
xiv.	SCRR Internal Screening Meeting Outcomes Report including the "screened in" list
xv.	Job description for the "Acute Directorate Head of Service Clinical Assurance"
xvi.	Trust Integrated Governance Framework
xvii.	Trust Risk Registers – Corporate and Directorate

13. The team also interviewed key staff involved in either drafting and forwarding correspondence to patients in relation to the USI and / or administering the USI within the Trust, namely (in order of interview):

- Sarah Ward – Acute Directorate Head of Service for Clinical Assurance;
- Ronan Carroll - Assistant Director Surgery, Elective Care and Anaesthetics, Theatre & Intensive Care Services (ATICS);
- Jane McKimm - Programme Director for Public Inquiry;
- Martina Corrigan - Assistant Director Public Inquiry and Trust Liaison;
- Stephen Wallace - Assistant Director Systems Assurance;
- Melanie McClements - Director of Acute Services;
- Mr Mark Haynes - Consultant Urologist and Divisional Medical Director for Urology Improvement.

CHRONOLOGY OF WHAT HAPPENED?

Context

14. There had been ongoing focus on the urology care received by some patients who were under the care on a named consultant urologist in the Southern Trust which resulted in 9 separate Serious Adverse Incident (SAI) Reviews being undertaken. This proceeded to a deeper review of treatment and care of further patients between 1 January 2019 and 30 June 2020 of this urologist.

15. On 24 November 2020 the Minister of Health announced to the Assembly his intent to set up a statutory public inquiry under the Inquiries Act 2005 into the Southern Health and Social Care Trust's urology service. He committed to clarifying the details of the Inquiry, including the confirmation of the Chair and the Terms of Reference, as soon as possible.

16. On 8 May 2021 Minister Swan announced that Ms Christine Smith, QC would chair the Inquiry and on 31 August 2021 the *"Terms of Reference for the Statutory Independent Public Inquiry Into Urology Services in the Southern Health and Social Care Trust* were published. It was specifically stated in the Terms of Reference document that the doctor's clinical practice was being investigated by the General Medical Council and was therefore not included in the Terms of Reference for this Public Inquiry.

17. On 1 November 2021 the Acute Directorate's Head of Service Clinical Assurance took up post. The investigation team reviewed the job description which indicates that the main duties of this role is the implementation of the 11 recommendations from the [Urology] Serious Adverse Incidents and support all aspects of the ongoing [Urology] Lookback Review. It should be noted that this job description does not reference that the focus was specifically on SAIs within urology and nor does it say that the review pertaining to urology services is a formal Lookback Review process. Urology is only referenced once in the job description and that is linked to ensuring that *"Best Practice Guidance relating to both urology and cancer pathways… is implemented in the service"*.

18. On 8 November 2021 the Trust received a "Section 21" from the USI requesting the names and addresses of patients included in the Urology Lookback Review. The Trust assumed that this was to enable the Chair of the USI to make direct contact with patients and families about the USI.

The "Letters"

19. Up to this point patients who were part of the deeper review (i.e. the Lookback Review) of the named urologist's treatment and care had not been advised of this. As the Trust had not communicated to that date with patients and / or families they

wanted to do so urgently, and in advance of receiving communication from the USI panel.

20. To inform a letter to patients the acute management team used information from the Minister's statement of 31 August 2021 and also detail from a Trust document called "Proposal for Structured Clinical Record Review" which was in draft and had not been finalised at that time.

21. This information was used to create a "parent" letter template from which a number of different letter templates were further created i.e. one for each category of patient or in the case of a deceased patient, their next-of-kin. Each of the letters have the same beginning (i.e. [inaccurate] detail about the USI) with the body and end of the letter differing depending on the category of patient. The variations of the letters were:

    - Letter A (1) Care reviewed, no clinical concerns – patient alive;
    - Letter A (2) Care reviewed, no clinical concerns – patient deceased;

    - Letter B (1) Records still to be reviewed – patient alive;
    - Letter B (2) Records still to be reviewed – patient deceased;

    - Letter C (1) Records still to be reviewed (alternative) – patient alive;
    - Letter C (2) Records still to be reviewed (alternative) – patient deceased;

    - SCRR Letter – bespoke to include specific clinical information; *[NB - The opening paragraph in the SCRR letter differed from the others but remained incorrect]*

    - Post-Clinic Update Letter.

22. When the "parent" draft of the template letter was complete, it was shared with senior staff (directorate and corporate) asking for it to be reviewed in terms of readability as opposed to factual accuracy checking. There was an urgency about this, therefore it was expected that staff would turn it around quickly. The investigation team were advised that only limited feedback was received and that was related to minor wording changes rather than either a correction of factual inaccuracies or on the style / format of the letter. The investigation team were also advised that some staff attempted to give verbal feedback, however, timing was such this was not provided, hence an attempt to correct or amend the letter was further missed.

23. It transpired that USI contextual information in the first and second paragraphs of the draft template letters was wrong i.e. it incorrectly states that the Minister announced the Public Inquiry on 31 August when in fact he had announced the Inquiry on 24 November 2020. It also specified that the Public Inquiry would

investigate the clinical practice of the doctor when the USI Terms of Reference clearly stated this was not the case.

24. While a range of senior staff across the organisation had sight of the "parent" template letter, no one noticed these basic errors leading to this incorrect detail being included in all Trust correspondence at that time. As nearly every patient whose case was being reviewed received a letter this resulted in a significant number of patients have been misinformed. Furthermore 73 patients who have received the Post-Clinic Update letter received a second letter which meant they received two letters with these inaccuracies.

25. On 15 February 2022 the Chair of the USI wrote to the Trust in respect of 'incorrect and misleading information' contained in the letter which had been sent to patients involved in the Lookback Review.

26. A summary of the letters forwarded to patients is tabled below. The investigation team were advised that Letters C (1&2) were never used to communicate with patients therefore is now redundant. The investigation team have not included Letter C in the table below. The numbers for each group received by the investigation team has been transcribed below – it has not been checked / quality assured for the purpose of this document, however a QA of all the numbers in each category is a recommendation going forward.

Letter Type	Clinical Information included?	Number issued
Letter A (1)	No	873
Letter A (2)	No	58
Letter B (1)	No	358
Letter B (2)	No	53
SCRR Letters	Yes	59
Post Clinic Update	Yes	73

27. One of the subcategories of patients was those patients who required a more in-depth review of their treatment and care due to errors being discovered in the Trust's clinical review of their case. This in-depth review process is called Structured Clinical Record Review (SCRR) and takes place independent of the Trust.

28. As noted in the table above, there were 59 patients in this group including a patient, Mr Patient 38. When the SCRR group of patients received their Trust letter not only did it contain generic information regarding the USI and the internal Trust process on reviewing Urology patients, it also contained clinical information pertaining to them.

Mr Patient 38 Correspondence

29. Mr Patient 38 wrote to Chair of the USI on 21 March 2022 informing her that he received a letter from Shane Devlin, the then Chief Executive, which contained clinical information that was incorrect. This letter was copied to the Southern Trust and was received on 24 March 2022.

30. The incorrect information was that "[his current named consultant] *discussed the option of radiotherapy with you and completed a referral to the Oncology Team in Belfast. You completed your radiotherapy in October this year".* Mr Patient 38 highlighted to Ms Smith that while radiotherapy was discussed, this was not the treatment option he chose. He opted for injection therapy and did not have radiotherapy at any time.

31. The investigation team clarified this was the case with Mr Patient 38's current named consultant.

32. In this instance an error occurred in the preparation of Mr Patient 38's letter. When asked, the Head of Service for Clinical Assurance advised she did not know how she could have made the mistake.

33. In the absence of a definitive reason for the error the investigation team undertook a deep dive review into the letters that had gone out to patients in the SCRR group (N=59).

34. The purpose of this deep dive was to:
    a. Independently evaluate the accuracy of the other SCRR letters in terms of clinical information;
    b. Establish if any conclusion could be derived as to why the error occurred.

SCRR Letter Review

35. The SCRR Letter review was undertaken on 5 April 2022 by both members of the investigation team. They were accompanied by the Head of Service for Clinical Assurance and a second Head of Service who was proficient in the use of the Patient Information System (PAS) and the Northern Ireland Electronic Care Record (NIECR).

36. The review took place in a room with a large wall mounted computer screen that could be seen by all. NIECR was projected onto that screen for the investigation team to review simultaneously. A paper copy of all 59 letters was available both investigators to cross reference with NIECR. Also available for use was the "screening outcomes report" which was a summary of the SCRR internal MDT screening meeting and which included detail on why the patient required an SCRR of their case.

37. All of the 59 letters were checked for factual accuracy against the clinical information on the NIECR. The investigation team established that all of the letters were factually correct with the exception of Mr Patient 38's letter, which was letter 27. Three letters had minor typographical errors (letter 20, 23 & 36) however this did not impact of the clinical detail contained.

38. Letter 26 was reviewed and cross referenced with NIECR and the MDT screening outcomes report. The sequence of MDT screening outcomes report highlighted that this patient's case was discussed by the MDT screening team immediately prior to Mr Patient 38's case.

39. The Head of Service for Clinical Assurance confirmed that she drafted the SCRR letters in the order that the patients had been screened therefore she would have drafted letter 26 immediately before letter 27 which was Mr Patient 38's letter. The investigation team noted that the clinical detail which was incorrect in Mr Patient 38's letter was the same as the detail contained in Letter 26 which was accurate for that patient.

40. The investigation team have concluded the error occurred because of the moving between three different source documents i.e. "parent" letter template, NIECR and MDT screening outcomes report, to create individualised letters. The factors which may have contributed to this error are discussed later in this report.

Additional Observations

41. Some additional observations by the investigation team are that the letters to the patients in general (all categories not just SCRR) lacked attention to detail. The formatting for example the letter being justified as opposed to being aligned to the left, 1.5 spacing, large and at times irregular spaces between paragraphs, different fonts in the same letter, made the letters look rushed and unprofessional. Overall language and flow of the letters could have been better.

42. In addition to the letter that patients (or relative) received, each patient also received a "patient information leaflet" which sign-posted them to the USI website and also to the Trust helpline. For the patients in the SCRR group their leaflet also referenced the SCRR process as well as giving detail about Trust helpline etc.

43. The investigation team reviewed the information leaflets and consider them to be not at a good standard. They are worded ambiguously and consequently may not have been helpful to patients (or relatives) in providing clarity regarding the various process in the Trust and how these interface with the Urology Services Inquiry.

44. The investigation team also reviewed the "Urology Patient Review Form", both the shorter version (4 questions) and the longer version (referred to as the "9 questions") used for reviewing patients in the outpatient review backlog and those

waiting for an elective procedure. To note the “9 question” form actually has 10 questions as there are two questions numbered 4. Whether or not others knew of this error the form was not amended to reflect 10 question and was still referred to as the “9 Question” process. This reflects a lack of attention to detail and the need for clarity at all times when communicating either written or verbal.

45. The investigation team were advised that one consultant urologist undertaking these clinics uses the longer form and the other consultants use the shorter form. It has been further advised that assessment against the longer form has flagged a small number patient who were currently on the correct pathway for care but who may have not been on the correct pathway in the past. It is not correct to have two different approached to clinical assessment and this needs to be addressed. To note; this was not a focus of this investigation but requires consideration going forward and is included in the recommendations at the end of this document.

46. The Trust’s structure and process for undertaking and overseeing the Lookback Review process is broadly one group called the Urology Lookback Steering Group which is chaired by the Director of Acute Services. This group meets two-weekly and receives verbal and written updates from the Head of Service for Clinical Assurance who is responsible for the Urology Lookback Review. The Urology Lookback Steering Group deals with the operational aspects of implementing the Lookback Review as well as oversight of those same processes.

47. It is not clear to the investigation team where Urology Lookback Steering Group formally reports internally and where internal oversight sits within the context of the Trust’s Assurance Framework. There is an oversight process outside of the Trust in that Strategic Planning and Performance Group (SPPG) in the DoH (previously the HSCB) have a group called the “Southern Urology Co-ordination Group” which is chaired by the Director of Planning and Commissioning at SPPG and also a Department of Health group called “Urology Assurance Group” chaired by the Permanent Secretary. Senior Trust management staff from the Southern Trust are members of both these groups.

WHY DID THE MISTAKES HAPPEN?

Hospital situation at the time

48. The health and care system has been under enormous pressure particularly from March 2020 when the global pandemic started to take hold. As time progressed the pressure continued to build with each wave of the pandemic impacting further and compounding the stress experienced by all staff. In the autumn and early winter months of 2021 (and still to date) when the USI work started to pick up pace the Trust's acute clinical and managerial teams were extremely busy dealing with wave 3 of COVID 19. This is in addition to many other operational challenges such as high levels staff sickness, "winter pressures", significant delays in the Emergency Departments, difficulties managing flow across the system, increased nosocomial spread of COVID 19 across the hospitals resulting in ward outbreaks, the requirement to significantly increase the critical care service, ever increasing waiting time to see urgent elective patients for urgent procedures and a "collapsing" emergency general surgery services (in Daisy Hill hospital). All of this was being managed by the same staff who were also responsible for undertaking a urology Lookback Review.

49. The pace and volume of work was in no doubt unprecedented and while it describes the context of the environment the management team were working in it is not in itself the reason why the errors happened. The investigation team decided to use "*Dupont's Dirty Dozen*" to help identify the human factors that led to the errors in this case.

50. Dupont's Dirty Dozen are twelve of the most common factors that influence people to make errors that can potentially lead to harm (Dupont, 1993) they are used successfully in multiple industries to identify why accidents or incidents occur and help to identify ways to ensure the likelihood of a similar event happening is greatly reduced.

51. Dupont's Dirty Dozen are:

1)	Communication	7)	Resources
2)	Complacency	8)	Pressure
3)	Knowledge	9)	Assertiveness
4)	Distraction	10)	Stress
5)	Teamwork	11)	Awareness
6)	Fatigue	12)	Cultural Norms

Communication

52. Having reviewed the documentation and spoken to staff involved, the investigation team have determined communication was a key factor in the errors in this case. Communication is complex and involves a range of approaches including written, verbal, non-verbal, listening and visual. With the pressure of workload in the Acute Directorate much of the communication between that team is verbal and in many cases linked to email communication. This is enabled by their team's co-location on the Administration Floor in Craigavon Area Hospital. Despite this adjacency, the investigation team identified that opportunities to communicate more effectively regarding the detail of the letter templates were missed.

53. There is significant information feeding into the directorate's Urology Lookback Steering Group which, as referenced previously, is chaired by the Director of Acute Services. Some of the detail is distilled at previous meetings via individual groups established for that purpose; for example, detail on SCRRs, feedback from patients and families regarding the urology SAIs. However, there is a notable gap in the formal structure governing the Urology Lookback Review.

54. There is no specific group with explicit operational responsibility to provide direct management of the Lookback Review process with clear terms of reference, accountability and a pathway for escalation of issues to the Urology Lookback Steering Group. Consequently, the directorate's Urology Lookback Steering Group deals with the operational minutia as well as the strategic elements necessary for this work. This lack of hierarchal structure weakens the accountability within the directorate required for such an important patient-centred process.

55. Furthermore, there does not appear to be operational one-to-one meetings, supervision, team meetings with agenda and notes, between the Assistant Director for Surgery, Elective Care and ATICS who is currently responsible the Urology Lookback Review, and the Head of Service for Clinical Assurance. Not only are one-to-ones good practice within the workplace, it is necessary to provide personal and professional support a newly promoted staff member and would aid communication throughout the Urology Lookback Review process.

56. The investigation team have concluded that limited formal methods of communication up and down within the directorate has specifically hampered communication regarding the letters. A formal communication structure would strengthen accountability and could have enabled others outside the directorate to feedback regarding the content of the letter instead of trying to catch up with individuals within busy and competing diaries. In addition, a formal structure would have ensured everyone who needed to be consulted / involved in the approval process was aware of their roles and responsibilities and to voice their views and / or concerns.

57. The investigation team further identified the absence of horizontal communication with regards to the Trust's internal Public Inquiry governance structure. All of the 3 strands (i.e. Urology Oversight Steering Group, the Trust's Public Inquiry Steering Group and the Trust's Public Inquiry Quality Assurance Group) appear to be working semi-independently with limited structured opportunities to bring them together around common issues, to identify and discuss emerging learning and develop an internal support network.

58. It was evident that early on there was a lack of clarity on whether the review of patients under the care of the specific consultant was a formal Lookback Review or not. Had it been communicated sooner and more clearly that it was a formal Lookback Review it should have triggered a more robust structure (including communication) to implement the Urology Lookback Review process. Furthermore, the acute teams could have utilised practical guidance that was available on the DOH website, albeit it historical, to provide structure and support the undertaking of the process.

Complacency

59. It appears that there was an assumption of knowledge and understanding in relation to the detail of the USI within the acute services management team tasked with producing the patient letters. Therefore, everyone assumed the detail in the letter was correct and accepted it as such. Opportunities to note the error relating to the USI were missed. There also appeared to be complacency in not recognising the need to work with accuracy as well as with haste. This led to the focus being on when the letters could be sent to patients as opposed to ensuring the detail contained in the letters was absolutely correct.

60. The investigation team established there were no "Standard Operating Procedures" in place in relation to the processes associated with the Urology Lookback Review, therefore there was a lack of clarity on who did what and when. A differentiation between decisions that could be made quickly and those that required more attention was not evident. All decisions and action appeared to be made and acted upon quickly without consideration / awareness of the potential consequence. Had the importance of these letters been recognised and that more time was needed to review information going to patients, perhaps more time could have been set aside to ensure this task was done accurately.

61. It could be considered that it was a lack of attention to detail that resulted in the error in relation to Mr Patient 38's letter. Whilst that may play some part it should be recognised that there is an inevitable error rate when an individual is undertaking a specific task repeatedly. In the case Head of Service for Clinical Assurance was single-handily administrating >1600 patient letters. The fact that the investigation team only found one substantial error (and 3 minor typographical errors) would

indicate the Head of Service for Clinical Assurance did commit herself unreservedly to this process but lacked administrative support that could have provided a safety net to catch such errors.

Knowledge

62. There was a lack of knowledge pertaining to the rigour required to undertake a Lookback Review and to the detail of the USI across the system. This is in most part because staff in the Trust dealing with the Urology Lookback Review have no prior experience of undertaking a Lookback Review process.

63. Regional guidance in respect of Lookback Review processes has been in place since 2007 i.e. *A Practical Guide to Conducting Patient Service Reviews or Look Back Exercises* (DoH, 2007)[1]. This was updated in July 2021 when a new regional policy was published and the document *Regional Guidance for Implementing a Lookback Review Process* (DoH, 2021)[2] was circulated. The acute services management team considered the 2021 guidance as soon as it was available, however they did not use the original 2007 guidance to help shape the clinical review of patients that started the previous year. This is regrettable as the early document, whilst outdated, remains helpful guidance and would have provided a framework for the team and may have resulted in a more organised approach to communication with patients (and relatives) in this case.

64. In absence of using any formal guidance until later in 2021 to inform and structure the Lookback Review, the team should have reflected and learned in real time enabling them to identify and address issues quickly. However, the investigation team consider that the pace and volume of Lookback Review in addition to the "day job" work was not conducive to this.

65. At the beginning of November 2021 the Head of Service for Clinical Assurance, which is a pivotal role in the Urology Lookback Review process, was just new to post. However, she did not receive an induction / orientation to this new role because she almost immediately got caught up in the business of corresponding with patients. The post holder has a nursing background which is very beneficial for the role, however as a nurse her experience in administration, letter drafting, document labelling and version control, set up and utilisation of data bases, spreadsheets, filing, etc. all of which are crucial in terms of systems and process, is less well developed. Therefore, it would have been more constructive and supportive had she received 1:1 meetings with her line manager and had access to experienced admin staff to undertake the admin aspects of the role.

[1] A Practical Guide to Conducting Patient Service Reviews or Look Back Exercises (DoH, 2007) https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2018-07.pdf

[2] *Regional Guidance for Implementing a Lookback Review Process* (DoH, 2021) https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-reg-guide-lookback-reveiw.pdf

66. There is further detail about a lack of knowledge under the section of “Awareness” below.

Distraction

67. The investigation team heard that the acute service managers were continually distracted by the business of operational work. For example, having multiple tasks to do at once, constant phone calls, dealing with staffing issues, physical interruptions. When this is the case it is easy to get distracted and lose focus on what is being done. For those who share office space there is the added distraction of background noise from colleagues going about their everyday business. There is no doubt this environment increases the risk of errors and contributed to the situation that presented itself in this case.

68. A further distraction from a complete focus on the Lookback Review is that the Head of Service for Clinical Assurance has a dual function. On review of the job description for the Head of Service for Clinical Assurance, the investigation team noted that the job description is weighted towards the recommendations from the previous urology SAIs. The postholder is also responsible for all aspects of the Lookback Review process. This is two significant elements of work for one person. Given what is now known about the all-encompassing task of the Lookback Review, this split role is not advisable particularly within the context of a lack of both administration and supervisory support.

Teamwork

69. The management team in the acute directorate work well as a team. They are situated beside each other along a corridor and help each other as colleagues when required. For the most part the Head of Service for Clinical Assurance works independently of the other acute operational Heads of Service. She is line managed within acute services by an Assistant Director who, as well as being responsible for the Urology Lookback Review, is also operationally responsible for a wide range of acute services i.e. Surgery, Elective Care and Anaesthetics, Theatre and Intensive Care Services.

70. The investigation team have established that the Urology Lookback Review work within the acute directorate is not yet sufficiently connected to other elements of the Trust’s Public Inquiry work i.e. internal quality assurance and corporate learning processes and the Trust’s USI response team. These horizontal linkages are vital to ensure the internal focus on the USI remains connected to patients, the directorate and corporate governance structures and processes including the learning in the organisation going forward. This disconnect is possibly due to the fact the acute directorate is so busy with day-to-day operational service management that there is insufficient time in the day to become more involved, or it could be a lack of understanding of the importance or need for robust

interconnectedness. Most likely it is both, however whatever the reason, the weakness of these links played a part in the errors in this case.

Fatigue

71. Fatigue is a feeling of constant tiredness and can be physical, mental or a combination of both. The acute management team are extremely busy with the day-to-day responsibility of providing acute services in the Trust within the context of unprecedented demand and for some without a proper break for more than 2 years (20 months when the errors occurred). Within acute services (and other service areas also) there is no "turning off" the demand and as such it constantly occupies the minds of staff. The Director of Acute Services is responsible for a portfolio of services beyond that of some of her peers in other Trusts. In addition she has the extra-ordinary demands of a formal Lookback review and a Public Inquiry to deal with. She constantly works very long hours just to remain in control of the services that she is responsible for. This is physically and mentally draining for both her and other members of her team.

72. As stated previously the Head of Service for Clinical Assurance is new to post and taking in new information continuously in addition to also working exceptionally long hours, beyond her contracted hours. Furthermore she is part of the acute first on call rota which is a very demanding role given the current pressures within ED, lack of beds and management of infection prevention and control issues out of hours etc. Her work in-hours requires concentration on her laptop screen for the majority of the time. There is no doubt that all these elements significantly contribute to fatigue and similar factors would apply to other staff involved in overseeing and inputting to this work.

Resources (Personnel and Space / Equipment)

73. The personnel resource in the acute directorate team for the Lookback Review and to interface with the Public Inquiry is limited. The only staff member in the directorate that has a dedicated role is the Head of Service Clinical Assurance (Band 8B). This is in contrast to the other elements associated with the Inquiry i.e. internal Quality Assurance / Corporate Learning aspect and the Trust's Public Inquiry Response team which are both overseen and managed by two new posts operating at Assistant Director level (Band 8C).

74. As referenced above, the Assistant Director responsible for the Lookback Review is also balancing the workload of a very demanding operational management job with no reduction in his operational portfolio to allow time to focus on the Lookback Review process.

75. The Head of Clinical Assurance has limited ad hoc Band 4 administrative support for letter printing and posting. The majority of the administrative work associated

with the Lookback Review, including updating of the databases, letter preparation, responding to the helpline enquiries, responding to information requests, administration of meetings, etc. are undertaken by her personally.

76. The clinical resource i.e. medical and nursing staff in Urology services, is severely overstretched dealing with everyday patient demand which is very far beyond the clinical capacity available in "normal" circumstance. Any additional clinical capacity that was secured within the urology team focused on patient-facing activity such as review clinics, patient screening, triage etc. Therefore the ability of the medical and nursing staff to support the administrative element of the Urology Lookback Review is very limited.

77. This lack of staff in the acute directorate supporting the Urology Lookback Review makes this process vulnerable and lacking in resilience.

78. From a space / equipment perspective, when the letters were being drafted and shared with patients, the Head of Service for Clinical Assurance had no dedicated office space. She was "hot-desking" using space that was free on the days the letters were drafted. There is no doubt this situation led to errors in the patient letters.

79. From the beginning of January the Head of Service for Clinical Assurance has been assigned a fixed desk on the admin floor in Craigavon Area Hospital. However, it is in an office shared with three other of Heads of Service in the Acute Directorate. This is a busy office which is subject to multiple interruptions both in terms of people, zoom meetings and phone calls. This makes it extremely difficult to concentrate and effectively undertake work that is at times repetitive and requires significant focus and attention to detail.

80. In addition the Head of Service for Clinical Assurance is using a laptop for work associated with her role. She has advised she is working across a range of databases and documents from a small screen. She has previously requested a desktop monitor and second screen to undertake this work, however at the time of this review this was still not in place.

Pressure

81. As outlined at paragraph 46 above, at the time that these letters were being prepared acute services were under extreme pressure in terms of operational workload. There was a short turnaround time for the Trust to return the Section 21 with patient details requested by the USI panel, increasing pressure on the directorate to get the Trust letters out to patients as soon as possible. This time pressure resulted in a short time frame to review the letter template(s), not waiting to glean as much feedback as possible, therefore sending letters that were not quality assured and not checked for accuracy. It is regrettable that despite the rush

by the Trust to communicate with patients the USI panel still was in contact with patients and families some weeks before the Trust.

Assertiveness

82. The investigation team do not consider lack of assertiveness to be a factor in this case.

Stress

83. It was evident from interviews with staff that they were, and continue to be, under significant stress in relation to workload. This applies equally to clinical and management staff. All staff are working very long hours to meet the demands of their job. This is exacerbated for the Head of Service for Clinical Assurance given she took up this new post at the start of November 2021 requiring significant work to understand the context and range of the role she was employed to do. She was also expected to "hit the ground running" and deliver to tight deadlines.

84. As previously stated the Head of Service for Clinical Assurance is also on the acute on call rota at head of service level, another new role for her, undoubtedly adding to her stress at a personal level.

Awareness

85. From interviews it was evident that there was a lack of awareness about the enormity of the task of undertaking a Lookback Review and staff "did not know what they didn't know". Most likely this was as a result of not ever being previously involved in this type of process. The situation of "not knowing what you don't know" is littered with hazards unless it is recognised and actively addressed.

86. In this circumstance when key staff had not been exposed to a process they were charged with undertaking they should have recognised there would be a gap in their knowledge and experience that could affect their ability to do the task fully. In this case there should have been proactive steps taken to find out more about the process i.e. try to establish "what you don't know" and consider the consequence of this. For example, a search of the Internet would have identified the 2007 DoH guidance on conducting a Patient Service Review. It would also have found a Republic of Ireland, Health Service Executive document published in 2015 (and reviewed in 2018) called "*Guideline for the Implementation a Look-back Review Process in the HSE*"[3]. Both of these documents would have raised awareness of the requirement for robust, proactive systems and processes when dealing with Lookback Reviews in the context of significant public scrutiny. This

[3] Guideline for the Implementation a Look-back Review Process in the HSE (Health Service Executive, 2015) https://www.hse.ie/eng/about/who/nqpsd/qps-incident-management/incident-management/lookback-review-guideline-final-dec-2015.pdf

would have informed the Acute Directorate's processes and in doing so would have helped to close the gap of known and unknown.

Cultural Norms

87. A cultural norm is "the way we do things round here". In this case the norm within the Acute Directorate management team is dealing with multiple situations, at the same time, at speed and in the moment. This style of managing services is similar in Acute Services in every other Trust in Northern Ireland is driven by the constant demand for healthcare services and a significant workload on the part of the managers. While it is demanding, staff who operative in this type environment and at this pace have (or develop) a skill set that allows them to normalise this way of working. It therefore becomes their default setting and their normal *modus operandi*. The attention to detail required to ensure there are no errors in a formal Lookback Review process is a different skill set to the "norm" used for everyday operational management within the acute team. This was a contributory factor in this case.

LEARNING

88. Based on the findings of this investigation and on consideration of Dupont's Dirty Dozen the learning emerging is the importance of:

- Recognising there is an inevitable error rate when an individual is undertaking a specific task repeatedly and taking steps to minimise this;
- Recognising of the need for attention to detail at all times;
- Good knowledge and understanding of the subject matter including active consideration of action and consequence;
- Recognising there is always detail that one is not aware that they don't know;
- Good standard operating procedures to define the associated processes;
- Accurate standardised documentation alongside robust systems for naming and electronically filing all documentation;
- A robust database with a repository of information specific to the needs of the Lookback Review process
- Good processes to support information sharing;
- Good communication and team working arrangements;
- Sufficient resources to meet the requirements of the Lookback Review;
- Robust organisational and clinical governance arrangements;
- Clear roles and responsibilities as well as monitoring and accountability;
- Good systems to ensure staff are supported.

RECOMMENDATIONS

89. There are 19 recommendations for consideration by the Chief Executive and Senior Management Team. These are clustered into the following headings:

- Letters;
- Mr Patient 38;
- Resources;
- Lookback Review Process; and
- Going Forward.

Letters

i. All of the letter templates should be reviewed and amended to include accurate information regarding the USI. These should be clear, concise and formatted appropriately;

ii. An apology letter should be sent to every patient (or relative) who received a letter with incorrect information, highlighting the error and clarifying the accurate context. Each patient should ideally receive the same letter whether their original letter had clinical detail or not;

iii. The patient information leaflets should be reviewed so there is no ambiguity in the reading. The appropriate leaflet should be included with the patient apology letter.

iv. Any outstanding and future letters to patients involved in the Lookback Review should be sent using the new template and new information leaflet.

Mr Patient 38

v. Mr Patient 38 should receive a letter of apology from the Chief Executive. This letter should reference the investigation and its outcome and should also rectify the inaccuracies regarding the context of the USI.

Resources

vi. The acute management team should be augmented with a senior manager at Assistant Director level with full operational responsibility for all aspects of the Urology Lookback Review reporting, service improvement following previous SAIs and future outcomes of SCRR. This focus of this should also be on ensuring the governance of the Lookback is clear and robust.

vii. There should be a review of the job description of the Acute Directorate Head of Service for Clinical Assurance to make it clear that this role pertains specifically to the urology service. Consideration should also be given to amending the job description to focus that role entirely on all aspects of the

Lookback Review process (see recommendation **xii** below) and for the title of the post should be changed to reflect the role more clearly. This position should have direct reporting arrangements to the newly established Assistant Director for the Urology Lookback Review.

viii. The Trust should also consider resourcing dedicated admin to support the administrative processes associated with the Urology Lookback Review.

ix. Arrangements to support all the staff involved in the Lookback Review should be in place this should include 1:1meetings, supervision etc.

x. All staff new to the Urology Lookback team should be inducted and orientated to the background to the Lookback Review including all the associated systems and processes as well as receiving contextual information about the USI and how the Lookback review sits within that process.

xi. Relocate staff (and locate new staff) undertaking work aligned to the Urology Lookback Review to promote concentration and reduce the risk of errors occurring.

Lookback Review Process

xii. Consideration should be given to separating the implementation of the Urology SAI recommendations from the Urology Lookback Review process at the Head of Service for Quality Assurance (note recommendation **vii** above about change of title) level. The Head of Service for Quality Assurance should focus solely on, and be accountable for, the Urology Lookback Review process. This would necessitate a review of the job description and change of title referenced in the *Resources* section above.

xiii. There should be a review of the Trusts Urology Lookback Review operation and governance arrangements within the Acute Directorate as well as corporate levels, to strengthen reporting, oversight and accountability. This should be aligned as much as possible with the 2021 DoH policy and guidance for *"Implementing a Lookback Review Process"*. To this end there should be:

a) An "Operational Lookback Review Team" established to ensure there is more rigour for, and support to, the operational aspect of the Urology Lookback. This Operational Lookback Review Team should provide oversight of the use of the database, screening and recall processes, interface with patients and family as required and provide an accurate and timely SITREP to the directorate's Urology Oversight Steering Group.

b) There should be a number of regular sub groups established such as a Clinical Reference Group as well as a number of Task and Finish groups take forward necessary work to support the Lookback process

c) The interfaces between this newly established Operational Lookback Review Team and the various sub-groups / T&F group need to be clear and functional.

d) A review of the terms of reference of the current "Urology Oversight Steering Group" and where it sits within the context Trust's extant Governance Framework, the new Operational Lookback Review Team, the horizontal linkages with the Trust's USI Programme Board as well as the external interfaces with the DoH including the Strategic Planning and Performance Group and Urology Advisory Group

xiv. Standard Operating Procedures associated with the Lookback Review process drafted to add more clarity and structure to ensure everyone involved is aware of who does what and when. These SOPs should include [this is not an exhaustive list]:

a. Process for letter approval;
b. Process for a second independent check of letters containing clinical information;
c. Process for naming and filing of electronic documents;
d. Processes associated with the L drive including access to this resource;
e. Processes for the electronic sharing of information to ensure compliance with information governance requirements;

Going Forward

xv. There should be an audit / QA of the overall numbers of patients currently included in this phase of Urology Lookback Review process to assure the Chief Executive that the detail at this time is correct. This information can be used with confidence when responding to questions, including Section 21s, and follow up meetings, etc., with the Trust's solicitors and with the USI panel.

xvi. The Medical Director and Operational Director should consider if all patients to date reviewed with the short Urology Patient Review Form should have the remaining 6 questions applied to their most recent clinical assessment.

xvii. There should be Trust decision, informed by senior clinical and managerial opinion and in conjunction with the DoH's Strategic Planning and Performance Group as to whether the Urology Lookback Review process should extend back to earlier years and agreement as to risk stratification and the methodology to undertake this.

xviii. The acute team undertaking the Lookback Review should participate in a learning process to inform an extension of the Lookback, to reflect on what

went well, what did not, what should be replicated and what should be changed, to enable learning going forward.

xix. A robust action plan to implement the above recommendations should be developed and urgently commenced. This action plan should clearly set out what is to be implemented, by whom and by when. Accountability for, and the reporting of progress against the action plan, should be to the Chief Executive.

MONITORING PROCESS IN RELATION TO 2017 ACTION PLAN MHPS AOB.

i. In a letter dated 06.02.2017 from Dr Khan it was described that his case was reviewed on 26.01.2017 and that it was determined that there was a case to answer in respect of the four concerns and that a formal investigation of the issues was required.

ii. In his summary of 09.02.2017 AK states that A was to return full time to his job as per his job plan and to include safeguards and monitoring around the four main issues of concern under investigation. An urgent job plan review was to be undertaken to consider any workload pressures to ensure appropriate supports could be put in place, and on 16.03.2017 the terms of reference for MHPS investigation were set

iii. The issue of monitoring dictation was discussed in early April 2019 with Mr. Haynes when he brought it to my attention on 11th March that he had concerns about how backlogs for Urology were being monitored. He copied me into an email trail which had begun on 4th December 2018 with a letter from Colette McCaul at 16:15 identifying recent backlogs for Urology as of 04/12/2018. In this she states no major outstanding backlog. The result to be dictated from the middle to the end of November. Audio typist has currently all results to be typed. area of backlog

iv. This was sent to a number of individuals including Mr. O'Brien. Ms. McCaul responded to Mr. Haynes on 6th December 2018 stating we are doing a bit of further looking into this request as we are taking this very seriously. He had emailed her on 5th December 2018 asking her to describe the method by which information is collated. He states "I can see how you obtained the waiting to be typed information but for instance how is the information on the result to be dictated Colette. Is it based on E finance data, number of results not signed off on ECR or some other method? I am concerned that the data presented doesn't sit with my impression of practice (I regularly see patients coming to OPA with scan results having been performed months earlier, requested by someone else but no results letter or action even done and no sign off either on

ECR or the paper copy). Similarly how is the clinic awaiting dictation data obtained?"

v. Mr. Haynes then gave Ms. McCaul an example of a patient who he states CT was done on 13/03/18, reported on 20/03/18, G.P. letter brought to his attention on 17/07/18 and renal cancer subsequently treated. He states that he was happy to discuss this with her but his concern was that there are individuals in the management structure who believe this data was robust when he wasn't certain that it was.

vi. Katherine Robinson then the Booking and Contact Centre manager responded on 6th and 14th December and states that she could establish if the result ever came back to Mr. O'Brien, either a hard copy or email. She states," I thought radiology flagged these up to be looked at and they collect. We cannot find it in Noelene's office. That said the secretary has a huge issue with her management, i.e. Colette and I asking her questions etc., and is extremely upset and feels we are harassing her. She said we are trying to get through this. I don't know how we can possibly get proper info without the secretary helping. The secretary does not want to be involved".

vii. Mr. Haynes then went back to her to say the issue wasn't whether or not it was ever received, his concern was that "there were individuals who think that the reported results where dictation data is robust. It isn't. The number is generated at best for some as a guess. Because this regular report is taken by senior personnel in the Trust as robust it was seen as a monitoring tool within governance processes that results are being actioned and communicated to patients in a timely manner with no risk of unactioned significant results. I fear your team are at risk as we have a situation where a patient comes to harm because a result isn't actioned and subsequent investigations reveal a large number of unactioned results. Your team would be open for criticism for reporting inaccurate information".

viii. He goes on to state that" I do sign off a number of outstanding plus any sets of notes with hard copy results is the number reported. He states ironically although they are up to date with most of this that regularly these appear to be

ones that are at times behind. He states a question to all secretaries asking them how they get the numbers that they report at a starting point along with a meeting to highlight how this information is collected and the potential consequences of misreporting". This email was sent to Kathrine Robinson and Colette McCaul on 15th December 2018.

ix. On 11th March 2019 Mr. Haynes contacted me to copy me into the email trail and I suggested a conversation at that point to try and understand the processes on 31st March.

x. On 29th March 2019 at 15:57 Vicky Graham was contacted by a Higher Clerical Officer to state that there were 24 referrals on 22/03/2019 needing triage for Urology and ECR and asked her to escalate. She then forwarded these to the Consultant Urologist stating that the red flag team was advised there were 24 referrals in ECR to be triaged dating back to 22/03/19 asking if these could be triaged. Mr. Haynes then forwarded to me on 30th March stating this relates to one of the AOB issues. He has been On-Call since 22/03/19 and should have been doing the triage. I then asked on 31st March if this had happened before and Mr. Haynes responded by saying that triaging Urology like most other surgical specialists is done by the On-Call Surgeon of the week. He highlighted what was in Mr. O'Brien's return to work action plan under Concern 1. He goes on to state, attached are a number of escalation emails pertaining to this from Ms. Vicky Graham which I have alluded to. I would assume that this has been shared with the Director of Acute Services and appropriately escalated to MHPS case manager. Anecdotally certainly the E triage is not completed by 4 p.m. on the Friday of his On-Call week, indeed looking now there are 79 referrals in E triage received between 21st March and 27th March (Mr. O'Brien's recently On-Call week) that have yet to be triaged, including 16 red flag referrals dating form 25/03 – 27/03 (see screenshot below). Mr. Haynes goes on to say I am not aware of the reporting and escalation that may have occurred of this following the return to work. On 31st March I informed him that I had forwarded this to the case manager.

xi. On 11th February 2019 the Higher Clerical Officer had escalated to Vicky Graham that on ECR from 07/02 for Urology there were referrals that required to be escalated to be triaged and she in turn escalated these to the Consultant Surgeons on 11th February 2019 stating that there were red flag results on ECR dating back to 07/02/19 and asking that these were triaged.

xii. My understanding at this point that this issue was then being resolved through administrative processes and by those who have been involved in managing Urology together with the clinicians and those who have been involved in oversight of his return to work plan. In addition to this given that Mr. O'Brien had been copied in these emails he would be cognizant of the concerns being raised outside of any other conversations he was likely to have with others.

xiii. In the course of preparing this answer it has come to my attention recently that there had been concerns about adherence with compliance with Action Plan 2017 monitoring in 2018 before my arrival.

xiv. When I arrived in the Trust IN December 2018, Mr O'Brien was being actively managed already through the Action Plan agreed following the Maintaining High Professional Standards process in March 2017 following a decision by the Case Conference on 26th January 2017 to lift the immediate exclusion which was in place from 30th December 2016.

xv. This 2017 action plan formed the basis for Mr. O'Brien's return to work at that time and was to be in place pending conclusion of the formal investigation process under Maintaining High Professional Standards Framework.

xvi. The decision of the members of the case conference was for Mr. O'Brien to return as a Consultant Urologist to his full job role as per his job plan and to put safeguards and monitoring around the four main issues of concern under investigation.

xvii. An urgent job plan review was to be undertaken to consider any workload pressures to ensure appropriate supports can be put in place.

xviii. It goes on to describe that Mr. O'Brien's return to work is based on

(1) Strict compliance with Trust policies and procedures in relation to triaging of referrals, contemporaneous note keeping, storage of medical records and private practice

(2) Agreement to comply with the monitoring mechanisms put in place to assess his administrative processes.

xix. It states that the work would be monitored by the Head of Service and reported to the Assistant Director in relation to managing clinical activity.

xx. It outlines the concerns and in relation to

xxi. Concern (1) it states all referrals received by Mr. O'Brien will be monitored by the Central Booking Centre in line with timescales and a report will be shared with the assistant director of Acute Services, Anaesthetics and Surgery at the end of each period to ensure all targets are met.

xxii. Concern (2) that notes must not be stored in Mr. O'Brien's office and should be tracked out to him for the shortest period of time for the management of the patient.

xxiii. Concern (3) that a plan or record for each clinic attendance must be recorded for each individual patient and this should include a letter for any patient who did not attend as there must be a record of this back to the G.P. and that in relation to

xxiv. Concern (4) the scheduling of the patients must be undertaken by the secretary who will check the list with Mr. O'Brien and then contact the patient for their appointment.

xxv. This process was in keeping with the practices established within the Urology team.

xxvi. It also then states that any deviation from compliance with this action plan must be referred to the MHPS case manager immediately.

xxvii. When he was found to have defaulted on aspects of the Action Plan on the 16th September 2019 he was offered support in clearing the backlog and it was

understood that this had come about at a time he had been supporting his family when his mother in law was unwell. When he was carefully monitored throughout this process he appeared to be able to comply with what was required and did not ask for any help and this was offered. Previously there had been extra administrative time provided on a Tuesday morning in his Job Plan and Mr Young had taken on some of his triage as had the others on occasion.

xxviii. The monitoring of the Action Plan was overseen by Dr Khan as Case Manager supported by Mrs Siobhan Hynds Senior HR manager. A job plan review had been offered throughout but Mr O'Brien was reticent to engage and **Mr Haynes records in an email dated 31st May at 9.08am to me and others** that Mr Obrien does not have a signed Job Plan. Discussion had occurred and the job plan has been "awaiting doctor agreement" since November 2018. An update on the process had been requested from the relevant CD. He goes on to state that he is aware of instances where the actions regarding Concern 1 have not been met specifically "triage of all referrals must be completed on the Friday after Mr O'Brien's Consultant of the Week ends. Red Flag referrals must be completed daily".

xxix. Mr Haynes goes on to state "Given that I am aware of aspects of the action plan not being met, I am concerned to see the statement that there have been "no exception reports flagged to case manager" the implication being that there has been an agreed deviation from the action plan and monitoring is now occurring against different standard, or that the monitoring and /or escalation process has not functioned as it should". He expresses the concern that the reporting process appears to have failed to flag these to the case manager

xxx. His case was discussed regularly through the Doctors' and Dentists' Oversight Group for Doctors in difficulty involving senior HR personnel and with the GMC. In addition to this he was supported throughout the MHPS process and Action Plan by Mr John Wilkinson as Non -Executive Director.

From the Permanent Secretary and HSC Chief Executive

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Our ref: PM-133
SSUB-0134-2022

Date: 07 July 2022

Dear Maria,

I would like to thank you for your letter dated 26th May 2022 and I apologise for the delay in responding.

We have to take seriously the concerns raised by Christine Smith, Urology Services Inquiry (USI) Chair. It is important to seek and provide assurances that each concern as identified is being addressed promptly and appropriately. Those assurances should also assist SHSCT going forward also.

The Department has considered the issues raised by Ms Smith and the responses you provided by correspondence on 26th May 2022. We have concluded that the matters raised relating to "Urology Clinician Assurance" and the "Investigation into inaccurate information provided to patients by SHSCT" should be subject to an independent review. I can therefore advise that the Department will be commissioning the RQIA to undertake an urgent review of SHSCT Urology Services and Lookback Review. The Terms of Reference for this review will be shared with you in due course.

The Department's Permanent Secretary-led Urology Assurance Group will continue to provide oversight of the Urology Lookback Review and related matters.

I am pleased to hear through correspondence from Ms Smith that engagement between SHSCT and the USI has been positive and collaborative recently and I very much hope that this continues as the Inquiry progresses its work.

I intend to write to Ms Smith to inform the Inquiry of the Department's impending actions and will share a copy of this letter with the Inquiry for their information.

Yours sincerely

Personal information redacted by USI

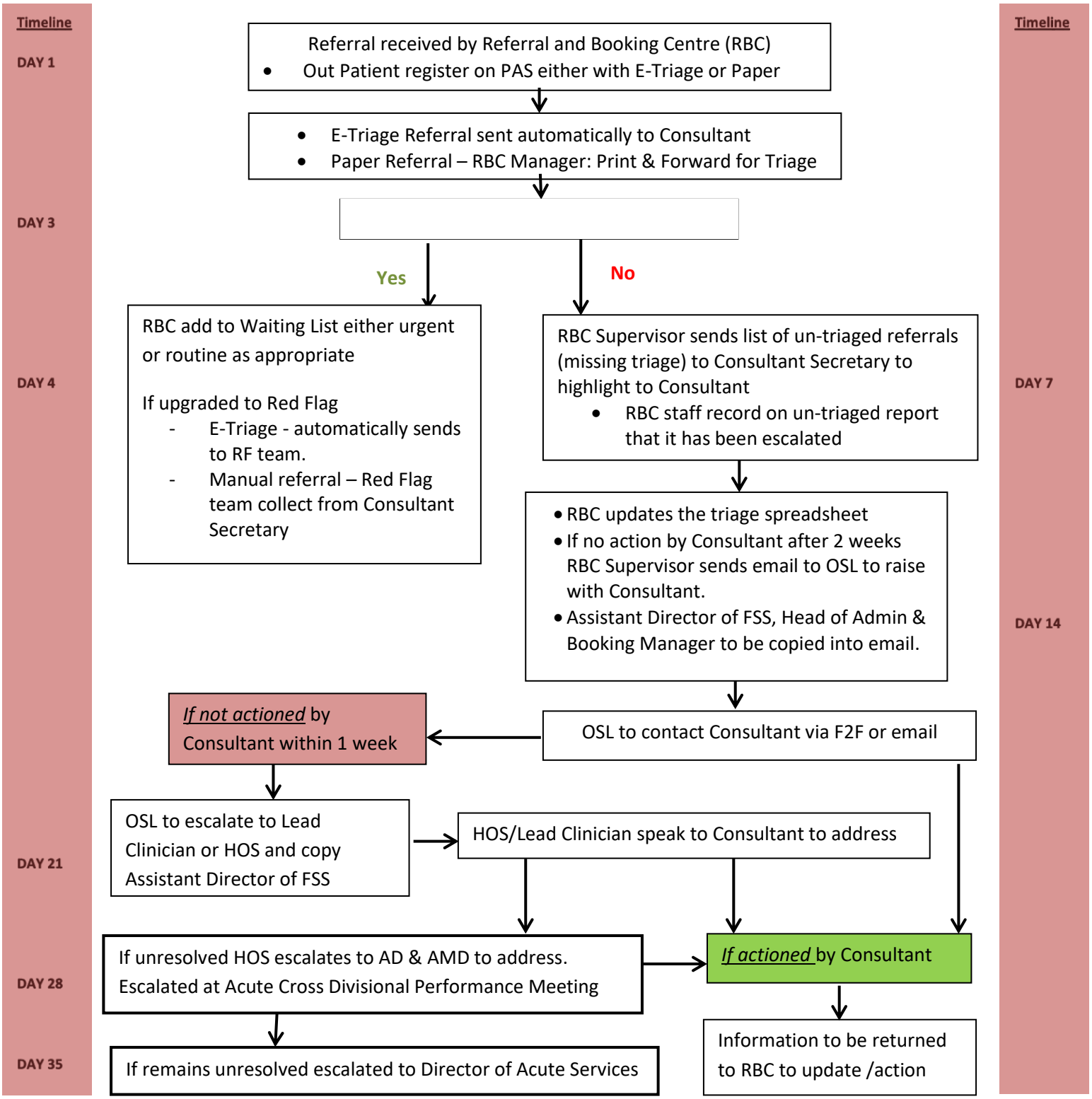
TRIAGE PROCESS

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

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

PURPOSE OF TRIAGE

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



Note: This process will incur a minimum of 5 weeks in total if referral is un-triaged within the target times which means that if the referral is upgraded to Red Flag it is in excess of 14 day Red Flag turnaround.
It is the responsibility of the Consultant to ensure Triage is done within the appropriate timescales detailed above.

Southern Health and Social Care Trust

Quality Care - for you, with you

ADMINISTRATIVE & CLERICAL Standard Operating Procedure

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

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

Introduction

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

Implementation

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

Consultant to Consultant Referrals

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

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

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

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

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

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

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

Southern Health and Social Care Trust

Quality Care - for you, with you

A GUIDE TO PAYING PATIENTS

V.2 [11th February 2016]

DOCUMENT – VERSION CONTROL SHEET	
Title	Title: Guide to Paying Patients Version: 2
Supersedes	Supersedes: Guidelines for Management of Private Patients
Originator	Name of Author: Anne Brennan Title: Senior Manager Medical Directorate
Approval	Referred for approval by: Anne Brennan Date of Referral: 27th March 2014 to: • Trust Senior Management Team • Trust LNC
Circulation	Issue Date: 16th October 2014 Circulated By: Medical Directorate Issued To: As per circulation List: All Medical Staff
Review	Review Date: February 2017 Responsibility of (Name): Norma Thompson Title: Senior Manager Medical Directorate

CONTENTS

1. INTRODUCTION

1.1 The Trust came into existence on 1 April 2007 and is responsible for providing acute care across three sites namely:-

- Craigavon Area Hospital, Portadown
- Daisy Hill Hospital, Newry
- South Tyrone Hospital, Dungannon

1.2 The Trust welcomes additional income that can be generated from the following sources:-

- Private Patients
- Fee Paying Services
- Overseas Visitors

1.3 All income generated from these sources is deemed to make a valued contribution to the running costs of the Trust and will be reinvested to improve our facilities to benefit NHS and private patients alike.

1.4 All policies and procedures in relation to these areas will be carried out in accordance with Trust guidelines.

1.5 For further information please do not hesitate to contact the Paying Patient Office. [email: paying.patients@southerntrust.hscni.net or http://www.southerndocs.hscni.net/paying-patients/

2. OBJECTIVES

2.1 The purpose of this guideline is to:

- Standardise the manner in which all paying patient practice is conducted in the organisation.
- Raise awareness of the duties and responsibilities within the health service of medical staff engaging in private practice and fee paying services within the Trust.
- Raise awareness of the duties and responsibilities of all Trust staff, clinical and non-clinical in relation to the treatment of paying patients and fee paying services within the Trust.
- Ensure fairness to both NHS patients and fee paying patients at all times.
- Clarify for relevant staff the arrangements pertaining to paying patients and to give guidance relating to
  - record keeping
  - charging

- procedures and
- responsibilities for paying patient attendances, admissions and fee paying services.

- Clarify charging arrangements when consultants undertake fee paying services within the Trust.

3. CATEGORIES OF WORK COVERED BY THIS GUIDE

3.1 Fee Paying Services

3.1.1 Any paid professional services, other than those falling within the definition of Private Professional Services, which a consultant carries out for a third party or for the employing organisation and which are not part of, nor reasonably incidental to, Contractual and Consequential Services. A third party for these purposes may be an organisation, corporation or individual, provided that they are acting in a health related professional capacity, or a provider or commissioner of public services. Examples of work that fall within this category can be found in Schedule 10 of the Terms and Conditions (Appendix 1).

3.2 Private Professional Services *(also referred to as 'private practice')*

3.2.1 The diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under Article 31 of the Health and Personal Social Services (Northern Ireland) Order 1972), excluding fee paying services as described in Schedule 10 of the terms and conditions.

3.2.2 Work in the general medical, dental or ophthalmic services under Part IV of the Health and Personal Social Services (Northern Ireland) Order 1972 (except in respect of patients for whom a hospital medical officer is allowed a limited 'list', e.g. members of the hospital staff).

3.3 Overseas Visitors

3.3.1 The National Health Service provides healthcare free of charge to people who are a permanent resident in the UK/NI. A person does not become an ordinarily resident simply by having British Nationality; holding a British Passport; being registered with a GP, or having an NHS number. People who do not permanently live in NI/UK are not automatically entitled to use the NHS free of charge.

3.3.2 **RESIDENCY** is therefore the main qualifying criterion.

4. POLICY STATEMENT

4.1 Medical consultant staff have the right to undertake Private Practice and Fee paying services within the Terms and Conditions of the new Consultant Contract as agreed within their annual job plan review and with the approval of the Medical Director.

4.2 This Trust provides the same care to all patients, regardless of whether the cost of their treatment is paid for by HSC Organisations, Private Medical Insurance companies or by the patient.

4.3 Private Practice and Fee Paying services at the Trust will be carried out in accordance with:

- The Code of Conduct for private practice, the recommended standard of practice for NHS consultants as agreed between the BMA and the DHSSPS (Appendix 2).
- Schedule 9 of the Terms and Conditions of the Consultant contract which sets out the provisions governing the relationship between HPSS work and private practice (Appendix 8).
- The receipt of additional fees for Fee Paying services as defined in Schedule 10 of the Terms and Conditions of the Consultant Contract (Appendix 1).
- The principles set out in Schedule 11 of the above contract (Appendix 5).

4.4 All patients treated within the Trust, whether private or NHS should, where possible:

- be allocated a unique hospital identifier
- be recorded on the Patient Administration System and
- have a Southern Health & Social Care Trust chart.

4.5 The Trust shall determine the prices to be charged in respect of all income to which it is entitled as a result of private practice or other fee paying services which take place within the Trust.

5. CONSULTANT MEDICAL STAFF RESPONSIBILITIES

5.1 Private Practice

5.1.1 While Medical consultant staff have the right to undertake Private Practice within the Terms and Conditions of the new Consultant Contract as agreed within their annual job plan review, it is the responsibility of consultants, prior to the provision of any diagnostic tests or treatment to:

- ensure that their private patients (whether In, Day or Out) are identified and notified to the Paying Patients Officer.

- ensure full compliance with the Code of Conduct for Private Practice (see Appendix 2) in relation to referral to NHS Waiting Lists.
- ensure that patients are aware of and understand the range of costs associated with private treatment including hospital costs and the range of professional fees which the patient is likely to incur, to include Surgeon/Physician, Anaesthetist, Radiologist, Pathologist, hospital charges. Leaflets can be obtained from the Paying Patients Officer or the Paying Patients section of Southern Docs website – click here.
- obtain prior to admission and at each outpatient attendance a signed, witnessed Undertaking to Pay form (Appendix 3) which must then be sent to the Paying Patient Officer for the relevant hospital at least three weeks before the admission date. This document must contain details of all diagnostic tests and treatments prescribed.
- Establish the method of payment at the consultation stage and obtain details of insured patients' private medical insurance policy information. The Trust requires this information to be forwarded to the Paying Patient Officer **prior to admission** so that patients' entitlement to insurance cover can be established. This should be recorded on the Undertaking to Pay form [Appendix 3].
- Ensure that all patients, where appropriate, are referred by the appropriate channels, i.e. GP/other consultant.
- Ensure that private patient services that involve the use of NHS staff or facilities are not undertaken except in emergencies, unless an undertaking to pay for treatment has been obtained from (or on behalf of) the patient, in accordance with the Trust's procedures.
- Ensure that information pertaining to their private patient work is included in their annual whole practice appraisal.

5.2 Fee Paying Services - *see Appendix 1 for examples*

5.2.1 The Consultant job plan review will cover the provision of fee paying services within the Trust. Consultants are required to declare their intention to undertake Fee Paying Services work by forwarding the Paying Patient Declaration form to the Medical Director's office.

5.2.2 A price list for fee paying services is available from the Paying Patients Office or the Paying Patients section of Southern Docs website – click here. It is the responsibility of the Consultant to ensure that the Trust is reimbursed for all costs incurred while facilitating fee paying services work undertaken. These costs could include:

- use of Trust accommodation;
- tests or other diagnostic procedures performed;
- radiological scans.

5.2.3 Consultants who engage in fee paying activities within the Trust are required to remit to the Trust on a quarterly basis the income due.

1.2.4 Consultants should retain details of all patients seen for medical legal purposes. These should be submitted by the consultant on a quarterly basis along with the corresponding payment. See Section 11 for further details.

5.3 Additional Programmed Activities

5.3.1 Consultants should agree to accept an extra paid programmed activity in the Trust, if offered, before doing private work. The following points should be borne in mind:

- If Consultants are already working 11 Programmed Activities (PAs) (or equivalent) there is no requirement to undertake any more work.
- A Consultant could decline an offer of an extra PA and still work privately, but with risk to their pay progression for the year in question.
- Any additional PAs offered must be offered equitably between all Consultants in that specialty; if a colleague takes up those sessions there would be no detriment to pay progression for the other Consultants.

5.3.2 Consultant Medical Staff are governed by The Code of Conduct for Private Practice 2003 (at Appendix 2).

6. RESTRICTIONS ON PRIVATE PRACTICE FOR CONSULTANT MEDICAL STAFF

6.1 New Consultants

6.1.1 Newly appointed consultants (including those who have held consultant posts elsewhere in the NHS, or equivalent posts outside the NHS) may not undertake private practice within the Trust or use the Trusts facilities or equipment for private work, until the arrangements for this have been agreed in writing with the Trust Medical Director. A job plan must also have been agreed. An application to undertake private practice should be made in writing to the Medical Director through completion of the Paying Patient Declaration. New consultants permitted to undertake private work must make themselves known to the Paying Patients Officer.

6.2 Locum Consultants

6.2.1 Locum consultants may not engage in Private Practice within the first three months of appointment and then not until the detailed Job Plan has been agreed with the relevant Clinical Manager and approval has been granted by the Medical Director. This is subject to the agreement of the patient/insurer.

6.3 Non Consultant Grade Medical Staff

6.3.1 Non-consultant medical staff practitioners such as Associate Specialists may undertake Category 2 or private outpatient work, with the approval of the

Medical Director following confirmation that the practitioner undertakes such work outside his/her programmed activities as per their agreed job plan.

6.3.2 Other than in the circumstances described above, staff are required to assist the consultant to whom they are responsible with the treatment of their private patients in the same way as their NHS patients. The charge paid by private patients to the hospital covers the whole cost of the hospital treatment including that of all associated staff.

7. CHANGE OF STATUS BETWEEN PRIVATE AND NHS

7.1 Treatment Episode

7.1.1 A patient who sees a consultant privately shall continue to have private status throughout the entire treatment episode.

7.2 Single Status

7.2.1 An outpatient cannot be both a Private and an NHS patient for the treatment of the one condition during a single visit to an NHS hospital.

7.3 Outpatient Transfer

7.3.1 However a private outpatient at an NHS hospital is legally entitled to change his/her status for any a subsequent visit and seek treatment under the NHS, subject to the terms of any undertaking he/she has made to pay charges.

7.4 Waiting List

7.4.1 A patient seen privately in consulting rooms who then becomes an NHS patient joins the waiting list at the same point as if his/her consultation had taken place as an NHS patient.

7.5 Inpatient Transfer

7.5.1 A private inpatient has a similar legal entitlement to change his/her status. This entitlement can only be exercised when a significant and unforeseen change in circumstances arises e.g. when they enter hospital for a minor operation and they are found to be suffering from a different more serious complaint. He/she remains liable to charges for the period during which he/she was a private patient.

7.6 During Procedure

7.6.1 A patient may request a change of status during a procedure where there has been an unpredictable or unforeseen complexity to the procedure. This can be tested by the range of consent required for the procedure.

7.7 Clinical Priority

7.7.1 A change of status from Private to NHS must be accompanied by an assessment of the patient's clinical priority for treatment as an NHS patient.

7.8 Change of Status Form

7.8.1 Where a change of status is required a 'Change of Status' Form (Appendix 4) must be completed and sent to the Paying Patients Officer. This includes the reason for the change of status which will be subject to audit and must be signed by both the consultant and Paying Patients Officer. The Paying Patients Officer will ensure that the Medical Director approves the 'Change of Status' request.

7.8.2 It is important to note that until the Change of Status form has been approved by the Medical Director the patient's status will remain private and they may well be liable for charges.

8. TRUST STAFF RESPONSIBILITIES RELATING TO PRIVATE PATIENTS AND FEE PAYING SERVICES

8.1 A private patient is one who formally undertakes to pay charges for healthcare services regardless of whether they self-pay or are covered by insurance and all private patients must sign a form to that effect (Undertaking to Pay form at Appendix 3) prior to the provision of any diagnostic tests or treatments. Trust staff are required to have an awareness of this obligation.

8.2 The charge which private patients pay to the Trust covers the total cost of the hospital treatment excluding consultant fees. Trust staff are required to perform their duties in relation to all patients to the same standard. No payment should be made to or accepted by any non-consultant member of Trust staff for carrying out normal duties in relation to any patients of the Trust.

9. OPERATIONAL ARRANGEMENTS

9.1 Each hospital within the Trust has a named officer [Paying Patients Officer] who should be notified in advance of all private patient admissions and day cases. The Paying Patient Officer is responsible for ensuring that the Trust recovers all income due to the Trust arising from the treatment of private patients.

9.2 The Paying Patients Officer, having received the signed and witnessed Undertaking to Pay **Form at least three weeks** before the planned procedure will identify the costs associated with the private patient stay, will confirm entitlement to insurance cover where relevant and will raise invoices on a timely basis. [See Flow Chart 1]

9.3 The Medical Director will advise the Paying Patients Officer when a consultant has been granted approval to undertaken private practice. The Paying Patients Officer will advise the consultant of the procedures involved in undertaking private practice in the Trust.

9.4 Clinical governance is defined as a framework 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.

9.5 This framework applies to all patients seen within this Trust. It is therefore a fundamental requirement of Clinical Governance that all patients treated within the Trust must be examined or treated in an appropriate clinical setting.

9.6 Any fee or emolument etc. which may be received by an employee in the course of his or her clinical duties shall, unless the Trust otherwise directs, be surrendered to the Trust. For further information please see Southern Trust Gifts and Hospitality Standards of Conduct policy.

9.7 Record Keeping Systems and Private Patients

9.7.1 All patients regardless of their status should, where possible, be recorded on Hospital Systems and their status classified appropriately. These systems include for example:

- Patient Administration System (PAS)
- Northern Ireland Maternity System (NIMATS)
- Laboratory System
- Radiology System(e.g. Sectra, PACS, NIRADS, RIS etc)

9.8 Health Records of Private Patients

9.8.1 All hospital health records shall remain the property of the Trust and should only be taken outside the Trust to assist treatment elsewhere:

- when this is essential for the safe treatment of the patient
- when an electronic record of the destination of the notes is made using the case note tracking system
- when arrangements can be guaranteed that such notes will be kept securely
- provided that nothing is removed from the notes

9.8.2 Consultants who may have access to notes for private treatment of patients must agree to return the notes without delay. Either originals or copies of the patient's private notes should be held with their NHS notes. Patients' notes should not be removed from Trust premises. Requests for notes for medico-legal purposes should be requested by plaintiff's solicitor through the normal channels.

9.8.3 Since the Trust does not have a right of access to patient notes held in non NHS facilities, when patients are seen privately outside the Trust their first appointment within the Trust, unless with the same consultant, will be treated as a 'new appointment' rather than a 'review appointment'.

9.8.4 In the event of a 'Serious Adverse Incident' or legal proceedings the Trust may require access to private patient medical records which should be held in accordance with GMC Good Record Keeping Guidance.

9.9 Booking Arrangements for Admissions and Appointments

9.9.1 A record of attendance should be maintained, where possible, for all patients seen in the Trust. All private in, day and out patients should as far as possible be pre-booked on to the hospital information systems. Directorates are responsible for ensuring that all relevant information is captured and 'booking in' procedures are followed. Each department should ensure that all such patients are recorded on PAS etc. within an agreed timescale which should not extend beyond month end.

9.10 Walk Ins

9.10.1 A private patient who appears at a clinic and has no record on PAS should be treated for record keeping purposes in exactly the same manner as an NHS patient (walk in) i.e. relevant details should be taken, registry contacted for a number and processed in the usual fashion. A record should be kept of this patient and the Paying Patient Officer informed.

9.11 Radiology

9.11.1 All patients seen in Radiology should be given a Southern Health and Social Care hospital number.

9.12 Private Patient Records

9.12.1 All records associated with the treatment of private patients should be maintained in the same way as for NHS patients. This includes all files, charts, and correspondence with General Practitioners.

9.12.2 Accurate record keeping assists in the collection of income from paying patients.

9.12.3 It should be noted that

- any work associated with private patients who are not treated within this Trust or consultants private diary work and correspondence associated with patients seen elsewhere should not be carried out within staff time which is paid for by the Trust.

9.13 Tests Investigations or Prescriptions for Private Patients

9.13.1 The consultant must ensure that the requests for all laboratory work, ie. radiology, prescriptions, dietetics, physiotherapy etc. are clearly marked as Private.

9.13.2 Consultants should not arrange services, tests investigations or prescriptions until the person has signed an Undertaking to Pay form which will cover the episode of care [Appendix 3]. This must be submitted three weeks before any planned procedure.

9.14 Medical Reports

9.14.1 In certain circumstances Insurance Companies will request a medical report from the consultant. It is the consultant's responsibility to ensure that this report is completed in the timeframe required by the insurance company otherwise the Trust's invoice may remain unpaid in whole or in part until the report has been received and assessed.

10. FINANCIAL ARRANGEMENTS - PRIVATE PATIENTS

10.1 Charges to Patients

10.1.1 Where patients, who are private to a consultant, are admitted to the hospital, or are seen as outpatients, charges for investigations/diagnostics will be levied by the hospital. A full list of charges is available from the Paying Patient Office on request. Patients should be provided with an estimate of the total fee that they will incur **before** the start of their treatment.

10.1.2 Prices are reviewed regularly to ensure that all costs are covered. A calendar of pricing updates will be agreed.

10.2 Charges for Use of Trust Facilities for Outpatients

10.2.1 It is the responsibility of the Doctor to recover the cost from the patient and reimburse the Trust, on a quarterly basis, for any outpatients which have been seen in Trust facilities. [See Flow Chart 2]

10.2.2 A per patient cost for the use of Trust facilities for outpatients is available. This will be reviewed annually.

10.2.3 It is responsibility of the doctor to maintain accurate records of outpatient attendances. It is an audit requirement that the Trust verifies that all income associated with use of Trust facilities for outpatients has been identified and collected. Accordingly, Doctors are required to submit a quarterly return to the Paying Patient office with the names of the patients seen together with details of any treatment or tests undertaken. This information should accompany the payment for the relevant fees as outlined above.

10.2.4 A Undertaking to Pay form will only be required if investigations/diagnostics are required.

10.3 Basis of Pricing

10.3.1 Charges are based on an accommodation charge, cost of procedure, including any prosthesis, and on a cost per item basis for all diagnostic tests and treatments e.g. physiotherapy, laboratory and radiology tests, ECGs etc. They do not include consultants' professional fees. Some package prices may be agreed.

10.4 Uninsured Patients – Payment Upfront

10.4.1 Full payment prior to admission is required from uninsured patients. Consultants should advise patients that this is the case. The patient should be advised to contact the Paying Patients Officer regarding estimated cost of treatment. [See Flow Chart 4]

10.5 Insured Patients

10.5.1 The Undertaking to Pay Form also requires details of the patient's insurance policy. The Paying Patients Officer will raise invoices direct to the insurance company where relevant, in accordance with the agreements with individual insurance companies.

10.5.2 Consultants, as the first port of contact and the person in control of the treatment provided, should advise the patient to obtain their insurance company's permission for the specified treatment to take place within the specified timescale. [See Flow Chart 4]

10.6 Billing and Payment

10.6.1 The Paying Patients Officer co-ordinates the collation of financial information relating to patients' treatment, ensures that uninsured patients pay deposits and that invoices are raised accordingly. The financial accounts department will ensure all invoices raised are paid and will advise the Private Patient Officer in the event of a bad debt.

10.7 Audit

10.7.1 The Trust's financial accounts are subject to annual audit and an annual report is issued to the Trust Board, which highlights any area of weakness in control. Adherence to the Paying Patient Policy will form part of the Trust's Audit Plan. Consultants are reminded that they are responsible for the identification and recording of paying patient information. Failure to follow the procedures will result in investigation by Audit and if necessary, disciplinary action under Trust and General Medical Council regulations.

11. FINANCIAL ARRANGEMENTS FOR FEE PAYING SERVICES

11.1 Consultants may see patients privately or for fee paying services within the Trust only with the explicit agreement of the Medical Director, in accordance with their Job Plan. Management will decide to what extent, if any, Trust facilities, staff and equipment may be used for private patient or fee paying services and will ensure that any such services do not interfere with the organisation's obligations to NHS patients. This applies whether private services are undertaken in the consultant's own time, in annual or unpaid leave. [See Flow Chart 3]

11.2 In line with the Code of Conduct standards, private patient services should take place at times that do not impact on normal services for NHS patients. Private patients should normally be seen separately from scheduled NHS patients.

11.3 Fee Paying Services Policy (Category 2)

11.3.1 Fee Paying Services (Category 2) work is distinct from private practice, however it is still non NHS work as outlined in the 'Terms and Conditions for Hospital Medical and Dental Staff'. Refer to schedules 10 and 11 (Appendices 1 & 5 respectively) for further details.

11.3.2 There are a number of occasions when a Category 2 report will be requested, and they will usually be commissioned by, employers, courts, solicitors, Department of Work and Pensions etc. the report may include radiological opinion, blood tests or other diagnostic procedures

11.3.3 It is the responsibility of the Doctor to ensure that the Trust is reimbursed for all costs incurred in undertaking Category 2 work, this not only includes the use of the room but also the cost of any tests undertaken.

11.3.4 In order to comply with the Trusts financial governance controls it is essential that all Fee Paying services are identified and the costs recovered. It is not the responsibility of the Trust to invoice third parties for Category 2 work.

11.3.5 It is the responsibility of the Doctor to recover the cost from the third party and reimburse the Trust, on a quarterly basis, for any Category 2 services they have undertaken, including the cost of any treatments/tests provided.

11.3.6 The Category 2 (room only) charge per session will be reviewed annually.

11.3.7 A per patient rate may be available subject to agreement with the Paying Patient Manager

11.3.8 It is responsibility of the doctor to maintain accurate records of Category 2 attendances. It is an audit requirement that the Trust verifies that all income associated with Category 2 has been identified and collected.

11.3.9 Doctors are required to submit a quarterly return to the Paying Patient office with the names of the patients seen together with details of any treatment or tests undertaken. This information should accompany the payment for the relevant fees of Category 2 work as outlined above and should be submitted no later than ten days after the quarter end.

11.3.10 In order to comply with Data Protection requirements, Doctors must therefore inform their Category 2 clients that this information is required by the Trust and obtain their consent. Consultants should make a note of this consent.

11.3.11 Compliance to this policy will be monitored by the Paying Patient Manager and the Medical Director's Office.

11.3.12 The Consultant is responsible to HM Revenue and Customs to declare for tax purposes all Category 2 income earned. The Trust has no obligation in this respect.

11.3.13 Any Category 2 work undertaken for consultants by medical secretaries must be completed outside of their normal NHS hours. Consultants should be aware of their duty to inform their secretaries that receipt of such income is subject to taxation and must be declared to HM Revenue and Customs. It is recommended that Consultants keep accurate records of income and payment.

12. RENUNCIATION OF PRIVATE FEES

12.1 In some departments, consultants may choose to forego their private fees for private practice or for fee paying services in favour of a Charitable Fund managed by the Trust that could be drawn upon at a later stage for, by way of example, Continuous Professional Development / Study Leave.

12.2 For income tax purposes all income earned must be treated as taxable earnings. The only way in which this income can be treated as non taxable earnings of the consultant concerned is if the consultant signs a 'Voluntary Advance Renunciation of Earnings form' (Appendix 7) and declares that the earnings from a particular activity will belong to a named charitable fund and that the earnings will not be received by the consultant. In addition a consultant should never accept a cheque made out to him or her personally. To do so attracts taxation on that income and it cannot be subsequently renounced. Therefore all such income renounced in advance should be paid directly into the relevant fund. Income can only be renounced if it has not been paid to the individual and a Register of these will be maintained by the Charitable Funds Officer.

12.3 The Trust will be required to demonstrate that income renounced in favour of a Charitable Fund is not retained for the use of the individual who renounces it. Thus, in the event of any such consultant subsequently drawing on that fund, any such expenditure approval must be countersigned by another signatory on the fund.

13. OVERSEAS VISITORS - NON UK PATIENTS

(Republic of Ireland, EEA, Foreign Nationals)

PLEASE NOTE THIS IS ONLY A BRIEF GUIDE FOR FURTHER INFORMATION PLEASE CONTACT THE PAYING PATIENT OFFICE

13.1 The NHS provides healthcare free of charge to people who are 'ordinarily resident' in the UK. People who do not permanently live in the UK lawfully are not automatically entitled to use the NHS free of charge.

13.2 **RESIDENCY** is the therefore the main qualifying criterion, applicable regardless of nationality, being registered with a GP or having been issued a HC/NHS number, or whether the person holds a British Passport, or lived and paid taxes or national insurance contributions in the UK in the past.

13.3 Any patient attending the Trust who cannot establish that they are an ordinary resident and have lawfully lived in the UK permanently for the last 12 months preceding treatment are not entitled to free non ED hospital treatment whether they are registered with a GP or not. A GP referral letter cannot be accepted solely as proof of a patient's permanent residency and therefore entitlement to treatment.

13.4 For all new patients attending the Trust, residency must be established. All patients will be asked to complete a declaration to confirm residency, (regardless of race/ethnic origin). If not the Trust could be accused of discrimination.

13.5 Where there is an element of doubt as to whether the patient is an 'ordinary resident' eg no GP/ H&C number or non UK contact details, the Paying Patients Officer must be alerted immediately.

13.6 Emergency Department

13.6.1 Treatment given in an Emergency Department, Walk in Clinic or Minor Inuries Unit is free of charge if it is deemed to be immediate and necessary.

13.6.2 The Trust should always provide immediate and necessary treatment whether or not the patient has been informed of or agreed to pay charges .There is no exemption from charges for 'emergency' treatment other than that given in the accident and emergency department. Once an overseas patient is transferred out of Emergency Department their treatment becomes chargeable.

13.6.3 All patients admitted from Emergency Department must be asked to complete declaration of residency status.

13.6.4 This question is essential in trying to establish whether the patient is an overseas patient or not and hence liable to pay for any subsequent care provided.

13.6.5 If the patient is not an ordinary resident or there is an element of doubt eg no GP/ no H&C Number, the patient should be referred to Paying Patients Office to determine their eligibility.

13.6.6 If the person has indicated that they are a visitor to Northern Ireland, the overseas address must be entered as the permanent address on the correct Patient Administrative System and the Paying Patients Office should be notified immediately.

13.7 Outpatient Appointments

13.7.1 In all cases where the patient has not lived in Northern Ireland for 12 months or relevant patient data is missing such as H&C number, GP Details etc the patient must be referred to the Paying Patients Office to establish the patient's entitlement to free NHS treatment. This must be established before an appointment is given.

13.8 Review Appointments

13.8.1 Where possible follow up treatment should be carried out at the patient's local hospital, however if they are reviewed at the Trust they must be informed that they will be liable for charges.

13.8.2 If a consultant considers it appropriate to review a patient then they must sign a statement to this effect waiving the charges that would have been due to the Trust.

13.9 Elective Admission

13.9.1 A patient should not be placed onto a waiting list until their entitlement to free NHS Treatment has been established. Where the Patient is chargeable, the Trust should not initiate a treatment process until a deposit equivalent to the estimated full cost of treatment has been obtained.

13.10 Referral from other NHS Trusts

13.10.1 When a Consultant accepts a referral from another Trust the patients' status should, where possible, be established prior to admission. However, absence of this information should not delay urgent treatment.

13.10.2 The Trust will operate a policy of 'Stabilise and Transfer'.

14. AMENITY BED PATIENTS

14.1 Within the Trust's Maternity Service, a number of beds are assigned Amenity Beds. It is permissible for NHS patients who require surgical delivery and an overnight stay to pay for any bed assigned as an Amenity Bed. This payment has no effect on the NHS status of the patient. All patients identified as amenity will be recorded on PAS as APG and an Undertaking to Pay for an Amenity Bed form (Appendix 6) should be completed ideally before obtaining the amenity facilities.

15. GLOSSARY

Undertaking to Pay Form

Private Patients may fund their treatment, or they may have private medical insurance. In all cases Private Patients must sign an 'Undertaking to Pay' form (Appendix 3). This is a legally binding document which, when signed prior to treatment, confirms the patient as personally liable for costs incurred while at hospital and confirms the Patient's Private status. ALL private patients, whether insured or not are obliged to complete and sign an 'Undertaking to Pay' form, prior to commencement of treatment. Consultants therefore, as the first point of contact should ensure that the Paying Patients Officer is advised to ensure completion of the 'Undertaking to Pay' form.

Fee Paying Services
Any paid professional services, other than those falling within the definition of Private Professional Services, which a consultant carries out for a third party or for the employing organisation and which are not part of, nor reasonably incidental to, Contractual and Consequential Services. A third party for these purposes may be an organisation, corporation or individual, provided that they are acting in a health related professional capacity, or a provider or commissioner of public services. Examples of work that fall within this category can be found in Schedule 10 of the Terms and Conditions (Appendix 1).

Private Professional Services *(Also referred to as 'private practice')*

- the diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under Article 31 of the Health and Personal Social Services (Northern Ireland) Order 1972), excluding fee paying services as described in Schedule 10 of the terms and conditions (Appendix 1).

- work in the general medical, dental or ophthalmic services under Part IV of the Health and Personal Social Services (Northern Ireland) Order 1972 (except in respect of patients for whom a hospital medical officer is allowed a limited 'list', e.g. members of the hospital staff).

Non UK patients
A person who does not meet the 'ordinarily resident' test.

Job Plan
A work programme which shows the time and place of the consultant's weekly fixed commitments.

16. APPENDIX 1: SPECIFIC EXAMPLES OF FEE PAYING SERVICES - SCHEDULE 10

1. Fee Paying Services are services that are not part of Contractual or Consequential Services and not reasonably incidental to them. Fee Paying Services include:

   a. work on a person referred by a Medical Adviser of the Department of Social Development, or by an Adjudicating Medical Authority or a Medical Appeal Tribunal, in connection with any benefits administered by an Agency of the Department of Social Development;

   b. work for the Criminal Injuries Compensation Board, when a special examination is required or an appreciable amount of work is involved in making extracts from case notes;

   c. work required by a patient or interested third party to serve the interests of the person, his or her employer or other third party, in such nonclinical contexts as insurance, pension arrangements, foreign travel, emigration, or sport and recreation. (This includes the issue of certificates confirming that inoculations necessary for foreign travel have been carried out, but excludes the inoculations themselves. It also excludes examinations in respect of the diagnosis and treatment of injuries or accidents);

   d. work required for life insurance purposes;

   e. work on prospective emigrants including X-ray examinations and blood tests;

   f. work on persons in connection with legal actions other than reports which are incidental to the consultant's Contractual and Consequential Duties, or where the consultant is giving evidence on the consultant's own behalf or on the employing organisation's behalf in connection with a case in which the consultant is professionally concerned;

   g. work for coroners, as well as attendance at coroners' courts as medical witnesses;

   h. work requested by the courts on the medical condition of an offender or defendant and attendance at court hearings as medical witnesses, otherwise than in the circumstances referred to above;

   i. work on a person referred by a medical examiner of HM Armed Forces Recruiting Organisation;

   j. work in connection with the routine screening of workers to protect them or the public from specific health risks, whether such screening is a statutory obligation laid on the employing organisation by specific regulation or a voluntary undertaking by the employing organisation in pursuance of its general liability to protect the health of its workforce;

   k. occupational health services provided under contract to other HPSS, independent or public sector employers;

   l. work on a person referred by a medical referee appointed under the Workmen's Compensation (Supplementation) Act (Northern Ireland) 1966; work on prospective students of universities or other institutions of further education, provided that they are not covered by Contractual and Consequential Services. Such examinations may include chest radiographs;

m. Appropriate examinations and recommendations under Parts II and IV of the Mental Health (Northern Ireland) Order 1986 and fees payable to medical members of Mental Health Review Tribunals;

n. services performed by members of hospital medical staffs for government departments as members of medical boards;

o. work undertaken on behalf of the Employment Medical Advisory Service in connection with research/survey work, i.e. the medical examination of employees intended primarily to increase the understanding of the cause, other than to protect the health of people immediately at risk (except where such work falls within Contractual and Consequential Services);

p. completion of Form B (Certificate of Medical Attendant) and Form C (Confirmatory Medical Certificate) of the cremation certificates;

q. examinations and reports including visits to prison required by the Prison Service which do not fall within the consultant's Contractual and Consequential Services and which are not covered by separate contractual arrangements with the Prison Service;

r. examination of blind or partially-sighted persons for the completion of form A655, except where the information is required for social security purposes, or by an Agency of the Department of Social Development, or the Employment Service, or the patient's employer, unless a special examination is required, or the information is not readily available from knowledge of the case, or an appreciable amount of work is required to extract medically correct information from case notes;

s. work as a medical referee (or deputy) to a cremation authority and signing confirmatory cremation certificates;

t. medical examination in relation to staff health schemes of local authorities and fire and police authorities;

u. delivering lectures;

v. medical advice in a specialised field of communicable disease control;

w. attendance as a witness in court;

x. medical examinations and reports for commercial purposes, e.g. certificates of hygiene on goods to be exported or reports for insurance companies;

y. advice to organisations on matters on which the consultant is acknowledged to be an expert.

17. APPENDIX 2 - A CODE OF CONDUCT FOR PRIVATE PRACTICE

November 2003

Recommended Standards of Practice for NHS Consultants

An agreement between the BMA's Northern Ireland Consultants and Specialists Committee and the Department of Health, Social Services and Public Safety for consultants in Northern Ireland.

A CODE OF CONDUCT FOR PRIVATE PRACTICE: RECOMMENDED STANDARDS FOR NHS CONSULTANTS, 2003

Contents

Part I: Introduction

Scope of Code

1.1 This document sets out recommended standards of best practice for NHS consultants in England about their conduct in relation to private practice . The standards are designed to apply equally to honorary contract holders in respect of their work for the NHS. The Code covers all private work, whether undertaken in non-NHS or NHS facilities.

1.2 Adherence to the standards in the Code will form part of the eligibility criteria for clinical excellence awards.

1.3 This Code should be used at the annual job plan review as the basis for reviewing the relationship between NHS duties and any private practice.

Key Principles

1.4 The Code is based on the following key principles:

- NHS consultants and NHS employing organisations should work on a partnership basis to prevent any conflict of interest between private practice and NHS work. It is also important that NHS consultants and NHS organisations minimise the risk of any perceived conflicts of interest; although no consultant should suffer any penalty (under the code) simply
- because of a perception;
- The provision of services for private patients should not prejudice the interest of NHS patients or disrupt NHS services;
- With the exception of the need to provide emergency care, agreed NHS commitments should take precedence over private work; and
- NHS facilities, staff and services may only be used for private practice with the prior agreement of the NHS employer.

Part II: Standards of Best Practice

Disclosure of Information about Private Practice

1.2 Consultants should declare any private practice, which may give rise to any actual or perceived conflict of interest, or which is otherwise relevant to the practitioner's proper performance of his/her contractual duties. As part of the annual job planning process, consultants should disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of NHS work and out of hours cover.

2.2 Under the appraisal guidelines agreed in 2001, NHS consultants should be appraised on all aspects of their medical practice, including private practice. In line with the requirements of revalidation, consultants should submit evidence of private practice to their appraiser.

Scheduling of Work and On-Call Duties

2.3 In circumstances where there is or could be a conflict of interest, programmed NHS commitments should take precedence over private work. Consultants should ensure that, except in emergencies, private commitments do not conflict with NHS activities included in their NHS job plan.

2.4 Consultants should ensure in particular that:

- private commitments, including on-call duties, are not scheduled during times at which they are scheduled to be working for the NHS (subject to paragraph 2.8 below);
- there are clear arrangements to prevent any significant risk of private commitments disrupting NHS commitments, e.g. by causing NHS activities to begin late or to be cancelled;