APPENDICES

Appendix 1

Regional Urology Steering Group

Membership

Mr Hugh Mullen (Chair)	SDU, Director of Performance and Provider Development
Mr Mark Fordham	External Advisor, Consultant Urologist
Ms Catherine McNicholl	SDU, Programme Director (Project Manager)
Mr Paul Cunningham	SDU, Performance Manager
Dr Hubert Curran	SDU, Primary Care Advisor
Dr Windsor Murdock	SDU, Primary Care Advisor
Dr Miriam McCarthy	DHSS&PS, Director Secondary Care
Dr Dermot Hughes	NICaN, Medical Director
Mr Patrick Keane	Belfast Trust, Lead Clinician NICaN Urology Group
Dr Diane Corrigan	SHSSB, Consultant Public Health
Dr Janet Little	EHSSB, Acting Director Public Health
Dr Christine McMaster	EHSSB, Specialist Registrar, Public Health
Dr Adrian Mairs	NHSSB, Consultant Public Health
Mr Alan Marsden	NHSSB, Elective Care Commissioning Manager.
Dr Bill McConnell	WHSSB, Director Public Health
Mrs Rosa McCandless	WHSSB, Information Manager
Mrs Karen Hargan	Western Trust, Assistant Director Surgery/Acute Services
Mr Colin Mulholland	Western Trust, Consultant Urologist
Ms Carmel Leonard	Western Trust, Lead Nurse Surgery
Mr Paul Downey	Northern Trust, Consultant Urologist
Mr Martin Sloan	Northern Trust, Director Elective and

	Acute Services
Dr Brian Armstrong	Belfast Trust, Co-Director Specialist Services
Mr Chris Hagan	Belfast Trust, Consultant Urologist
Mr Brian Duggan	Belfast Trust, Consultant Urologist
Mr Brian Best	South Eastern Trust, Consultant Urologist
Mr John McKnight	South Eastern Trust, Consultant Urologist
Mrs Diane Keown	South Eastern Trust, Assistant Director Surgery.
Ms Joy Youart	Southern Trust, Acting Director Acute Services
Mr Michael Young	Southern Trust, Consultant Urologist
Mrs Jenny McMahon	Southern Trust, Nurse Specialist.

Appendix 2

Regional Review of Adult Urology Services

Terms of Reference

Overall Purpose

To develop a modern, fit for purpose in the 21st century, reformed service model for Adult Urology services which takes account of relevant Guidelines (NICE, Good Practice, Royal College, BAUS, BAUN). The future model should ensure quality services are provided in the right place, at the right time by the most appropriate clinician, through the entire pathway from Primary Care to Intermediate to Secondary and Tertiary Care.

It is anticipated that the Review Report will be available for submission to the Department in December 08, subject to Steering Group approval. A multi-disciplinary, key stakeholder Steering Group, chaired by Mr Hugh Mullen will meet to consider and approve the review findings and proposals.

The Review will include the following;

1. Baseline assessment of current service model identifying what is provided where, by whom, performance against access standards and the current profile of investment.

2. Expand on the current capacity/demand modelling exercise to take account of case mix with a view to identifying capacity gaps and informing future investment plans.

3. Develop a service model with agreed patient pathways which informs the distribution of services. The model will also outline proposals for optimising safe, effective and efficient Urology services which meet both access and quality standards/outcomes. The following aspects of the service will be considered;

    - Management of referrals and diagnostics including urodynamics.
    - Development and use of ICATS services
    - Management of acute urological admissions
    - Core Urology (secondary care) Services
    - Andrology Services
    - Interventional Uro-Radiology
    - Endourology/Stone Service
    - Uro-oncology Services
    - Relationship with Uro-gynaecology Services
    - Reconstruction and Neurourology Service
    - Acute Urological management of nephrology patient

4. Make recommendations, as appropriate, on the relationship with the Transplant service and waiting time targets for live donor transplantations.

5. Review workforce planning and training / development needs of the service group and ensure any proposals take account of the need to comply with EWTD (European Working Time Directive.

Appendix 3

UROLOGY REPORTS/ REVIEWS

Northern Ireland Review Reports

Report of the EHSSB Sub Group on Urological Cancer	Sept 1997
Report of the Working Group on Urology Services in Northern Ireland	May 2000
Update on Urology Cancer Services in the EHSSB	Oct 2001
External Review of Urology Services for Craigavon Area Hospital Group	Aug 2004
Draft Service Framework for Cancer Prevention, Treatment and Care – (Urology section)	Version 7 June 2008

National Reports

BAUS – A Quality Urological Service for Patients in the New Millennium	Oct 2000
BAUS – The Provision of Urology Services in the UK	Feb 2002
NICE – (Guidance on Cancer Services) Improving outcomes in Urological Cancers	Sept 2002
Modernisation Agency – Action on Urology – Good Practice Guide	Mar 2005
Providing Care for Patients with Urological Conditions: guidance and resources for commissioners (NHS)	2008
NICE – Urinary Incontinence: the management of urinary incontinence in women	2006
NICE – Prostate Cancer: diagnosis and treatment	2008
NICE – (Urological) Referral guidelines for suspected cancer	2005

Appendix 4

GP REFERRAL EXERCISE - PERCENTAGES

Gender	Belfast	Northern	Western	Southern	SE	Regional Average
Male	77	74	76	79	75	**76**
Female	23	25	22	21	25	**23**
Blank	0	2	2	0	0	**1**
Total	**100**	**100**	**100**	**100**	**100**	**100**
Age Range	**Belfast**	**Northern**	**Western**	**Southern**	**SE**	**Regional Average**
0-14	1	0	0	2	0	**1**
15-30	12	8	11	6	10	**10**
31-40	13	8	11	15	5	**11**
41-50	20	17	9	13	7	**15**
51-60	13	25	20	11	5	**14**
60+	41	42	49	53	12	**38**
Blank	0	2	0	0	60*	**12**
Total	**100**	**100**	**100**	**100**	**100**	**100**
Urgency	**Belfast**	**Northern**	**Western**	**Southern**	**SE**	**Regional Average**
Red Flag	4	4	7	6	5	**5**
Urgent	21	21	22	19	16	**20**
Routine	75	75	71	75	78	**75**
Blank	0	0	0	0	0	**0**
Total	**100**	**100**	**100**	**100**	**100**	**100**
Named Cons	**Belfast**	**Northern**	**Western**	**Southern**	**SE**	**Regional Average**
Y	24	25	13	23	21	22
N	76	75	87	77	79	78
Total	**100**	**100**	**100**	**100**	**100**	**100**
Ref Source	**Belfast**	**Northern**	**Western**	**Southern**	**SE**	**Regional Average**
Non-GP ref's	10	23	2	9	19	**13**
GP Ref's	90	77	96	91	81	**87**
Blank	0	0	2	0	0	**0**
Total	**100**	**100**	**100**	**100**	**100**	**100**

* 44 out of 73 referrals in SET had DOB deleted-therefore not possible to record age range.

Appendix 5

GP REFERRAL EXERCISE – PRESENTING SYMPTOMS (PERCENTAGES)

Presenting Symptom/Condition		Belfast		Northern		Western		Southern		SE		Regional	
Haematuria (ALL)		**13**		**19**		**22**		**9**		**16**		**15**	
	frank		*58*		*30*		*40*		*40*		*50*		*46*
	microscopic		*32*		*50*		*60*		*40*		*50*		*45*
	blank		*11*		*20*		*0*		*20*		*0*		*9*
Prostate/raised PSA		**10**		**13**		**18**		**17**		**16**		**14**	
Other		**15**		**8**		**11**		**15**		**11**		**13**	
Ncode procedure (All)		**15**		**4**		**2**		**6**		**19**		**11**	
	vasectomy		*52*		*0*		*100*		*33*		*29*		*41*
	foreskin		*5*		*0*		*0*		*67*		*50*		*24*
	epididymal cyst		*14*		*100*		*0*		*0*		*21*		*20*
	hydrocele		*19*		*0*		*0*		*0*		*0*		*10*
	varicocele		*5*		*0*		*0*		*0*		*0*		*2*
	blank		*5*		*0*		*0*		*0*		*0*		*2*
Recurrent UTI's		**12**		**17**		**9**		**11**		**5**		**11**	
LUTS		**8**		**13**		**4**		**9**		**10**		**9**	
Prostate/BPH/prostatitis		**8**		**9**		**9**		**11**		**3**		**8**	
Renal stones/colic/loin pain		**8**		**9**		**2**		**4**		**5**		**6**	
Testicular/ Scrotal lumps or swelling		**6**		**0**		**11**		**0**		**11**		**6**	
Andrology (ALL)		**5**		**4**		**7**		**11**		**3**		**5**	
	erectile dysfunction		*29*		*100*		*0*		*50*		*50*		*40*
	peyronie's disease		*29*		*0*		*67*		*0*		*0*		*20*
	blood in ejaculate		*43*		*0*		*0*		*0*		*0*		*15*
	ulcer/lesion on gland		*0*		*0*		*33*		*17*		*0*		*10*
	balanitis/discharge		*0*		*0*		*0*		*33*		*0*		*10*
	blank		*0*		*0*		*0*		*0*		*50*		*5*
Unknown		**2**		**2**		**2**		**4**		**0**		**2**	
Ca Bladder/Kidney		**1**		**2**		**0**		**2**		**0**		**1**	
Blank		**0**		**0**		**2**		**0**		**0**		**0**	
Total		**100**		**100**		**100**		**100**		**100**		**100**	

Appendix 6

NICE – Improving outcomes in Urological Cancers (IOG) – The Manual (2002)

Key Recommendations

The key recommendations highlight the main organisational issues specific to urological cancers that are central to implementing the guidance. As such, they may involve major changes to current practice.

- All patients with Urological cancers should be managed by multidisciplinary Urological cancer teams. These teams should function in the context of dedicated specialist services, with working arrangements and protocols agreed throughout each cancer network. Patients should be specifically assured of:
    - Streamlined services, designed to minimise delays;
    - Balanced information about management options for their condition;
    - Improved management for progressive and recurrent disease.
- Members of Urological cancer teams should have specialised skills appropriate for their roles at each level of the service. Within each network, multidisciplinary teams should be formed in local hospitals (cancer units); at cancer centres, with the possibility in larger networks of additional specialist teams serving populations of at least one million; and at supra-network level to provide specialist management for some male genital cancers.
- Radical surgery for prostate and bladder cancer should be provided by teams typically serving populations of one million or more and carrying out a cumulative total of at least 50 such operations per annum. Whilst these teams are being established, surgeons carrying out small numbers (five or fewer per annum) of either operation should make arrangements within their network to pass this work on to more specialist colleagues.
- Major improvements are required on information and support services for patients and carers. Nurse specialist members of urological cancer teams will have key roles in these services.
- There are many areas of uncertainty about the optimum form of treatment for patients with urological cancers. High-quality research studies should be supported, with encouragement of greater rates of participation in clinical trials.

Appendix 7

Estimated Cost of Implementation of Recommendations.

Staffing	Number	Band/Grade	Unit Cost	Total
Consultant Urologist	6	Consultant	£104,000	£624,000
Consultant Anaesthetist @ 0.6 wte per Con. Urologist	3.6	Consultant	£104,000	£374,400
Consultant Radiologist @ 0.3 wte per Con. Urologist	1.8	Consultant	£104,000	£187,200
Radiographer @ 6 per wte Con Radiologist	10.8	Band 5	£27,995	£302,346
Nursing @ 1.8 wte per Con. Urologist	10.8	Band 5	£27,995	£302,346
Nursing @ 0.46 wte per Con. Urologist	2.7	Band 3	£19,856	£53,611
Specialist Nursing	5	Band 7	£41,442	£207,210
Nursing @ 0.64 wte (day surgery)	0.64	Band 5	£27,995	£17,917
Pers. Secretary @ 0.5 wte per consultant urologists	3	Band 4	£23,265	£69,795
Admin support to radiologists at 0.5 wte per Radiologist	1	Band 3	£19,856	£19,856
Admin Support to Specialist Nurses @ 0.5 wte per Nurse	3	Band 3	£19,856	£59,568
Medical Records support 0.5 per unit	2.5	Band 4	£23,265	£58,162
MLSO – Bio-medical Science	1	Band 7	£41,442	£41,442
Support Costs				
Surgical G&S @ £94,500 per Con. Urologist	X 6		£95,400	£567,000
Theatre Goods/Disposables @ £50,000 per Con.Urologist	X 6		£50,000	£300,000
Radiology G&S per Con. Urologist	X 6		£2,500	£15,000
CSSD @ £32,000 per Con. Urologist	X 6		£32,000	£192,000
Outpatients Clinics @ 2 per Con. Urologist	X 12		£10,000	£120,000
Sub Total				**£3,511,853**
Less Consultant funded in 2008				**(£437,076)**
Sub Total				**£3,074,777**
Less 2008/09 Cancer Funds				**(£200,000)**
FINAL TOTAL				**£2,874,777**

Appendix 8

Evaluation Criteria

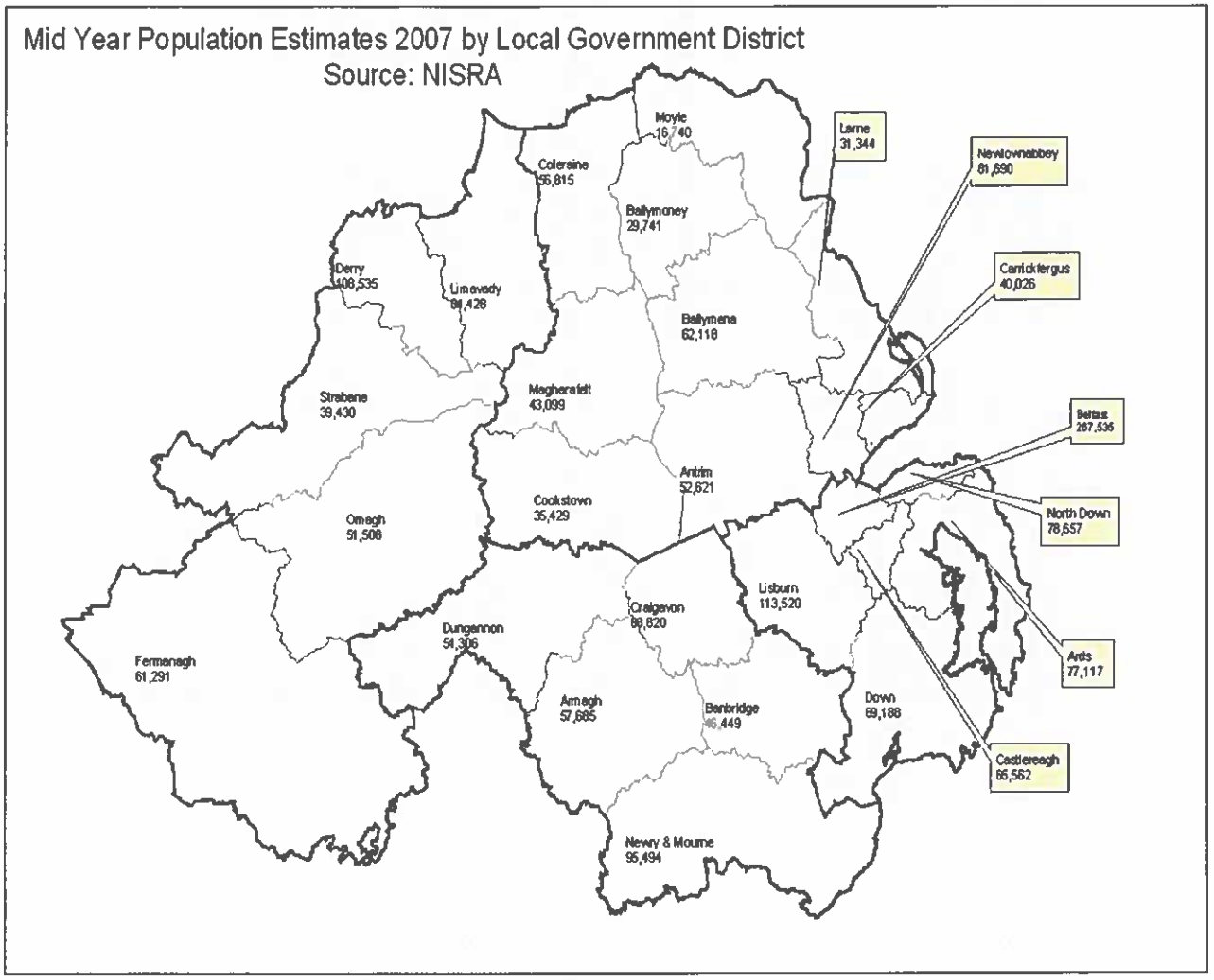
Criteria	Definitions
1. Service Stability / Sustainability	This is the criterion of the highest priority/value. The long term stability and hence viability and success of the service depends on a stable workforce – a workforce that can develop the service further and continue to attract the necessary expertise across all its professions. The criterion is sub-divided into four closely related sub-categories. a. Population – smaller catchment populations restrict the generation of a critical mass of work (cancer and non cancer). Using BAUS recommendations of 1 consultant per 80,000, each team should serve a catchment population of no less than 400,000. b. Team Size – A team of at least five to six consultants is preferred. This will improve long term attractiveness of each team in terms of recruitment and retention. It will also enable at least 2-3 to sub specialise, with dedicated sessions in the sub specialty e.g. uro-oncology, endourology/stones, female urology c. On site interventional radiology and trained urological nursing – These are key quality aspects. On site radiology to ensure timely access to interventions for emergency and urgent cases and sufficient total activity to justify 24 hour urology nursing experience in wards and theatres. This is to enhance multi-disciplinary working and support the development of nurse-led services. d. Commitment to Rotas and Working Time Directive – The service must be capable of sustaining adequate and acceptable on-call arrangements (elective and emergency), compliance with EWTD and equitable provision of emergency care.
2. Feasibility (ease and speed of implementation)	This criterion concerns the need to maximise the use of existing capital infrastructure (beds, theatres, equipment, clinic accommodation). The additional activity required and the appointment of additional Consultants and Nurse Specialists will require additional access to clinical facilities (as described above). It is assumed that the more new capital development is required, the longer the lead in time for starting new teams, and the longer the reliance on the independent sector. Preference will be given to those models that require the least capital resources and restructuring of premises. Consideration of the availability of trained staff will also be given. A particular model will lose points if it is unlikely that trained staff will be available in the numbers required to fill necessary posts.
3. Compliance with DHSSPS Strategy / Commissioner Support / Compatibility with Trust Strategic Plans/impact on other services	A model will lose points if it does not reflect specific regional health and wellbeing strategies/policies – DBS (the location of major hospitals with inpatient care), Cancer Framework (location of cancer units and Cancer Centre). Models should also attract commissioner support. Alignment with Trust Strategic Plans and impact on other services should also be considered.
4. Accessibility for Inpatient Elective Care	It is assumed that each model will be able to facilitate the flexible locating of outpatient and diagnostic service and will therefore be difficult to discriminate scores on this basis. Agreed pathways for emergency care is also assumed. Variation in local provision of elective inpatient care is more discriminatory. A model will lose points if it requires significantly greater travel time (from the do nothing case) for a substantial number of patients.
5. Organisational Complexity	A service should have unambiguous clinical and managerial leadership and accountability arrangements. Some potential models will need to transcend Trust organisational boundaries. This criterion concerns how complicated such arrangements are likely to be and weights each model accordingly – the more complicated the fewer the points awarded.

Appendix 9

Model 3: Three Teams/Networks

Team North and West:	• Upper 2/3rds of Northern and Western integrate to form one Team/Network
	• Main base Hospital - Altnagelvin
	• Potential for small number of inpatient beds in Causeway Hospital to be used for selected elective work subject to satisfactory arrangements for the post-operative management of these patients
Team South and West:	• Lower 1/3rd of Western (Fermanagh) and all of Southern integrate to form one Team/Network
	• Main base Hospital – Craigavon
Team East:	• SET and Belfast integrate to form one Team/Network
	• Continue to provide services to the southern sector of Northern population by outreach – Outpatient/Diagnostics/Day Surgery in Antrim and Whiteabbey hospitals with inpatients going to Belfast

Appendix 10



Southern Health and Social Care Trust

Quality Care - for you, with you

Personal and Public Involvement (PPI) Baseline Report

Executive Summary

November 2009

Contents

1. Introduction

In keeping with the Trust's focus on developing the practice of Personal and Public Involvement (PPI) across the organisation it has completed a baseline mapping exercise across Directorates and Programmes of Care. The focus of the mapping exercise has been to identify the nature and range of PPI mechanisms in place and to undertake a brief evaluation of these in relation to their ability to address the Department's (DHSSPS) four core values of PPI namely:

- Dignity and respect;
- Inclusivity, equity and diversity;
- Collaboration and partnership working;
- Transparency and openness.

The findings have been verified within the Directorates and cross-referenced with a number of groups and individuals to help quality assure the information attained.

As an outcome of the mapping and evaluation exercise Directorate specific reports have been produced providing a detailed breakdown of the information received in relation to their respective divisions and services.

Work is now ongoing between Directorates and the PPI support team to shape the development of Directorate specific Action Plans to address the findings and the ongoing development of PPI across the work of the organisation.

2. Methodology

A baseline mapping questionnaire was developed and circulated to all Directorates for dissemination to their Assistant Directors, Heads of Service and Team Leaders.

A total of **191** questionnaires have been returned from teams across the Trust:

- Older People and Primary Care 71
- Mental Health & Disability 40
- Acute Services 32
- Children & Young People's Services 43
- Performance & Reform 1
- Human Resources & Organisational Development 4

A number of respondents submitted a return on behalf of their Team while others submitted a return on behalf of an area of service or several teams. Therefore the number of returns per Directorate does not necessarily reflect greater or lesser PPI activity.

Of the **191** returns **164** stated that they involved services users and/or carers in the planning, development and/or delivery of services. **86** of those stated that they made arrangements to ensure the inclusion of people from "hard to reach" communities using a range of methodologies. There were a total of **436** examples of service users and carers being involved in the evaluation of Trust services and **194** examples of service users and carers being involved in the development of Trust services. A summary of the responses by specific Directorate is provided in Appendix 1.

The baseline reports detail by Division within each Directorate the following:

- Who responded;
- Divisional Overview;
- Divisional specific good practice;
- Assessment against PPI Core Values;
- Assessment against PPI Principles.

3. Summary of the Findings and Areas for Development

Whist detailed reports on the findings have been provided to individual Directorates for consideration and action the following provides a summary of the key findings from a corporate perspective.

- Involvement of individuals, clients, communities and other stakeholders is evident at all five levels of the PPI Framework with a significant majority of involvement at Levels 1-3 (Appendix 2). The potential exists to enhance personal and public involvement at strategic and corporate levels. This affirms the feedback from the consultation process which identified this gap and the expressed interest of the public, service users and carers to engage with the Trust in this process.

- The purpose of involvement is varied from needs assessment, identifying specific service requirements, shaping service developments, evaluation, informing planning and priority

setting and strategic planning. (Appendix 3) PPI needs to be integral to all elements of the organisational development and delivery process and in particular in informing future strategic plans and priorities.

- There are a wide variety of methods used to identify and recruit individuals to PPI processes. These include direct links with individuals, carers and families, random selection in both urban and rural settings, nomination by peers, expressions of interest, working through community networks and support groups and by active marketing processes. The methods for recruitment need to be further developed in partnership with community and voluntary partners to ensure they are as inclusive as possible and specifically target those individuals and groups who are traditionally "harder to reach." In addition the purpose of involvement and the method for communicating outcomes needs to agreed at the outset.

- A range of tools and methods are utilised to support PPI including 1-1 interviews, questionnaires and surveys, focus groups, citizen's juries, committee representation, workshops, and support groups. The perceived value and effect of these was varied. (Appendix 4) Directorates and staff teams need to be skilled in the utilisation of a variety of tools and methodologies and be able to select those most appropriate to the particular task in hand. The potential exists for the greater use of patient stories, experienced based design and Performance Related Outcome Measures (PROMS).

- A wide range of service and issue based specific information materials exist across the organisation. Difficulties were identified in relation to access and availability, readability and understanding and maintenance of information in a timely and up-to-date manner. Mechanisms need to be further developed to ensure information provision is managed and maintained, appropriately targeted, timely and up-to-date. In addition other communication mechanisms such as website and information based technologies need to be further developed to improve accessibility and communication both into and out of the organisation.

- There was evidence of involvement that demonstrated action to address all of the Departments Core values for PPI, outlined above. Standardised approaches need to be developed that will assist in identifying and measuring the implementation of the core values across all Trust services. The Trust has now adopted the Patient Client Experience Standards and is implementing mechanisms to evaluate compliance with the standards of respect, attitude, behaviour, communication, privacy and dignity.

- A range of initiatives were identified that were designed to provide feedback to individuals and groups as a result of their involvement with the Trust. However, there needs to be a greater emphasis given to the provision of feedback and action on the impact and outcomes of individual and collective involvement.

- A number of specific barriers and issues in relation to the outworking of the vision and action plan for PPI were identified by staff. (Appendix 5) These included the provision of resources and dedicated time for PPI, lack of knowledge and understanding of the concepts and practices of PPI, skills in motivation and consultation, development of resource materials and approaches, assistance with identifying, recruiting and supporting individuals, and access to transport for individuals. The need for development of independent advocacy was also highlighted.

- The evaluation of PPI mechanisms and processes was not either consistent or widespread and there needs to be a greater focus given to the development and utilisation of effective evaluative processes. However, where the involvement process was evaluated many staff, service users and carers felt that it was a useful process with enhanced outcomes in terms of health and wellbeing. For a small number of service users and carers the process was not so positive and that as part of future working together mutual understanding and respect needs to be developed. A summary of the feedback received from individuals and service users is detailed in Appendix 6.

- The importance and value of PPI needs to be reinforced and maintained across the organisation and a range of support structures, mechanisms and processes developed to assist the

work of staff teams in undertaking effective PPI. The PPI Support Team has subsequently begun to address a number of the support issues identified by staff.

- The mapping exercise identified pools of staff across the Directorates who have accessed Trust training in the following areas: PPI Awareness (87); Community Development Awareness (250); Community Development Management Training (111) and Community Development Specialist Training (121).

- As a result of the mapping exercise some 339 volunteers and 306 partnerships were specifically identified within the Trust which as contributing significantly to the overall development and delivery of Trust business. Appendix 7 outlines specific examples of PPI activity by Directorate across the Trust.

4. Conclusions and Next Steps

The information gathered through this comprehensive baseline mapping exercise provides valuable information on the level of personal and public involvement across the Southern Trust. Each Director has been provided with a copy of the detailed PPI Baseline report developed for his/her area of responsibility. These reports are also available on the Trust's website www.southerntrust.hscni.net

While there is evidence of significant good practice in user involvement across the Trust there is a need to improve consistency and coordination. There is also a need to develop systematic mechanisms to measure the impact of the user involvement processes and to evaluate PPI by demonstrating how user involvement leads to significant improvement in the planning, development and delivery of Trust services.

The next stage in the process is for Directorates to implement their PPI Action Plans which have been developed using the information and recommendations in the PPI Baseline Reports. These will contribute to an overall Trust PPI Action Plan detailing how the Southern Trust intends to build on the very solid foundations laid and further enhance personal and public involvement in the planning, delivery and evaluation of its services.

Appendix 1 Summary of Directorate Specific Findings

1. Acute Services

Integrated Maternity & Women's Health

- There were five returns in total – 1 from the Head of Service; 1 regarding the MSLC Newry; two from Lead Midwife inpatient/Outpatient Wards/Departments; 1 from Lead Community Midwife;
- Two teams responded that they are involving Service Users at Level 1; four at Level 2; two at Level 3; two at Level 4; none at Level 5;
- The Division has evidenced a range of methods of involving Service Users to evaluate services. For example, breast feeding support groups, Maternity Services Liaison Committee, Miscarriage Pathway;
- The Division provided 2 examples of involving Service Users to develop services;
- Three respondents provided examples of information leaflets that explain the service provided, only 1 respondent indicated that they had an information leaflet on specific conditions or issues;
- Five examples of specific projects were submitted which evidence some of the elements required for good practice in PPI;
- Service User feedback was mostly positive about their involvement in projects;
- There was good evidence of how projects met the core values of PPI;
- The most popular methods of involving Service Users were questionnaires, 1:1 interviews, and satisfaction surveys;
- The majority of projects stated that the purpose of the PPI activity was to assess need, and to identify a specific service required; the least number of projects stated that the purpose was to inform future strategic plans and priorities;
- Some examples were provided of recruitment and selection processes;
- Some good examples were provided of ensuring hard to reach groups were included, and one project stated that they linked in with key community organisations like Women and Family Health Initiative;
- While comment was made in relation to exit questionnaires and 1:1 feedback, there was no evidence of any specific evaluation of the usefulness of the process employed with Service Users and Carers;
- Two respondents gave examples of how they provided feedback to Service Users on the impact of their involvement;
- The main barriers identified by the Division were lack of resources (staff, time), and lack of resources (financial);
- Three members of staff have completed the Community Development Specialist Training;
- Approximately 26 volunteers have been placed in a range of roles throughout the Division;
- There was little evidence of existing partnerships within the Division.

Medicine and Unscheduled Care Services Division

- There were seven returns in total – 1 return from the Assistant Director, 1 from the Head of Social Work, 1 from Renal Unit, 2 from Cardiology, and 2 from Quality and Patient Support Services;
- Seven teams indicated that they are involving Service Users at Level 1; seven at Level 2; seven at Level 3, none at Level 4 and none at Level 5;
- The Division has evidenced a range of methods of involving Service Users to evaluate services. For example, patient satisfaction surveys, suggestion box, world café workshop;
- The Division has evidenced a range of methods of involving Service Users to develop services. For example, steering group meetings, patient focus group, development of policies and procedures, direct feedback to Patient Support Service;
- All of the respondents indicated that there was an information leaflet that explains the service provided and how it can be accessed, and a range of examples were provided of information leaflets about specific conditions or issues;
- Five examples were submitted giving details of specific projects involving Service Users;
- Service User feedback was positive about their involvement in projects;
- There was good evidence of how the projects met the core values of PPI;
- The most popular methods of involving Service Users were focus groups and questionnaires;
- The majority of projects stated that the purpose of the PPI activity as to assess need and the least number of projects stated that the purpose was to inform future strategic plans and priorities;
- Good examples were given of how staff recruit and select Service Users;
- The provision of interpreters and transport, were examples given in terms of ensuring hard to reach groups are including. There was no evidence of a robust approach to ensure Section 75 groupings are included;
- Apart from informal discussion with the Service User, none of the respondents indicated that they evaluate the usefulness of the process of involvement with Service Users/Carers;
- Three teams indicated that they provide feedback to Service Users on the impact of their involvement;
- The main barriers identified were lack of resources (staff, financial, and support to involve Service Users);
- Six members of staff from the Division have completed the Community Development Specialist Training;
- Two members of staff have completed the PPI Awareness Training;
- Approximately 16 volunteers have been placed in some of the wards undertaking various roles;
- The Division has demonstrated that staff were involved in some partnerships.

Cancer and Clinical Services Division

- There were 5 returns in total – 2 from the Head of Cancer Services, 1 from Head of Anaesthetics, 1 from the Head of Diagnostics, and 1 from the Physiotherapy Department. There were also two nil returns from Infection Control and Laboratory Services;
- Two teams responded that they do not involve Service Users at all;
- Three teams responded that they are involving Service Users at Level 1; two at Level 2; two at Level 3; none at Level 4; and none at Level 5;
- The Division has evidenced a range of methods of involving Service Users in evaluating services including Patient Satisfaction Questionnaire, Focus Groups, Audits;
- The Division evidenced some examples of involving Service Users to develop services;
- Four respondents indicated that there was an information leaflet that explains the service provided and how it can be accessed, 5 respondents provided examples of leaflets on conditions or issues relating to their area of work;
- Five specific projects were submitted. These demonstrate some of the elements required for good practice in PPI;
- Service User comments were provided for one project and this was positive feedback about their involvement in the project. It was not possible to get Service User comments as some of the projects were about surveys which were anonymous, the GAIN project are hoping to hold focus groups in October;
- There was good evidence of how the projects met the core values of PPI;
- The most popular methods of involving Service Users were questionnaires and satisfaction surveys;
- The majority of projects stated that the purpose of involvement was to assess need; the least number of projects stated that the purpose was to identify a specific service required;
- One team indicated that they provide feedback to Service Users on the impact of their involvement
- Only 2 teams provided evidence of ensuring people from ‘hard to reach’ groups are included. There was no evidence of a robust approach to ensure Section 75 groupings are included;
- Apart from informal discussion with the Service User none of the respondents indicated that they evaluate the usefulness of the process of involvement with Service Users/Carers;
- Some examples were provided of recruitment and selection processes;
- The main barrier identified was the lack of resources (staff, time);
- Four members of staff have received the Community Development Specialist Training;
- Seven members of staff have received the PPI Awareness Training;
- There are currently no volunteers in the Cancer and Clinical Services Division;
- Some examples of partnerships were provided.

Surgery and Elective Care Services Division

- One return was received from this Division from Urology Services;
- The Assistant Director submitted the Picker Inpatient Survey Report as an example of Service User involvement;
- There are currently no volunteers working within this Division;
- One example of partnership working was provided.

Functional Support Services

- The Assistant Director for Functional Support submitted a return indicating that Service Users are involved at Level 2. The Division carries out a series of environmental cleanliness audits throughout the Trust to assess the level of hygiene. In each locality there was a representative from the Southern Health & Social Services Council who had been trained on the use of the toolkit and was involved in the audit programme;
- The Assistant Director also submitted details of a project that was carried out by the SHSCC in 2007. This took the form of a survey of patients in both Craigavon Area Hospital and Daisy Hill Hospital to find out what they thought of the food and the catering service generally, and to determine whether the new nutritional standards for patient food were being adhered to.

2. Children & Young People's Services

Corporate Parenting

- There were 10 responses from the Corporate Parenting division, some of which were composite for the team/section;
- This Division demonstrated a wide and varied list of evaluation tools and methods for involving Service Users and Carers/Relatives in evaluating services. Examples include the user involvement group involved in the build of the new children's home in Newry;
- The majority of replies indicated that they have information leaflets that explain the service they provide and how it can be accessed;
- Some good examples were given regarding service users involvement in developing service and evidence shown that all parents and young people have a direct influence on service delivery;
- Of the ten responses received, there were eight examples of a specific user/carer involvement activity within their area of responsibility;
- Of methods of service user involvement employed, holding focus groups was identified by staff as being most effective;
- Staff have commented that user involvement is engrained in their work culture already and helps staff to gain a deeper understanding as to what the health issues and concerns are of their clients;
- Five of the projects indicated that they provide feedback to service users and carers on the impact of their involvement however this needs a more robust approach;

- All users are encouraged to get involved within this division however more clarity on ensuring 'harder to reach groups' are involved is needed;
- Lack of knowledge and resources (financial and staff) are the main barriers to user involvement and examples of support required have been mentioned – e.g. "*additional time to allow staff to co-ordinate ideas such as quarterly newsletter, facilitating a reference group*."
- Seven members of this division have completed the community development specialist training and community development for managers training;
- This division have evidenced an extensive directory of partnerships.

Family Support & Safeguarding

- There were ten returns from the division and the majority evidenced elements required for good practice in PPI;
- In terms of involving Service Users and Carers in evaluating services this division presented a broad collection of examples;
- The division have clearly demonstrated the use of users/clients in activities in evaluating and developing services (mainly from support groups and feedback on the provision of services);
- The majority of the respondents indicated that they have an information leaflet that explains the service provided and how it can be accessed;
- Six respondents provided details of specific user/carer involvement ranging from level 2 – level 3 of involvement;
- Service user comment was positive of being involved in the specific projects;
- Most popular methods employed when involving service users are: 1 – 1 consultation, individual consultation with parents and information leaflets;
- One respondent indicated that they provided feedback to service users and carers on the impact of their involvement. This issue perhaps needs a more vigorous approach;
- Staff have shown that they are aware of Section 75 groupings when including service users;
- The main barrier to user engagement for staff is financial support – staff felt that they would need support from the user involvement team when planning further user involvement projects;
- Four members of this division have completed the Community Development Specialist training (1), PPI training (2) and Community Development training for Managers (1);
- This division has evidenced a diverse list of partners and links with the community and voluntary sectors
- Approximately 7 volunteers have been placed in this division undertaking roles within Sure Start and An Tearmann project.

Specialist Child Health & Disability

- There were 16 returns from this division – all respondents involve service users at levels 1 and 2, thirteen respondents at level 3 and five respondents at levels 4 and 5;

- The Specialist Child Health and Disability Division have demonstrated the use of a wide range of methods for involving Service Users and Carers in evaluating services.
- The Division has evidenced a range of methods of involving Service Users to develop services. For example, Focus Groups, 1:1 Meetings, Questionnaires and Audits;
- Eleven of the respondents indicated that they have an information leaflets that explains the service provided and how it can be accessed;
- Ten of the respondents indicated that information leaflets were provided on conditions or issues relating to their area of work.
- Of the 16 respondents, 13 provided details of specific user/carer involvement activity within their area of responsibility ranging from levels 1 – 4 of involvement;
- Service user comments/feedback was positive;
- Information leaflets and questionnaires are the most common methods employed to involve Service Users and the main purpose of this is to evaluate effectiveness;
- Teams indicated that they provide feedback to Service Users on the impact of their involvement. Some examples are Service Newsletters, Reports, Individual Telephone Contact and at Focus Group meetings;
- There are many arrangements in place to ensure hard to reach groups are included and staff have shown that they are aware of Section 75 groupings when including service users;
- The main barrier to user engagement for staff is not having enough support in terms of training and time. One member stated that "Understanding from line management that User involvement requires considerable time, effort and expense."
- Four members of this division have completed the Community Development Specialist training
- This division has evidenced a diverse range of partners and has good links with the community and voluntary sectors
- Approximately 10 volunteers have been placed in this division undertaking various roles.

Social Services Workforce Training and Development

- There were three returns from the Social Services Workforce Training and Development division;
- Levels of involvement ranged from level 2 – level 3;
- In terms of involving Service Users and Carers in evaluating services no activities were highlighted.
- The questionnaires received had details of 4 specific user/carer involvement activities within their area of responsibility;
- Service user feedback/comments were positive regarding their involvement;
- Of methods of service user involvement employed 1 -1 interviews and the full involvement in delivering training to staff were effective;
- In terms of benefits to the Trust one staff commented – 'Service Users are 'experts' in their own lives and circumstances – they play an important role in the Training of Social Work Students;

- All teams indicated that they provide feedback to Service Users on the impact of their involvement through course evaluation sheets and personal feedback;
- Arrangements to ensure the inclusion of “hard to reach” groups are involved has not been addressed by the Training Unit at this point however Social Work students often work with ‘hard to reach’ groups;
- Two teams indicated that they evaluate the usefulness of the process of involvement with Service Users/Carers by course evaluations and 1 – 1 interviews;
- Recruitment and Selection processes were identified through various forms e.g. local teams/services, SHSSB Carers Reference Group;
- Two members of staff have attended the Community Development Specialist training and one member has attended the Community Development Training for Managers;
- No existing partnerships were identified;
- There are currently no volunteers in the Social Services Workforce Training and Development division.

Social Services and Social Care Governance

- The Assistant Director for Social Services and Social Care Governance submitted a return indicating that they involve Service Users at all Levels, (Level 5 - Involvement in children’s services planning);
- In terms of involving Service Users and Carers in evaluating services examples given were Participation of young people in LAC review audits and Involving service users with Social workers in evaluating governance arrangements in their Directorate;
- There was one response on what activities have specifically involved users/carers in developing services e.g. Involvement in Directorate groups which have user involvement e.g. children with disability/adult disability;
- There are currently no volunteers attached to this division;

3. Mental Health and Disability

Learning Disability

- There were sixteen returns in total – 5 from Supported Living Services, 4 from Learning Disability Services and 7 from Acute (including 3 nil returns);
- Three teams responded that they do not involve Service Users;
- Eleven teams indicated that they are involving Service Users at Level 1; twelve at Level 2, seven at Level 3, seven at Level 4, and four teams at Level 5;
- The Division has evidenced a range of methods of involving Service Users in evaluating services. For example, annual reviews, client committees, and satisfaction surveys;
- Some examples were given of involving Service Users in developing services;

- Only half of respondents said they had an information leaflet that explained their service, and four gave examples of information leaflets about specific conditions or issues;
- Eight specific projects were submitted which evidence some of the elements required for good practice in PPI;
- Service User feedback was positive about their involvement in projects;
- There was good evidence of how projects met the core values of PPI;
- Most popular methods of involving Service Users were focus groups and 1:1 interviews;
- Ensuring Hard to Reach Groups are included – an excellent example was provided by Appleby SEC who provide a sitting service for carers to allow them to attend meetings. While people with a learning disability are considered a 'hard to reach group', a sub-division of learning disability in this respect would be those people with communication difficulties and staff need to think more about this group of people when involving Service Users;
- The majority of projects stated that the purpose of the PPI activity was to improve or influence service developments and the least number of projects stated that the purpose was to inform future strategic plans/priorities;
- Whilst some examples were given of feeding back the impact of their involvement to Service Users, this issue needs a more robust approach;
- There were some examples of how staff evaluate the involvement process with Service Users, however there needs to be more formal mechanisms developed for carrying out this task;
- Some examples were given of how staff recruit and select Service Users. Staff need to be clear on equitable ways of recruiting Service Users;
- Main barriers identified were lack of resources (staff, time), lack of independent advocacy, and obtaining accessible transport;
- Ten staff from this Division have completed the community development specialist training
- Ten staff have availed of the PPI Awareness Training
- Approximately 40 volunteers have been placed in a range of facilities throughout the division undertaking various roles e.g. befriending, activities assistant;
- The Division has demonstrated that staff are involved in a wide range of partnerships.

Physical and Sensory Division

- There were six responses in total from this Division;
- This Division evidenced an excellent range of methods of involving Service Users in evaluating services – Client Committees, Service User Forums, Satisfaction Surveys, Newsletters, Evaluation Forms, and Focus Groups;
- The Division provided good evidence demonstrating how they were involved Service Users in developing services e.g. Carers Forum, Brain Injury Forum, Focus Groups, Consultations etc

- Most of the respondents said they had an information leaflet which explains their service and all of the respondents said they had information leaflets on conditions or specific issues relating to their service.
- Six examples of specific projects were submitted evidencing some of the elements required for good practice in PPI. As some of the Service User comments about the projects demonstrate a different perspective from that of staff. There is a need to take on board what Service Users have said and take steps to reach some resolution on the issues raised;
- There was good evidence of how projects met the core values of PPI;
- Most popular methods employed when involving Service Users are 1:1 Interviews, Focus Groups and Representatives on Committees;
- Some examples demonstrated the provision of feedback to Service Users on the impact of their involvement;
- The provision of interpreting services and transport, were examples given in terms of ensuring hard to reach groups are included – however staff need to think about Section 75 groupings when including Service Users;
- While there were some examples given of how staff evaluate the involvement process with Service Users, there needs to be more formal mechanisms developed for carrying out this task;
- Good examples were given of how staff recruit and select Service Users;
- The main barriers identified were lack of resources (staff, time);
- Ten staff from this Division have completed the community development specialist training;
- Seventeen staff have completed the PPI Awareness Training;
- Approximately 71 volunteers have been placed in a range of facilities throughout the Division undertaking various roles e.g. befriending, gardening, and sighted guides.
- The Division has demonstrated that staff are involved in a range of partnerships;

Mental Health

- There were 15 returns in total – 3 from Acute Services, 7 from Support Services, and 5 from Specialist Services (including 2 nil returns)**;**
- Two teams responded that they do not involve Service Users;
- Eleven teams indicated that they are involving Service Users at Level 1; twelve at Level 2; five at Level 3; two at Level 4; and one at Level 5;
- The Division has evidenced a range of methods of involving Service Users in evaluating services including, Mental Health Forum, Advocacy Service, and multidisciplinary reviews;
- The Division has demonstrated a range of examples of involving users in developing its services. An excellent example is the Newry & Mourne Mental Health Forum where users of mental health day care services had numerous opportunities to become involved in the development of mental health services in general and in particular the development of day care;
- Only half of respondents said they had an information leaflet that explained their service, 10 respondents provided examples of information leaflets on specific conditions or issues;

- Nine specific projects were submitted. These demonstrate some of the elements required for good practice in PPI;
- Service User comments were positive about their involvement in the projects;
- There was good evidence of how the projects met the core values of PPI;
- The most popular method of involving Service Users was 1:1 interviews as it enables staff to have more time with the person and it's easier to explain the process;
- The majority of projects stated that the purpose of user involvement was to identify a specific service required, whilst the least number of projects stated that the purpose was to inform future strategic plans and priorities;
- From the responses received it would appear that staff are providing feedback to Service Users in relation to services however Service Users should also receive feedback on how their involvement made a difference;
- Only 3 teams responded that they ensure hard to reach groups are included. More focus is required in this area;
- From the feedback received it would appear that staff are carrying out evaluations of their respective services however not evaluating the actual process of involving Service Users and Carers;
- Some good examples of recruitment and selection processes were provided;
- The main barriers identified were lack of resources (staff, time), and the need for support to involve Service Users;
- Two staff members have completed the Community Development Specialist Training
- One person has availed of the PPI Awareness Training;
- Three volunteers have been placed in facilities throughout the Division undertaking various roles;
- The Division has demonstrated that staff were involved in a wide range of partnerships.

Nursing & AHP Division

- The AHP Teams within this Division work throughout the other Directorates therefore their PPI activity will be recorded in the appropriate Divisions according to the Programme of Care. This also applies to the Nursing Teams and to the Practice Development Facilitators. The Assistant Director of Nursing, Workforce Development & Training's remit is to co-ordinate pre and post-registered nurse education and training. As the programmes are commissioned through QUB PPI is not considered to be relevant at this time;
- The Bereavement Co-ordinator for the Southern Trust and her role sits within the Nursing team of the Nursing and AHP Division. Four examples of PPI were submitted;
- Some partnerships were listed.

4. Older People & Primary Care

Older People

- There were 14 returns in total from this Division – 3 returns from Domiciliary Care, 11 returns from Supporting People and Residential and a nil return from the Independent Sector Care as there are no Teams in this area of service and staff interface with the independent sector.
- The Older People's Division have evidenced a wide and varied range of evaluation tools and methods for involving Service Users and Carers/Relatives in evaluating services. For example Annual Audits, Representatives on Service User Groups, User Satisfaction Questionnaires and Service User Involvement in planning of activities;
- This Division has demonstrated excellent examples of service user involvement in the development of its services. A simple but effective example is that service users explained the type of information which they require and the format of same e.g. care plans in Braille, larger font?;
- 65% of respondents said they had information leaflets regarding the service they delivered and 76% stated that they provide leaflets on certain conditions or issues relating to their area of work;
- There were eight specific projects received and all show good levels of user activity;
- Service User feedback was limited due to the nature of the projects;
- There was good evidence of how projects met the core values of PPI;
- 1 -1 interviews proved to be the most popular method of involving service users while questionnaires came second;
- While there were good examples of feeding back the impact of their involvement to service users, this issue needs a more robust approach;
- Good examples of how staff recruit and select service users/carers were provided;
- Some good arrangements are in place to ensure people from 'Hard to Reach' groups are included;
- The main barriers to service user activity were described as lack of resources (staff, time etc) and staff support. Support identified included training, links with community groups, help compiling relevant questionnaires and protected staff time;
- Nine staff have completed the Specialist Community Development training, three staff have completed the Community Development training for Managers and one member of staff has attended the PPI one day training event;
- Approximately 52 volunteers have been placed in a range of facilities throughout the Division undertaking various roles e.g. reminiscent volunteer, gardener, hairdressing services etc;
- The Older People Division has demonstrated a range of existing partnerships.

Primary Care

- 13 questionnaires were received from Primary Care;
- This Division demonstrated a wide and varied list of evaluation tools and methods for involving Service Users and Carers/Relatives in evaluating services. Examples include: patient satisfaction surveys, group work/talks, user surveys in relation to GP OOHS;
- Examples were provided of service user involvement in developing services. One good example is the involvement of Carer's Forum's and Individual Assessments;
- Of the 13 respondents 6 indicated that they have information leaflets that explain the service they provide and how it can be accessed;
- 9 out of the 13 respondents indicated that information leaflets were provided on conditions or issues relating to their area of work;
- Projects submitted evidence some of the elements required for good practice in PPI;
- Service user comments were mostly positive however there were some negative comments regarding the lack of feedback ;
- Good evidence was provided on how projects met the core values of PPI;
- The most common methods of involvement identified were 1 -1 interviews and information leaflets;
- As only one project indicated that 'Hard to Reach' groups are included, there needs to be greater emphasis in this area and staff need to think about Section 75 groupings when including service users;
- Only two groups stated that they provide feedback on the impact of user involvement and this issue needs a more robust approach;
- There were some examples of how staff evaluate the involvement process with Service Users, however more formal mechanisms developed;
- Good examples of recruiting and selecting service users were provided and having links and partnerships with other organisations proved a positive aspect of the process;
- Lack of resources in terms of staff, time and financial were given as barriers to user involvement;
- 8 staff have completed the Specialist Community Development training, 4 staff have completed the Community Development training for Managers and 10 members of staff has attended the PPI one day training event;
- Staff have stated that they would like to see a patient forum established to support the patient in their role and to facilitate succession when volunteers no longer wish to be involved;
- Staff would appreciate any support and guidance in getting user involvement processes started;
- Approximately 35 volunteers have been placed in various facilities throughout this Division;
- The Division has demonstrated involvement in a range of partnerships.

Enhanced Services

- There were 17 responses from the Enhanced Services Division;

- This Division demonstrated good levels of involvement and 4 teams responded that they involve service users at level 5;
- Patient Satisfaction Surveys were most popular in terms of evaluating service users' inputs. There were innovative tools/methods used regarding the GP OOHS in Kilkeel;
- Good examples of service users being involved in developing services were highlighted, one being the Improving Stroke Care Standards;
- 13 responses indicated that there was a service directory, 14 responses indicated that information leaflets were provided on conditions or issues relating to their area of work and GPs in the Out of Hours Service and Minor Injury Units have access to recommended websites to print out patient information leaflets;
- Seven returns provided details of specific user/carer involvement activity within their area of responsibility ranging from levels 1 – 5;
- These projects evidenced a range of elements required for good practice in PPI;
- Satisfaction Surveys followed by Focus Groups proved to be the most effective methods of involving service users within the Enhanced Services Division;
- Three teams stated that they provide feedback to the service user on the impact of their involvement;
- Some arrangements are in place to ensure people from 'Hard to Reach' groups are included;
- The main barriers identified for this division were resources in terms of staff, time and finance;
- Two staff have attended the PPI one day training, 1 staff member has completed the Specialist Community Development training and 1 has completed the Community Development training for Managers;
- There are approximately 30 volunteers placed in various facilities within the Enhanced Services Division;
- The Division has demonstrated staff were involved in a range of partnerships.

Promoting Wellbeing

- The Promoting Wellbeing Department submitted 27 completed questionnaires;
- All returns show good levels of involving service users ranging from level 1 – 5;
- The Promoting Wellbeing Department takes an active role in supporting service users to engage in service evaluation across the Trust's services. Practical examples of this include evaluation of Carers' services, promotion of CENI self- evaluation programme;
- There was a good response in terms of activities that have specifically involved users/carers in developing services in this Division. E.g. Service Users and Community Representatives engaged in the planning and development of a Trust wide bid "REACH" to Big Lottery Fund, Traveller

Peer Researchers attended local and regional meetings regarding the planning and delivery of the All Ireland Traveller Health Study;

- Of the 27 respondents 11 indicated that they have information leaflets that explain the service they provide and how it can be accessed;
- 20 out of the 27 respondents indicated that information leaflets were provided on conditions or issues relating to their area of work;
- Of the 27 responses received, 24 provided details of specific user/carer involvement activity within their area of responsibility;
- The most popular methods employed when involving service users was focus groups and posters. The teams also provided a list of other methods employed e.g. Open Space Discussion, World Café, Person Centred Planning MAPS & PATHS, Rickter Scale, Table discussion, word of mouth;
- The main purposes for involving service users was to improve or influence service delivery and to identify specific services required;
- 21 respondents indicated that they provide feedback to Service Users on the impact of their involvement;
- Ensuring Hard to Reach Groups are included has been highlighted in the returns. An excellent example was provided in relation to Drugs & Alcohol promotion where information on the service most commonly used by target groups has recently been translated into other languages. In terms of follow up a pilot scheme has also been planned to engage with those from the migrant population. and material has been translated into 3 Eastern European languages. The Traveller Community is kept informed by the working relationship with the Support Workers in the department. Engagement with South Armagh Traveller Women's Group has also started;
- 20 staff indicated that they evaluate the usefulness of the process of involvement with Service Users/Carers;
- The main barriers identified for this division were resources in terms of staff, time and finance;
- The Promoting Wellbeing Department evidenced a large number of partnerships.

Appendix 2 Summary Findings on the Levels of Involvement across the organisation

Level	Examples of User Involvement	Number Involved
Level 1 Individual Level	Service users are directly involved in the planning, delivery and monitoring of their individual care or service either at home, in the hospital or in the wider community	138
Level 2 Service Level	Individuals, families, carers and the community are supported to influence and shape the provision of care and quality of services provided	131
Level 3 Issue Specific Level	Individuals, families, carers and the community are supported to influence and shape the planning, development and deliver of services on specific issues or areas	86
Level 4 Directorate and Strategic Level	Service users, carers, and communities are actively involved in strategy development, including needs analysis, planning, commissioning and changes to significant areas of service development and provision	38
Level 5 Corporate and Wider Strategic Partnership Level	Communities, stakeholders and partner organisations are actively involved in shaping the corporate and organisational priorities and the overall direction of the Trust	25

Appendix 3 Purpose of Involvement

The table below illustrates the main purpose of user involvement activity across the Trust.

Purpose	No.
To assess need	**88**
To identify specific service required	**94**
To improve or influence service development	**122**
To evaluate effectiveness	**104**
To inform future plans and priorities for service delivery	**104**
To inform future strategic plans and priorities	**64**
Other	**19**

Appendix 4 Range of tools and methods for involving users and carers

Method/Tool	Number using this method
Questionnaires	71
Focus Groups	63
1:1 Interviews	56
Information Leaflets	51
Satisfaction Surveys	50
Committee reps	36
Posters	36
Complaints procedure	29
Public meetings	23
Telephone Interviews	20
Team/Service Leaflet	20
Health Panel	5
Citizen's Juries	4
Others	33

Most effective methods of involvement

Method	Reported most effective
1:1 Interview/Review meetings	27
Focus Groups	22
Questionnaires	17
Committee reps	9
Public meetings	2
Satisfaction Surveys	3
Health Panel	1
Information Leaflets	1
Others	13

Appendix 5 Barriers to user involvement

The table below highlights the main barriers identified by staff where user involvement activity does not currently exist, or where staff wish to further develop user involvement in their area of responsibility.

Barriers	Reported by
Lack of resources (staff, time etc.)	89
Would need support to involve users	60
Lack of resources (financial)	57
Lack of knowledge on subject	28
There are no opportunities to involve service users	7
Don’t see the benefits of user involvement	3
Other – Please specify	29

Appendix 6 Summary of the Feedback from Service Users, Individuals and Groups contacted to verify the findings of the mapping exercise.

Where possible the information provided by Directorates was cross-referenced with individuals and groups involved with Directorates to provide an external viewpoint and verification.

In general, feedback from service users and carers on their involvement experience was very positive.

"I feel valued as an individual and I felt that my opinion might really help somebody else, and in some small way could make something better for someone else in the service. That meant so much to me, having been there and knowing what a black place depression can be"

"I was a bit nervous at the meetings but I liked going to them because they knew what we wanted and what we did not want
(Mental Health & Disability Service User)

"Working in partnership with service users very often addresses the simple and practical issues which make a difference to the quality of service users lives."
(Children and Young People's Services - parent)

"My involvement with the Improving Stroke Carer Standards has been such a good experience. I have also experience of the Carers Strategy which benefits my local group and the Trust"
(OPPC Service User)

"I felt the meetings were very informative and I felt they listened. Sometimes health professionals don't listen, but definitely I felt we were listened to at these meetings".

"If they had gone and done their own thing without involving carers, I wouldn't have gone back to the meetings".
(Acute Services)

Within Acute Services 13 projects featured within the baseline report were positively evaluated by service users. Within Mental Health and Disability Services 17 were positively evaluated by service users.

Both Older People and Primary Care and Children and Young People's Services had 18 projects featured in their reports positively evaluated.

While involvement was generally seen as a positive experience by many, there was also recognition that there was still room for improvement.

"Services are like a daisy chain, the Trust need to get better at keeping the daisy chain intact, keeping information flows going, and informing people about available services".

Commonly where service users and carers raised issues requiring attention in their feedback it was relatively easy to address and this was shared with the staff concerned. Staff responded positively and where required, follow up meetings were held with user groups to address the issues raised. These issues fell into two broad categories:

1 Communication

"Don't feel the Trust involves us enough - we heard about the staffing situation second hand. We would like more information about what's happening - we feel like we are kept in the dark sometimes" (OPPC Service Users)

"The project wasn't really explained properly beforehand and at the first meeting I felt there were lots of things coming at you at the one time and lots of jargon that I didn't understand. Letters weren't always sent out on time – short notice for cancelling the meetings and maybe you were already on your way. Also I had to arrange childcare and it was a bit of a juggling act. I got fed up and didn't go to the last meeting because was having trouble getting a babysitter."
(Mental Health and Disability Services- Service User)

2 Valuing Service User Involvement

"There needs to be service user involvement right from the start, it's no good, for example, changing the way a service is delivered, and then telling people about it".
(Acute Services)

"…always felt that our expertise was not welcomed or recognised. When the project team was set up to look at the respite unit, at times it was difficult in trying to work as equal partners with the Trust". (Mental Health and Disability Services)

"Haven't had any reimbursement since I started with the MSLC 5 years ago. It undervalues people, it's not really about the money, it's the fact that we are promised something and it never happens".
(Acute Services)

"To develop user involvement there has to be a better understanding of support needed for involvement and to recognise the skills and experience of Service Users and Carers."

3 Partnership Working

While there was evidence of effective partnership working across the Trust it was not uniform. One Service User stated:

"There's no them and us, I feel equal".

But in one case there was an issue raised that reflected the power imbalance:

"Maybe focus group meetings would have been better – were afraid of saying too much at those meetings in case it affected the services you were getting." (Mental Health and Disability Services)

The benefits of Service User Involvement

For the most part Service Users and Carers were very positive and enthusiastic about the benefits of being involved:

"I think the benefits of parental involvement are these: Who better than someone who lives with the behaviours this unit is being set up to cope with, to point out problems the management just wouldn't have the knowledge of. Also, to suggest different disabilities, e.g. Epilepsy - When I mentioned

this and the need for an adapted bedroom I was told that it hadn't been thought of."

"Getting involved in the committee was a great thing for me - getting to know other people in the Centre are great and I've enjoyed every minute of it so far. I am pleased to be part of the committee - it means that you feel valued".

"Feel greater control of what we want, we feel more part of the home. It's good, we have a say e.g. in our menus. We feel we can always talk to the staff who will provide feedback to us"

"I've been involved for 2 years and have found useful contacts and feel able to share views etc – I get useful information on up and coming grants."

"Having our say is important. As an individual you are a small fish in a big pond. Being part of a group gives you more clout".

Evaluation of Involvement Processes

While there was evidence of specific evaluation of the involvement processes employed this was not consistent or widespread. Only 60 out of the 188 returns indicated that they evaluated the usefulness of the involvement process with service users and carers.

"Had a meeting recently to discuss feedback from the training, but nothing about the impact of my involvement".
(Children and Young people's Services – Service User)

Where the involvement process was evaluated many staff, service users and carers felt that it was a useful process.

Typically involvement at individual level (level1) demonstrated enhanced positive outcomes for the health and well being of service users:

"I found that after finishing the project I had better control of my blood results and the results were down: I also felt more in control of my illness and diet and also what was really happening to me. I got great explanations from all involved. After each meeting there was a short evaluation where we could tell our views."

The involvement of carers also highlighted positive health and well being outcomes not only for the person being cared for, but for the carer themselves.

"It's brilliant. I felt much stressed with my husband's illness – the nurses are great. This system is great."
I find the nurses explain things at a normal rate. We aren't running to the GP practice as much. I would be very worried if I wasn't involved. I feel I can sleep better from being involved."

At levels three, four and five comments on the usefulness of the involvement process where also mainly positive:

"I felt the Trust was genuinely interested in carers' needs and a good understanding of what was going on. I came away from the meeting feeling very positive an I felt I had been listened to and they were taking on board what we were saying and that we weren't going to be another statistic in a questionnaire".

"PLIG has presented an opportunity for our group to signpost or link those that need help to the relevant service providers. It has given us a voice that can be heard to identify gaps and flaws in the system, but importantly it has also brought new opportunities for involvement. It has opened up opportunities for learning and training, good networking, shared best practice models and new friends!"

"This is a good way of getting people involved, getting to know people. You can get advice and it's a good way of communicating and networking – coming together to share knowledge and get ideas."

"I've felt more involved here in 10 months than I ever did in England".

Unfortunately for a small number of service users and carers, the process was not so positive:

"Outcome was great in that respite unit was established, however the process of involvement was very poor and training and more understanding of partnership working needs to be developed to continue these successful outcomes".

However, it was recognised that the way forward was to work together to refine user involvement processes and develop mutual understanding and respect.

"The wide knowledge of both parties is crucial in developing any service that the Trust provides. It also encourages Service Users and Carers and Trust staff to use a co-ordinated approach and work together, pooling resources, experience, knowledge and skills."

Lessons to be learnt on how this whole process was carried out. There has to be a commitment to User Involvement and when things go wrong Trust should not be afraid to say they got it wrong. No service is to be developed without Service Users/Carers involved from day 1".

Feedback to service users on impact of involvement

While some respondents indicated that feedback was provided to service users and carers on the impact of their involvement, again this was not consistent or widespread. Of the 188 returns made, 94 respondents indicated that they provided feedback to service users and carers on the impact of their involvement.

One service user of Mental Health and Disability Directorate services told us:

"I had a lovely thank you letter for being involved in the meeting. It was nice to get because you might not think that what you had to say was important but this made me realise that it is and that your discussion was very much appreciated".

Feedback from the recent consultation on the Trust's Strategic PPI Action Plan Framework also highlighted the importance that service users and carers place on receiving feedback on the impact of their involvement.

> ***"Communication mechanisms are crucial – do not forget the importance of feedback when consulting"***
>
> ***Comment from consultation sessions.***

> ***"It's important to know that you are listened to."***
>
> ***Comment from consultation sessions***

Appendix 7 Specific Examples of PPI Activity

Acute Services Projects
British Association on Day Surgery's/ Health Quality's Accreditation
Cardiac Catheterisation Lab
Care of adults with a learning disability in acute hospital services
Guidelines and Audit Implement Network (GAIN) patient information audit
Global Rating Scheme/Joint Advisory Group Accreditation
Midwifery Led Antenatal Care
Miscarriage Pathway
Maternity Services Liaison Committee
Parent Craft Education
Patient information support audit
Policy and Procedure re presentations of domestic violence
Review of Hospital Discharge Protocols SHSCT
Satisfaction questionnaire for Phase 3 Rehab
Setting Standards, designing questionnaires and surveys and organising annual events
Survey of Patient Satisfaction with Food at DHH and CAH
Uplift Programme
Views and experiences of Service Users within Radiology Services
Wraparound

Older People and Primary Care Services Projects
Activity Programme
All Ireland Traveller Health Study
Befriending Scheme
Befriending/bereavement training
Belong
C&B Mental Health Forum
Cancer Support Group / Memory Boxes / Where the patient lives and dies booklet
Combating Social Isolation Promotional DVD
Craigavon & Banbridge Carers Forum
Craigavon & Banbridge Community Forum
Craigavon & Banbridge Migrant Workers Forum
Day Care OPPC
Development of Service Provision within Skeagh House & Themed Activities
Drug and Alcohol Risk Taking Behaviour
Enteral Tube Feeding Workshop
Fit 4 U Project
Health & Wellbeing Programme
Health and Capacity Building
Implementation of Improving Stroke Care Standards
It's a matter of urgency
My Life Story
Newry Neighbourhood Renewal Consultation
NI Cardiac Patient Council
Paediatric Over to You
Patient Satisfaction Survey

Patients as Partners in Care - A Tele Monitoring Pilot Project
Peer Project
Promoting Health & Wellbeing Programme (Neighbourhood Renewal)
Protect Life Implementation Group
Respiratory Focus Group
Restructuring of Domiciliary Care services in Armagh/Dungannon
Review of Residential Care for Older People
South Down Family Health Initiative and Kilkeel Community Assocation
Senior Citizens Forums
Service User Satisfaction Survey 2009
Smoking Cessation
Southern Area Youth Health and Wellbeing Forum
Structured education programmes
The Active Group
Volunteering
Young People as Influences of Change

Children and Young People Services - Projects
ACES Summer Scheme
Anaphylaxis training of school staff
Armagh Breast Feeding Support Group
Assessment of Student Social Workers
Baby Massage/Baby yoga
Breast feeding support group
Care in the System - This is how we see it
Carers Assessment and Professional Practice Training Workshops
Children's Community Speech and Language Therapy Service - Craigavon & Banbridge
Community Access
Development and delivery of Dental Services to Dependent, Older People
Evaluation of Individual Development Plans
Family Support Worker for children with ASD
Family Weight Management Programmes - Get n Gear 4 Health and Active 4 Life
Fit Food Challenge Programme
Foster Care Support Group
Friends of Oakland's
Get N Gear 4 Health Active 4 life
Health Assessments for the Looked After Child
Health Review
House Meetings
Little Voices Big Breams
Newry Children's Home
Participation of Young People in LAC reviews
Speech and language link
Supported Playgroup Scheme
Therapeutic Residential Weekend for Parents
Tots tooth brushing clubs, Tiny tots teeth, boost better breaks, smile month activities, Sure Start projects, smiles 4 schools, crest, learning support units, prevention & first aid for mouth injuries, special schools, SEC, residential and nursing homes,

Training Delivery
User focus group
Women's Aid Liaison
Wraparound
X-pert programme

Mental Health and Disability Services – Projects
An Essence of Care to involve users/carers
Acorn Active Group
Adult Learning Programme - computer class
Adult Respite Unit Dungannon
Bereavement Support Group - Dungannon Pilot Project
Brain Injury Forum
Carers Champion Initiative
Change in Mind Project Board
Change in Mind Work Packages

- Acute
- Primary mental Health Care
- Support and Recovery

Community Addiction
Development of an assessment model for signposting adults with physical/sensory disabilities to Person Centred day time opportunities
Dream Team Advocacy Group
DREEM Implementation Project – Evaluation of three parts of the service re: implementation of the recovery model
Fit 4 U Project
Friends of Orchard Centre
Friends of Orchard House
Implementation Team for the Development of "Operational Policy and Procedures Mental Health Resource Centres"
Manor Empowerment Committee – (Copperfield's Association of Patrons, Friends, Advocates & Carers)
Mental Health Service User and Carer Engagement Group
Mental Health Ward Inpatient Meetings
Multi disciplinary treatment care plans
N/A Individual requests
News & Views
Orchard Tenants Group
Presenting on Social Policy and Learning Disability UUJ
Recovery Model Project Team
Special Olympics
Structural amendments
Trauma Counselling Support Group
User Resettlement
Work with individual victims, survivors and carers

Performance and Reform
Portadown Community Treatment and Care Centre
Banbridge Community Treatment and Care Centre and Day Care Centre Project
New Mental Health Unit – Bluestone
Newry SEC

Newry Children's Home
All Capital Projects

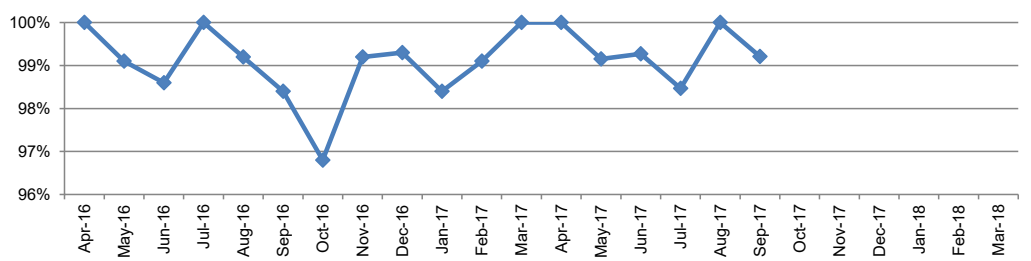
Human Resources and Organisational Development
Disability Action Plan and work streams
Southern Widening Participation Partnership.

OGI 4.9.2: CANCER PATHWAY (31 Day): Lead Director Mrs Esther Gishkori, Director of Acute Services

During 2017/2018, at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of a decision to treat.

Updated: 20 November 2017

Baseline:	98.98%
OGI:	98%
TDP Assessment:	Target is achievable and affordable



Performance	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cum.	RAG	Trend
2017/2018	100.00%	99.15%	99.27%	98.47%	100.00%	99.21%							99.32%	G	↔
2016/2017	100.00%	99.10%	98.60%	100.00%	99.20%	98.40%	96.80%	99.20%	99.30%	98.40%	99.10%	100.00%	98.98%	G	↔

** Note refresh of June data*

Reporting one month in arrears

Narrative:	* Performance against the 31-day OGI is based on completed waits ie. those patients that have had their cancer confirmed and who have received their first definitive treatment. * The Trust continues to perform well on this part of the cancer pathway, from diagnosis to treatment, with 15 out of 1,481 patients identified in 2016/2017 who did not receive their first definitive treatment within 31 days of decision to treat. Cumulative performance April to October 2017 demonstrates 5 patients out of 736 who did not received their first definitive treatment within 31 days of decision to treat.

Current Actions:	* 31-Day Cancer projections of performance have been prepared and submitted to HSCB. * Robust cancer tracking and monitoring in place to ensure pathway actions are met in accordance with timescales.	**Who:** **When:**	Assistant Director Cancer and Clinical Services & Integrated Maternity and Women's Health On-going

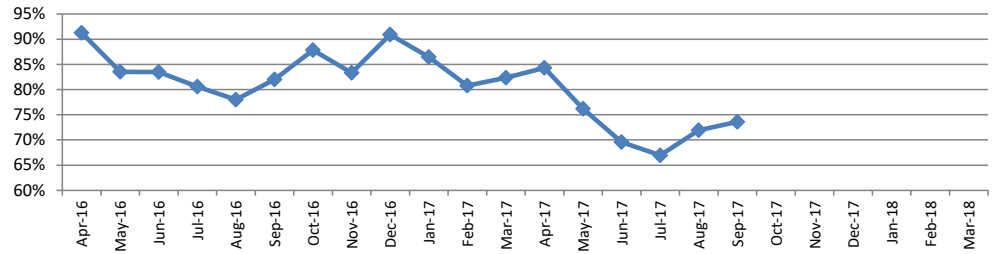
Forward Look:	* No identified risk to the achievement of this objective.	**Risk or Consequence:**	* Impact on patient journey time.

OGI 4.9.3: CANCER PATHWAY (62-Day): Lead Director - Mrs Esther Gishkori, Director of Acute Services

During 2017/2018, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62 days.

Updated: 20 November 2017

Baseline:	84.2%
OGI:	95%
TDP Assessment:	Target unlikely to be achievable/affordable



Performance	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Cum.	RAG	Trend
2017/2018	84.31%	76.19%	69.60%	66.96%	71.91%	73.58%							73.60%	R	↑
2016/2017	91.27%	83.52%	83.45%	80.58%	78.01%	82.03%	87.83%	83.33%	90.91%	86.44%	80.77%	82.35%	84.2%	R	↓

** Note: refresh of May data*

Reporting one month in arrears

Narrative:	* Performance against the 62-day cancer pathway was weaker than the previous year, however, this is in the context of increased volumes of total referrals for the cancer pathways. Referrals received for both the 31 and 62-day pathways have increased presenting increased demands on the fixed capacity available. In particular out-patient assessment/review and diagnostics, which in turn impacts on the 62-day pathway. * September demonstrated a continued improvement in performance to 73.58% with 18 patients breaching the 62-day OGI (10 Inter-Trust Transfer and 8 Internal). The majority of breaches occurred within Urology 44% (8 out of 18) whilst the remaining breaches occurred within Lung; Skin; Upper Gastrointestinal; Colorectal; and Gynaecology. Complexity of patient pathways, delays in access to diagnostics and out-patients continue to impact the 62-day pathway. * At 31 October 2017 there were 10 patients on the 62-day pathway waiting in excess of 85-days (9 SHSCT and 1 Inter-Trust Transfer to SHSCT from SEHSCT). * The submitted projections of performance anticipate a cumulative performance of 73% at 31 March 2018.

Current Actions:	* 62-Day Cancer projections of performance submitted to HSCB. * Internal cancer performance meetings continue on a monthly basis at Assistant Director and Head of Service level to review all of the breaches; pressures on the pathway; and to identify available actions that could positively impact the pathway. * An analysis of the total patient pathway is being developed which aims to detail the total demand on the services; the points in the pathway where patients are breaching internal timescales; and the number of days in which patient's pathways are closed off with no cancer diagnosis. * The Trust is ring fencing urology capacity for biopsy and surgical work to meet the demand of those in the current cancer pathway. * The Trust has highlighted delays in PET scanning and access to specific urological surgical services, provided outside Northern Ireland, and Regional work is ongoing to secure additional capacity for these essential services. * Robust cancer tracking and monitoring in place. * The Trust continues to engage with Regional discussions regarding the future model of provision for In-Patient Upper Gastrointestinal Cancer services and continues to work with the Belfast Trust to support the provision of urological cancer work in the absence of local capacity.	**Who:** **When:**	Assistant Director Cancer and Clinical Services & Integrated Maternity and Women's Health On-going

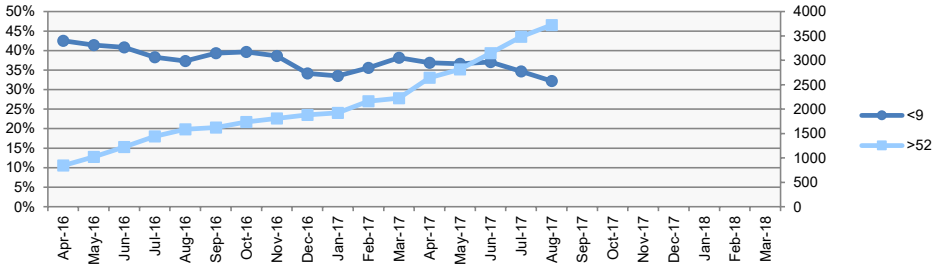
Forward Look:	* Performance against this objective is not anticipated to improve further associated with the complexity of patient pathways and diagnostic delays associated with on-going workforce challenges.	**Risk or Consequence:**	* Impact on patient outcome associated with delay in commencement of treatment.

OGI 4.10: OUT PATIENT APPOINTMENT: Lead Director Mrs Esther Gishkori, Director of Acute Services

By March 2018, 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.

Updated: 20 November 2017

Baseline:	38.16% <9-weeks	2225 >52-weeks
OGI:	50% <9-weeks	0 >52-weeks
TDP Assessment:	<9 weeks: Target unlikely to be achievable/affordable	>52 weeks: Target unlikely to be achievable/affordable



** Note: Excludes Visiting Services (Oral Surgery, Ophthalmology, Paediatric Cardiology, Paediatric Dentistry, Paediatric Neurology, Clinical Oncology and Thoracic Surgery). April to July excludes ICATS OP waiting lists, as this was not previously available. Data from August 2016 onwards shows total waiters including ICATS.*

Performance	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	RAG	Trend
2017/2018 - <9	36.90%	36.60%	37.10%	34.70%	32.20%	33.00%	33.00%						R	⇔
2016/2017 - <9	42.52%	41.39%	40.83%	38.28%	37.33%	39.36%	39.67%	38.63%	34.15%	33.49%	35.56%	38.16%	R	⇔
2017/2018 - >52	2644	2816	3146	3483	3725	4003	4371						R	↓
2016/2017 - >52	843	1020	1222	1443	1587	1625	1738	1809	1884	1924	2160	2225	R	↓

Note: Amended August > 52 weeks data

Narrative:	* Achievement of this objective continues to be impacted by multiple factors including increasing demand, insufficient capacity and lack of recurrent investment in capacity gaps. The Trust continues to prioritise available capacity to red flag (cancer) and clinically urgent referrals in the first instance. * October demonstrates an increase of +9% (368) in waits over 52-weeks whilst the volume of total waits demonstrated a slight decrease of -0.3% (-136). * The longest wait at the end of October was 123-weeks (Ortho-Geriatrics) compared to 120-weeks at end of September. * Waits in excess of 52-weeks continue across 14 specialties, all with established capacity gaps and/or accrued backlogs within: Breast Family History; Breast Surgery; Cardiology; Diabetology; ENT; Endocrinology; Gastro-enterology; General Surgery; Neurology; Ortho-Geriatrics; Orthopaedics; Rheumatology; Thoracic Medicine; and Urology. * The waits in excess of 52-weeks (4,371) equate to 11% of the total waiting list, demonstrating a growth in comparison to September, 9.8% (3,793).

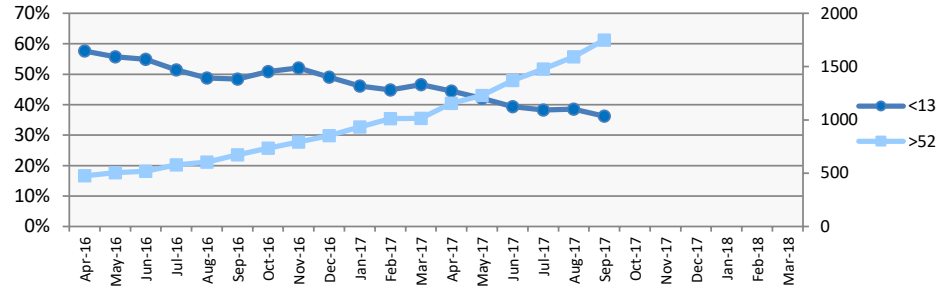
Current Actions:	* Direction of any non-recurrent Regional funding and re-direction of any internal funding to out-patient areas presenting patient safety risk; this includes reviews beyond their clinically indicated timescales and additional capacity for assessment of red flag and urgent cases which does not contribute to the achievement of this objective as the majority of these cases are under 9-weeks. * 2017/2018 non-recurrent funding, for Q1/2, of circa £760,000, provided by HSCB, was utilised to provide an additional capacity for 1,021 new out-patients across 8 specialty areas, to address those areas of clinical concern. * Collated bids for Q4 additionality are in the process of being costed for submission to HSCB in November. * The Trust will continue to strive to improve on the current position through the application of best practice and standards and new ways of working and will continue to participate in regional Outpatient Reform Groups including e-triage initiatives. * Ongoing validation of longest waits in co-operation with Integrated Care Partnerships.	**Who:** **When:**	Assistant Directors of Acute Services and Assistant Director of Paediatrics On-going
Forward Look:	* Due to high volume of waits and accrued backlogs achievement of this objective is unlikely. In the context of the Minister's Elective Plan February 2017, should funding become available this target will still remain challenging associated with ability to establish additional capacity required in the specific areas required.	**Risk or Consequence:**	* Impact on patient experience and outcome. * Adverse publicity on length of waiting time for patients. * Failure to reflect true demand for diagnostic/ in-patient areas.

OGI 4.12: IN-PATIENT / DAY CASE TREATMENT: Lead Director - Mrs Esther Gishkori, Director of Acute Services

By March 2018, 55% of patient should wait no longer than 13 weeks for in-patient/day case treatment and no patient waits longer than 52 weeks.

Updated: 20 November 2017

Baseline:	46.6% <13-weeks	1014 >52-weeks
OGI:	55% <13-weeks	0 >52-weeks
TDP Assessment:	<13 weeks: Unlikely to be achievable / affordable	>52 weeks: Unlikely to be achievable / affordable



October 2017 information outstanding from the Acute Information Team @ 7/11/17

Performance	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	RAG	Trend
2017/2018 - <13	44.53%	42.08%	39.31%	38.21%	38.48%	36.21%	N/A						R	↓
2016/2017 - <13	57.60%	55.70%	54.90%	51.40%	48.80%	48.40%	50.90%	52.10%	49.00%	46.10%	44.80%	46.60%	A	↓
2017/2018 - >52	1155	1230	1371	1478	1593	1750	N/A						R	↓
2016/2017 - >52	475	504	517	577	603	671	734	793	852	933	1012	1014	R	↓

** Note: Data shown excludes Visiting Services (Oral Surgery, Ophthalmology, Paediatric Cardiology, Paediatric Dentistry, Paediatric Neurology, Clinical Oncology and Thoracic Surgery)*

Narrative:	* Achievement of this objective continues to be impacted by multiple factors including increasing demand, insufficient capacity and lack of recurrent investment in capacity gaps. The Trust continues to prioritise available capacity to red flag(cancer) pathway patients and clinically urgent cases in the first instance * Collective IP/DC SBA performance at August 2017 demonstrates -5% (-584), however, individual IP SBA performance demonstrates underperformance of -34% (-946) whilst individual DC SBA performance demonstrates over-performance of +4% (+361). * Cancellation of elective admissions continues to impact on SBA and access times with a total of 495 elective admissions cancelled between April and October. The level of elective cancellations in 2017/2018 is +32% (+120) greater than the corresponding period in 2016/2017 (375). * The volume of patients waiting less than 13-weeks in September (3310) has decreased by -4% (-129) in comparison to August (3,439) with total waits showing an increase of 2% (+202). Waits in excess of 13-weeks have demonstrated an increase of +6% (+331) in September (5,830) in comparison to August (5,499); and waits in excess of 52-weeks have shown increase of +10% (+157) in September (1750) in comparison to August (1593). * Waits over 52-weeks are reported across five specialties, all of which have estabioished capacity gaps and/or accrued backlogs; these are Cardiology; General Surgery; Orthopaedics; Pain Management and Urology.

Current Actions:	* Direction of any non-recurrent Regional funding and re-direction of any internal funding to areas presenting patient safety risk or where opportunity presents to increase capacity without adverse impact on internal bed capacity for unscheduled care. The ability to increase capacity in-house is challenged by available workforce, funding and infrastructure including bed capacity * Improvement plans have been submitted with trajectories for all specialties identified as not delivering the core commissioned level of capacity.	**Who:** **When:**	Assistant Directors of Acute Services On-going
Forward Look:	* Even if additional funding was to become available, as per the Ministers Elective Plan (February 2017), it is unlikely that the Trust could source the increased capacity required to achieve a reduction in those waiting over 52-weeks, particularly in urology where complexity of casemix affects the ability to utilise the Independent Sector.	**Risk or Consequence:**	* Impact on patient experience and outcome. * Adverse publicity on length of waiting time for patients.

20200602
Q11.96

From: Magwood, Aldrina [redacted]
Sent: 02 June 2020 11:35
To: McClements, Melanie; Carroll, Anita
Cc: PADirectorofP&RSHSCT; Leeman, Lesley
Subject: FW: IEAP
Attachments: Integrated Elective Access Protocol Draft27April.doc!docid=1385059!.doc; [redacted]00-IEAPJUNE2020.pdf

Melanie/ Anita
See attached correspondence re IEAP. Given the current position and issues raised by clinical teams Melanie I expect we may wish to reflect in some comments back. Can you please share and comments back via my office please

Jane – BF

Thanks
Aldrina

From: AD Scheduled Care PA [mailto [redacted]
Sent: 01 June 2020 11:03
To: 'Charlene.Stoops [redacted] 'roisin.coulter [redacted] Magwood, Aldrina; 'Molloy Teresa'; 'Neil Martin'
Subject: IEAP

"This email is covered by the disclaimer found at the end of the message."

SENT OBO [redacted]

Dear All

Please see attached.

Kind regards

Leanne Higgins
Admin Support Officer
Performance Management & Service Improvement Directorate
Health & Social Care Board
12-22 Linenhall Street
Belfast
BT2 8BS

Tel: [redacted]

Health and Social Care Board

Performance Management and Service Improvement

HSC Board Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS

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

Trust Directors of Performance

Our Ref: LMcW100

Date: 1 June 2020

Dear Colleagues

REVIEW OF THE INTEGRATED ELECTIVE ACCESS PROTOCOL

A working group chaired by the Health and Social Care Board (HSCB) and consisting of senior managers from the Trusts, Integrated Care and the Public Health Authority (PHA) was established to review and update the current Integrated Elective Access Protocol (IEAP).

The updated document which is attached for your consideration, reflects the changes in clinical practice including the use of the Clinical Communication Gateway (CCG), the Northern Ireland Electronic Care Record (NIECR), E-triage, virtual clinics, and telephone reviews.

The document also formalises previous Departmental guidance on the processes for managing non attendance (Did Not Attend) and patient cancellations for hospital appointments (Could Not Attend) and patients who refuse a reasonable offer of treatment.

I would be grateful if you could review the attached draft and forward any comments to Personal Information redacted by the USI by Friday 12 June 2020. The HSCB has worked closely with Trust leads to update the IEAP and an earlier draft was presented at Trust Directors of Planning.

Yours sincerely

Personal Information redacted by the USI

Lisa McWilliams
Interim Director of Performance Management and Service Improvement

Cc Linus McLaughlin
David McCormick

Integrated Elective Access Protocol

Protocol Summary -

The purpose of this protocol is to outline the approved procedures for managing elective referrals to first definitive treatment or discharge.

Version	**2.0** This guidance replaces the Integrated Elective Access Protocol, 30th April 2008.
Status	Draft for approval
Date	27 April 2020

Integrated Elective Access Protocol

Version

Version	Date of issue	Summary of change	Author
1.0	25 August 2006	New Regional Guidance: Integrated Elective Access Protocol	M Irvine M Wright S Greenwood
2.0	30 April 2008	Protocol refresh to encompass guidance on all aspects of the elective care pathway	M. Irvine, M. Wright, R. Hullat
3.0		Update and relaunch IEAP to provide updated regional guidance on administration of patients on elective care pathways.	L. Mc Laughlin, Regional IEAP Review Group.

Integrated Elective Access Protocol Review Group

The Integrated Elective Access Protocol Review Group consisted of;

Marian Armstrong, BHSCT,
Roberta Gibney, BHSCT
Andrea Alcorn, NHSCT,
Christine Allam, SEHST,
Anita Carroll, SHSCT,
Paul Doherty, WHSCT,
Deborah Dunlop, WHSCT,
Sorcha Dougan, WHSCT,
Donagh Mc Donagh, Integrated Care
Geraldine Teague, PHA
Linus Mc Laughlin, HSCB

Integrated Elective Access Protocol

Document control

The current and approved version of this document can be found on the Department of Health website https://www.health-ni.gov.uk and on the Health and Social Care Board and Trusts intranet sites.

Document:	Integrated Elective Access Protocol 3.0
Department:	Department of Health
Purpose:	To advise and inform patients and clinical, administrative and managerial staff of the approved processes for managing patients access to outpatient, diagnostic, elective and elective Allied Health Professional (AHP) services.
For use by:	All clinical, administrative and managerial staff who are responsible for managing referrals, appointments and elective admissions.
This document is compliant with:	Northern Ireland Health and Social Care (NI HSCC) and Department of Health (DOH) Information Standards and Guidance and Systems Technical Guidance. https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Home.aspx
Screened by:	
Issue date:	
Approval by:	
Approval date:	
Distribution:	Trust Chief Executives, Directors of Planning and Performance, Directors of Acute Care, Department of Health.
Review date:	

Monitoring compliance with protocol

Monitoring compliance with the processes in this document should be part of Trusts internal audit processes.

Contents

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Abbreviations

AHP	Allied Health Professional
CCG	Clinical Communication Gateway
CNA	Could Not Attend (appointment or admission)
DNA	Did Not Attend (appointment or admission)
DOH	Department of Health
CPD	Health and Social Care Commissioning Plan and Indicators of Performance Direction,
E Triage	An electronic triage system
GP	General Practitioner
HR	Human Resources (Trusts)
ICU	Intensive Care Unit
IEAP	Integrated Elective Access Protocol
IS	Independent Sector (provider)
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
IT	Information Technology
LOS	Length of Stay
MDT	Multidisciplinary Team
NI	Northern Ireland
PAS	Patient Administration System, which in this context refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting.
PTL	Primary Targeting List
SBA	Service and Budget Agreement
TCI	To Come In (date for patients)

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 1

CONTEXT

1.1 INTRODUCTION

1.1.1 This protocol has been developed to define the roles and responsibilities of all those involved in the elective care pathway and to outline good practice to assist staff with the effective management of outpatient appointments, diagnostic, elective admissions and allied help professional (AHP) bookings, including cancer pathways and waiting list management.

1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital and AHP services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations, elective inpatient or daycase treatment and AHP services is the responsibility of a number of key individuals within the organisation. General Practitioners (GPs), commissioners, hospital medical staff, allied health professionals, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time targets as defined in the Department of Health (DOH) Commissioning Plan Direction (CPD) and good clinical practice, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communication with patients is a core responsibility of the hospital and the wider local health community.

1.1.3 The purpose of this protocol is to outline the approved processes for managing referrals to outpatient clinics, diagnostic procedures, elective procedures and operations and AHP booking procedures, through to discharge, to allow consistent and fair care and treatment for all patients.

1.1.4 The overall aim of the protocol is to ensure patients are treated in a timely and effective manner, specifically to:

- Ensure that patients receive treatment according to their clinical priority, with routine patients and those with the same clinical priority treated in chronological order, thereby minimising the time a patient spends on the waiting list and improving the quality of the patient experience.

- Reduce waiting times for treatment and ensure patients are treated in accordance with agreed targets.
- Allow patients to maximise their right to patient choice in the care and treatment that they need.
- Increase the number of patients with a booked outpatient or in-patient / daycase appointment, thereby minimising Did Not Attends (DNAs), cancellations (CNAs), and improving the patient experience.
- Reduce the number of cancelled operations for non-clinical reasons.

1.1.5 This protocol aims to ensure that a consistent approach is taken across all Trusts. The principles can be applied to primary and community settings, however it is recommended that separate guidance is developed which recognises the specific needs of the care pathway provided in these settings.

1.1.6 The purpose of this protocol is to define those roles and responsibilities, to document how data should be collected, recorded and reported, and to establish a number of good practice guidelines to assist staff with the effective management of outpatient, diagnostic, inpatient and AHP waiting lists. It will be a step-by-step guide to staff, and act as a reference work, for the successful management of patients waiting for treatment.

1.1.7 This protocol will be reviewed regularly to ensure that Trusts' policies and procedures remain up to date and that the guidance is consistent with good practice and changes in clinical practice, locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.

1.2 METHODOLOGY

1.2.1 The Department of Health (DOH) has set out a series of challenging targets for Trusts in Northern Ireland in the field of elective treatment management. Trusts will recognise the need to move the treatment agenda forward in the context of its shared responsibility for the delivery of these goals.

1.2.2 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.

1.2.3 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.

1.2.4 For the purposes of this protocol, the term;

- outpatient refers to a patient who has a clinical consultation. This may be face to face or virtually,
- elective admissions refer to inpatient and daycase admissions,
- inpatient refers to inpatient and daycase elective treatment,
- diagnostic refers to patients who attend for a scan / test or investigation
- AHP refers to allied health professionals who work with people to help them protect and improve their health and well-being. There are thirteen professions recognised as allied health professions in Northern Ireland (NI),
- partial booking refers to the process whereby a patient has an opportunity to agree the date and time of their appointment
- fixed booking refers to processes where the patient's appointment is made by the Trust booking office and the patient does not have the opportunity to agree/confirm the date and time of their appointment
- PAS refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting and those used in diagnostic departments such as NIPACS and systems used for other diagnostics / physiological investigations.

1.2.5 Trusts must maintain robust information systems to support the delivery of patient care through their clinical pathway. Robust data quality is essential to ensure accurate and reliable data is held, to support the production of timely operational and management information and to facilitate clinical and clerical training. All patient information should be recorded and held on an

electronic system (PAS). Manual patient information systems should not be maintained.

1.2.6 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on electronic hospital/patient administration systems and the waiting times for treatment.

1.2.7 Trusts should provide training programmes for staff which include all aspects of this Integrated Elective Access Protocol (IEAP). It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts. Trusts will provide appropriate information to staff so they can make informed decisions when delivering and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.

1.2.8 This protocol will be available to all staff via Trusts' Intranet.

1.3 UNDERPINNING PRINCIPLES

1.3.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined and agreed at specialty / procedure / service level.

1.3.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.

1.3.3 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority.

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

1.3.5 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures and that daycase is promoted. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving daycase surgery to outpatient care and outpatient care to primary care or alternative clinical models where appropriate.

1.3.6 Referrals into Trusts should be pooled where possible as the norm within specialties.

1.3.7 Trusts will maintain and promote electronic booking systems aimed at making hospital appointments more convenient for patients. Trusts should move away from fixed appointments to partially booked appointments.

1.3.8 Trusts should also promote direct access services where patients are directly referred from primary and community care to the direct access service for both assessment and treatment. Direct access arrangements must be supported by clearly agreed clinical pathways and referral guidance, jointly developed by primary and secondary care.

1.3.9 All patient information should be recorded and held on an electronic system. Trusts should not use manual administration systems to record and report patient's information.

1.3.10 In all aspects of the booking processes, additional steps may be required for **children, vulnerable adults, those with physical/learning difficulties and those who require assistance with language**. It is essential that patients who are considered vulnerable for whatever reason have their needs identified and prioritised at the point of referral and appropriate arrangements made. Trusts must have mechanisms in place to identify such cases.

1.3.11 Trusts have a responsibility to ensure that children and vulnerable adults who DNA or CNA their outpatient, inpatient, diagnostic or AHP appointment

are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

1.3.12 Trusts must ensure that the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.4 CAPACITY

1.4.1 Trusts will set out to resource enough capacity to treat the number and anticipated casemix of patients agreed with commissioners.

1.4.2 It is important for Trusts to understand their baseline capacity, the make-up of the current cohort of patients waiting and the likely changes in demand that will impact on their ability to treat patients and meet the Departmental Targets. Capacity should be linked to Service and Budget agreements.

1.4.3 To manage at specialty and departmental level it is anticipated that managers will have, as a minimum, an overview of their core capacity including:

- Number of clinic and theatre sessions.
- Session length.
- Average procedure / slot time.
- Average length of stay.

1.4.4 It is expected that similar information will be available at consultant level. For inpatients this is at procedure level, and for outpatients, diagnostics and AHPs at service level.

1.4.5 This information will enable Trusts to evaluate its waiting/booked lists in terms of theatre sessions (time in hours) and length of stay (time in bed days).

1.4.6 Each specialty should understand its elective bed requirements in terms of both inpatients and daycases, setting challenging daycase and length of stay (LOS) targets and agreeing plans to deliver them.

1.4.7 Theatre sessions should be maximised.

1.4.8 Trusts will treat patients on an equitable basis across specialties and managers will work together to ensure consistent waiting times for patients of the same clinical priority.

1.4.9 It is important for all services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.

1.4.10 Trusts should ensure that ongoing capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.

1.4.11 In summary, the intention is to link capacity to the Service and Budget Agreement, i.e. to agree the plan, put in place the resources to achieve the plan, monitor the delivery of the plan and take corrective action in the event of divergence from the plan proactively.

1.5 BOOKING PRINCIPLES

1.5.1 These booking principles will support all areas across the elective and AHP pathways where appointment systems are used.

1.5.2 Offering the patient choice of date and time where possible is essential in agreeing and booking appointments with patients through partial booking systems. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them.

1.5.3 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place.

1.5.4 All booking principles should be underpinned with the relevant local policies to provide clarity to operational staff.

1.5.5 Trusts should ensure booking processes are continually reviewed and updated as required to reflect local and regional requirements at an operational level.

1.5.6 The definition of a booked appointment is:

a) The patient is given the choice of when to attend.
b) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment.
c) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within two weeks if cancer is suspected.
d) The patient may choose to agree a date outside the range of dates offered or defer their decision until later.

1.5.7 Principles for booking Cancer Pathway patients:

a) All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral.
b) Dedicated registration functions for red flag (suspect cancer) referrals should be in place within centralised booking teams.
c) Clinical teams must ensure triage, where required, is undertaken daily, irrespective of leave, in order to initiate booking patients.
d) Patients will be contacted by telephone twice (morning and afternoon).
e) If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum of three days of receipt of referral.
f) Systems should be established to ensure the Patient Tracker / Multidisciplinary Team (MDT) Co-coordinator is notified of the suspected cancer patient referral, to allow them to commence prospective tracking of the patient.

1.5.8 Principles for booking Urgent Pathway patients:

a) Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff.
b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation.
c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the referrers's classification of urgency.
d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.
e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.5.9 Principles for booking Routine Pathway patients:

a) Patients should be booked to ensure appointment within the maximum waiting time guarantees for routine appointments.
b) Referrals will be received, registered within one working day at booking teams and forwarded to consultants for prioritisation.
c) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified.
d) Patients should be selected for booking in chronological order from the Primary Targeting List (PTL).
e) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment.

1.5.10 Principles for Booking Review Patients;

a) Patients who need to be reviewed within 6 weeks will agree their appointment before they leave the clinic, where possible.
b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list.

c) Patients will be added to the review waiting list with a clearly indicated date of treatment and selected for booking according to this date.
d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment.

1.5.11 It is recognised that some groups of patients may require booking processes that have additional steps in the pathway. These should be designed around the principles outlined to ensure choice and certainty as well as reflecting the individual requirements necessary to support their particular patient journey.

1.6 COMPLIANCE WITH LEAVE PROTOCOL

1.6.1 It is essential that planned medical and other clinical staff leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments.

1.6.2 There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.

1.6.3 The protocol should require a **minimum** of **six** weeks' notification of intended leave, in line with locally agreed HR policies, in order to facilitate Trusts booking teams to manage appointment processes **six** weeks in advance.

1.6.4 The booking team should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

1.7 VALIDATION

1.7.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis. This is essential to ensure the efficiency of the elective pathway at all times. In addition, Trusts should ensure that waiting lists are regularly validated to ensure that only those patients who want or still require a procedure are on the waiting list.

1.7.2 Involvement of clinicians in the validation process is essential to ensure that waiting lists are robust from a clinical perspective. Trusts should ensure an ongoing process of clinical validation and audit is in place.

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 2

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

2.1 INTRODUCTION

2.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of outpatient services, including those patients whose referral is managed virtually.

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

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

2.1.4 Fixed appointments should only be used in exceptional circumstances.

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

2.2 KEY PRINCIPLES

2.2.1 Referrals into Trusts should be pooled where possible within specialties.

2.2.2 All new referrals, appointments and outpatient waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in three priorities, i.e.

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

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

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

2.2.4 Patient appointments for new and review should be **partially booked.**

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

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

2.2.7 Patients should not be disadvantaged where a decision is made to assess their clinical need through the use of virtual clinics.

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

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

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

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

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

2.3 NEW REFERRALS

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

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

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

2.3.4 All referrals will be prioritised (including those prioritised via E-Triage) within **a maximum of three** working days of date of receipt of referral. Note; Red flag referrals require **daily** triage.

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

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

2.4 CALCULATION OF THE WAITING TIME – STARTING TIME

2.4.1 The starting point for the waiting time of an outpatient new referral is the date the referral is received by the booking office/department.

2.4.2 In exceptional cases where referrals bypass the booking office (e.g. sent directly to a consultant) the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the booking office and registered at the date on the date stamp.

2.5 REASONABLE OFFERS

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

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

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

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

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

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

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

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

2.6 REVIEW APPOINTMENTS

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

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

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

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

2.6.5 Telephone review appointments should be partially booked. If the patient cannot be contacted for their telephone review they should be sent a partial booking letter to arrange an appointment.

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

2.7.1 DNAs – New Outpatient

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

2.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they

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

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

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

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

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

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

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

2.7.2 DNAs – Review Outpatient

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

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

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

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

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

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

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

2.7.2(g) There may be instances for review patients where the clinician may wish to review notes prior to any action to remove a patient because of a DNA or failure to respond to a partial booking letter. Trusts

should ensure that there are locally agreed processes in place to administer these patients.

2.7.3 CNAs – Patient Initiated Cancellations of Outpatient Appointments

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

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

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

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

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

2.8 CNAs – HOSPITAL INITIATED CANCELLATIONS

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

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

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

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

2.9 CLINIC OUTCOME MANAGEMENT

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

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

2.10 CLINIC TEMPLATE CHANGES

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

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

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

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

2.11 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

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

2.12 OPEN REGISTRATIONS

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

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

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

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

2.13 TIME CRITICAL CONDITIONS

2.13.1 All referrals for new patients with time critical conditions, should be booked in line with the agreed clinical pathway requirement for the patient and within a maximum of the regionally recognised defined timescale from the receipt of

the referral (e.g. for suspect cancer (red flag) and rapid access angina assessment the timescale is 14 days).

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

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

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

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

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

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

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

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

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

2.14 TECHNICAL GUIDANCE

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

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

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

- ICATS waiting times and activity (including paper triage)
- Biologic therapies activity.
- Cancer related information.
- Centralised funding waiting list validation.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Obstetric and midwifery activity.
- Outpatients who are to be treated for Glaucoma.
- Management of referrals for outpatient services.
- Rapid angina assessment clinic (RAAC).
- Regional assessment and surgical centres.

- Consultant virtual outpatient activity.
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.
- Recording Consultant Virtual Outpatient Activity

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 3

GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

3.1 INTRODUCTION

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

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

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

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

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

3.2 KEY PRINCIPLES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.3 NEW DIAGNOSTIC REQUESTS

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

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

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

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

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

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

3.4 CALCULATION OF THE WAITING TIME – STARTING TIME

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

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

3.5 REASONABLE OFFERS

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

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

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

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

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

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

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

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

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

3.6 FOLLOW UP APPOINTMENTS

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

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

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

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

3.7 PLANNED PATIENTS

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

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

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

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

3.8 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

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

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

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

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

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

3.9.1 DNAs – Diagnostic Appointment

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

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

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

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

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

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

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

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

3.9.2 DNAs – Follow up Diagnostic Appointment

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

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

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

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

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

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

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

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

3.9.3 CNAs – Patient Initiated Cancellations of Diagnostic Appointment

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

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

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

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

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

3.10 CNAs - HOSPITAL INITIATED CANCELLATIONS

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

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

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

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

3.11 SESSION OUTCOME MANAGEMENT

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

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

3.12 SESSION TEMPLATE CHANGES

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

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

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

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

3.13 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

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

3.14 TECHNICAL GUIDANCE

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

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

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 4

GUIDANCE FOR MANAGEMENT OF ELECTIVE ADMISSIONS

4.1 INTRODUCTION

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

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

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

4.2 KEY PRINCIPLES

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

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

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

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

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

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

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

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

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

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

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

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

4.3 PRE-ASSESSMENT

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

4.3.2 Pre-assessment may include an anesthetic assessment or guidance on how to comply with pre-procedure requirements such as bowel preparation. It will

be the responsibility of the pre- assessment team, in accordance with protocols developed by the relevant clinical teams, to authorise fitness for an elective procedure.

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

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

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

4.4 CALCULATION OF THE WAITING TIME

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

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

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

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

4.5.2 All patients must be offered reasonable notice. Patients should be made reasonable offers to come in (TCI) on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.

4.5.3 A reasonable offer is defined as:

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

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

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

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

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

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

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

4.6 INPATIENT AND DAYCASE ACTIVE WAITING LISTS

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

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

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

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

4.7 SUSPENDED PATIENTS

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

4.7.2 A period of suspension is defined as:

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

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

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

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

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

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

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

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

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

4.8 PLANNED PATIENTS

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

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

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

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

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

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

4.9 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

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

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

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

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

DNAs – Inpatient/Daycase

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

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

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

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

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

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

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

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

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

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

4.10.2 CNAs – Patient Initiated Cancellations of inpatient/daycase admission

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

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

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

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

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

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

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

4.11. CNAs - HOSPITAL INITIATED CANCELLATIONS

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

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

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

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

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

4.12 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

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

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

4.13 TECHNICAL GUIDANCE

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

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

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

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 5

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

5.1 INTRODUCTION

5.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of the elective booking processes for elective Allied Health Professionals (AHP) services.

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

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

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

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

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

5.1.7 Fixed appointments should only be used in exceptional circumstances.

5.1.8 In all aspects of the AHP booking process, additional steps may be required for **children, vulnerable adults, those with physical/learning difficulties**

and those who require assistance with language. Local booking polices should be developed accordingly.

5.2 KEY PRINCIPLES

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

1. urgent and
2. routine.

No other clinical priorities should be used for AHP services.

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

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

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

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

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

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

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

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

5.3 NEW REFERRALS

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

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

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

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

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

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

5.4 CALCULATION OF THE WAITING TIME

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

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

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

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

5.5 REASONABLE OFFERS

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

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

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

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

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

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

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

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

5.6 REVIEW APPOINTMENTS

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

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

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

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

5.6.5 Telephone review appointments should be partially booked. If the patient cannot be contacted for their telephone review they should be sent a partial booking letter to arrange an appointment.

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

5.7.1 DNAs – New AHP Appointments

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

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

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

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

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

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

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

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

5.7.2 DNAs – Review Appointments

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

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

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

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

5.7.2(d) Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where

unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the waiting list at the date they make contact with the Trust.

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

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

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

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

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

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

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

5.7.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include

seeking a clinical review of the patient's case where this is appropriate.

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

5.8 CNAs – SERVICE INITIATED CANCELLATIONS

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

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

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

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

5.9 CLINIC OUTCOME MANAGEMENT

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

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

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

5.10 CLINIC TEMPLATE CHANGES

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

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

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

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

5.11 TRANSFERS BETWEEN TRUSTS or to INDEPENDENT SECTOR

5.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trusts or to independent sector (IS) providers. Transfers should not be a feature of an effective scheduled system.

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

5.12 TECHNICAL GUIDANCE

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

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

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

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

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Q11. 97

From: Carroll, Ronan [redacted]
Sent: 15 June 2020 11:50
To: Magwood, Aldrina; Leeman, Lesley; Lappin, Lynn
Cc: McClements, Melanie; Clayton, Wendy; Corrigan, Martina; Murray, Helena; Nelson, Amie
Subject: FW: *For Urgent Review* IEAP
Attachments: Integrated Elective Access Protocol Draft27April.doc!docid=1385059!.doc; [redacted]00-IEAPJUNE2020.pdf
Importance: High

Aldrina/Lesley/Lynn
Apologies for the delay. Please see comments from SEC
[redacted]an

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery/Elective Care
Mob [redacted]

From: Clayton, Wendy
Sent: 11 June 2020 15:56
To: Scott, Jane M; Carroll, Ronan; Corrigan, Martina; Murray, Helena; Nelson, Amie
Subject: FW: *For Urgent Review* IEAP
Importance: High

Ronan

Amie, Jane and I have gone through the new version of the IEAP attached. Most of our original comments have been included which is good to see. The comments are relevant to when the Trust is back to core sessions with no s[redacted]bbing prior to admission. If the Trust feels that we will be swabbing for the foreseeable future then regionally they may want to include something around swabbing and self isolation into the IEAP

The comments below are all around the 6- weeks notice of rotas/booking:

1.5.9
c)Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified.
e)Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment.

1.5.10
d)Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment.

As per previous discussions at HOS, we only ask the consultants to give us 6-weeks notice. Realistically the rota's will not be agreed until approx 4-5 weeks notice by the time all specialty rotas are collated and agreed.

1.6.3 The protocol should require a **minimum** of **six** weeks' notification of intended leave, in line with locally agreed HR policies, in order to facilitate Trusts booking teams to manage appointment processes **six** weeks in advance.

Realistically if minimum of 6 weeks notification of leave management of appointment will be 4-5 weeks in advance, due to having to complete rotas

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

Southern Trust endoscopy patients do not receive pre-assessment

Regards

Wendy Clayton
Acting Head of Service for Trauma & Orthopaedics
Ext: Personal Information redacted by the USI
Mob: Personal Information redacted by the USI

From: Carroll, Ronan
Sent: 09 June 2020 17:27
To: Scott, Jane M; Clayton, Wendy; Corrigan, Martina; Murray, Helena; Nelson, Amie
Subject: FW: *For Urgent Review* IEAP
Importance: High

important document so I would Welcome any comments you have – even no comment pls by thurs –
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery/Elective Care
Mob Personal Information redacted by the USI

From: Stinson, Emma M
Sent: 09 June 2020 15:53
To: Boyce, Tracey; Burke, Mary; Carroll, Anita; Carroll, Ronan; Conway, Barry; McVey, Anne
Cc: Hogan, Kerri; Lappin, Aideen; Livingston, Laura
Subject: *For Urgent Review* IEAP

Dear all

Could you advise by this Thursday any views/challenges or that you are content with this document and forward to Aldrina's office as I will be on annual leave Thursday and Friday?

Many thanks
Emma

Emma Stinson
PA to Mrs Melanie McClements, Interim Director of Acute Services

SHSCT, Admin Floor, Craigavon Area Hospital
Direct Line: Personal Information redacted by the USI
Personal Information redacted by the USI
Please consider the environment before printing this email

Click on the link to access the Acute Services Page

From: Magwood, Aldrina
Sent: 02 June 2020 11:35
To: McClements, Melanie; Carroll, Anita
Cc: PADirectorofP&RSHSCT; Leeman, Lesley
Subject: FW: IEAP

Melanie/ Anita
See attached correspondence re IEAP. Given the current position and issues raised by clinical teams Melanie I expect we may wish to reflect in some comments back. Can you please share and comments back via my office please

Jane – BF

Thanks
Aldrina

From: AD Scheduled Care PA [mailto:ADScheduledCarePA@hscni.net]
Sent: 01 June 2020 11:03
To: 'Charlene.Stoops Personal Information redacted by the USI ; 'roisin.coulter Personal Information redacted by the USI ; Magwood, Aldrina; 'Molloy Teresa'; 'Neil Martin'
Subject: IEAP

"This email is covered by the disclaimer found at the end of the message."

SENT OBO LISA MCWILLIAMS

Dear All

Please see attached.

Kind regards

Leanne Higgins
Admin Support Officer
Performance Management & Service Improvement Directorate
Health & Social Care Board
12-22 Linenhall Street
Belfast
BT2 8BS

Tel: Personal Information redacted by the USI

Department of
Health, Social Services
and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

INTEGRATED ELECTIVE ACCESS PROTOCOL
30th April 2008

DOCUMENT CONTROL INTEGRATED ELECTIVE ACCESS PROTOCOL			
Authors	Michelle Irvine – Programme Director, Elective Workstream Maria Wright – Associate Director, Outpatients Rosemary Hulatt – Associate Director, Diagnostics		
Issue Date **1st Draft**	Wednesday 20th February 2008		
Comments by	Close of Play - Friday 7th March 2008		
2nd Draft	27th March 08		
Final Protocol **Date Approved**	30th April 08		
Issue Date	Friday 9th May 2008		
Screened By	Service Delivery Unit, DHSSPSNI		
Approved By		**Signature**	
Distribution	Trust Chief Executives; Directors of Planning and Performance; Directors of Acute Care; DHSSPS		
Review Date	April 2009		

CONTENTS

ABBREVIATIONS

AHP	Allied Health Professional
BCC	Booking and Contact Centre (ICATS)
CNA	Could Not Attend (Admission or Appointment)
DHSSPSNI	Department of Health, Social Services and Public Safety
DNA	Did Not Attend (Admission or Appointment)
DTLs	Diagnostic Targeting Lists
ERMS	Electronic Referrals Management System
GP	General Practitioner
HIC	High Impact Changes
HROs	Hospital Registration Offices
ICATS	Integrated Clinical Assessment and Treatment Services
ICU	Intensive Care Unit
LOS	Length of Stay
PAS	Patient Administration System
PTLs	Primary Targeting Lists
SDU	Service Delivery Unit
TCI	To Come In (date for patients)

SECTION 1

CONTEXT

1.1 INTRODUCTION

1.1.1 This protocol has been developed to encompass the elective pathway within a hospital environment. The principles can be applied to primary and community settings, however it is recommended that guidance is developed which recognises the specific needs of the care pathway provided in these settings.

1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations and elective inpatient or day case treatment is the responsibility of a number of key individuals within the organisation. General Practitioners, commissioners, hospital medical staff, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time guarantees, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communications with patients is a core responsibility of the hospital and the wider local health community.

1.1.3 The purpose of this protocol is to define those roles and responsibilities, to document how data should be collected, recorded and reported, and to establish a number of good practice guidelines to assist staff with the effective management of outpatient, diagnostic and inpatient waiting lists. It will be a step-by-step guide to staff, and act as a reference work, for the successful management of patients waiting for hospital treatment.

1.1.4 This protocol will be updated, as a minimum, on an annual basis to ensure that Trusts' polices and procedures remain up to date, and reflect best practice locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.

1.1.5 This protocol will be available to all staff via Trusts' Intranet.

1.1.6 The DHSSPSNI has set out a series of challenging targets for Trusts in Northern Ireland in the field of elective treatment management. Trusts will recognise the need to move the treatment agenda forward in the context of its shared responsibility for the delivery of these goals.

1.1.7 There is an imperative to identify capacity constraints that could threaten the delivery of these key access targets and speed up the planning and delivery of extra capacity, where it is needed, to address these constraints. The health community will need to develop a co-ordinated approach to capacity planning taking into account local capacity on a cross Trust basis and independent sector capacity on an on-going partnership basis.

1.1.8 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.

1.1.9 The intention is that this protocol will be further developed to consider all aspects of access to a range of quality healthcare at a date and time of the patients' choice.

1.1.10 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.

1.1.11 Delivery of this protocol will require a step change in the way Trusts function. Trusts will need to transform themselves and this can only be achieved through a change in the way its staff approach their work on a day-to-day basis. Through this protocol, Trusts will aspire to work with patients and staff to raise expectations basing them not on where we are but on where we need to be.

1.1.12 For the purposes of this protocol, the term inpatient refers to inpatient and day case elective treatment. The term 'PAS' refers to all patient

administration systems, whether in a hospital or community setting, or an electronic or manual system.

1.1.13 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on PAS and the waiting times for treatment. All staff involved in the implementation of this protocol, clinical and clerical, will undertake initial training and regular annual updating. Trusts will provide appropriate information to staff so they can make informed decisions when implementing and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.

1.2 UNDERPINNING PRINCIPLES

1.2.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined specifically by specialty / procedure / service.

1.2.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.

1.2.3 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient - they are fit, ready, and able to come in.

1.2.4 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures, not the norm. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving day case surgery to outpatient care, and outpatient care to primary care or alternative clinical models where appropriate.

1.2.5 Change No 1 within the publication "10 High Impact Changes for Service Improvement and Delivery"[1] focuses on day surgery and the document provides Trusts with tools and resources to help implement this high impact change.

1.2.6 Trusts will introduce booking systems aimed at making hospital appointments more convenient for patients. Booking systems are chronologically based and will move Trusts onto a system of management and monitoring that is chronologically as opposed to statistically based.

1.2.7 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority with immediate effect. The intention is to provide patients with certainty and choice enabling them to access services that are sensitive to their needs.

1.2.8 This will require changes in working practices. It will also require technological change to information systems to enable provision of quality information to support the booking process.

1.2.9 There is a need to balance the flow of patients from primary care through outpatients and on to booking schedules should they need elective admission. It follows that the level of activity in the Service and Budget Agreements and the level of provision of outpatient and inpatient capacity must be linked. If one changes, all should change.

1.2.10 This "bottom up" approach is based on the belief that services need to be built on firm clinical foundations. Trusts need a clinical vision built up specialty by specialty and department by department through debate and agreement between clinicians across the health community as to the best way to meet patient needs locally.

1.2.11 It is essential that patients who are considered vulnerable for whatever reason have their needs identified at the point of referral.

[1] "10 High Impact Changes for Service Improvement and Delivery" – September 2004, NHS Modernisation Agency, www.modern.nhs.uk/highimpactchanges

1.2.12 All relevant information must be recorded to ensure that when selecting a vulnerable patient for admission, their needs are identified early and appropriate arrangements made. This information should be recorded in detail in the episodic comment field of PAS relating to the listing. The patient master index comment field should not be used due to confidentiality issues.

1.2.13 Communication with this patient group will recognise their needs and, where appropriate, involve other agencies.

1.2.14 An operational process should be developed by Trusts to ensure that children and vulnerable adults who DNA or CNA their outpatient appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

1.2.15 In implementing this protocol the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.3 OWNERSHIP

1.3.1 Ownership is key to delivering quality of care. Trusts must ensure that all staff are conversant with the Departmental targets and standards and are comfortable with the local health communities' approach to their delivery.

1.3.2 These targets and standards must be seen to be core to the delivery of all aspects of care provision by all levels of staff within the Trust.

1.3.3 This is a major change agenda requiring significant commitment and investment at corporate and individual level. An Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to.

1.3.4 Trusts must be committed to training and developing staff and providing the supporting systems to ensure that together we can bring about the improvement in patient care.

1.4 REGIONAL TARGETS

1.4.1 The targets in respect of elective treatments are:

- A maximum waiting time of 13 weeks for inpatient and daycase admissions by March 2009
- A maximum waiting time of 9 weeks for a 1st outpatient appointment by March 2009
- A maximum waiting time of 9 weeks for a diagnostic test by March 2009
- A maximum waiting time of 13 weeks from referral to treatment by an Allied Health Professional (AHP) by March 2009
- By March 2009, sustain the target where 98% of patients diagnosed with cancer should begin treatment within a maximum of 31 days of the diagnosis
- By March 2009, 95% of patients with suspected cancer who have been referred urgently should begin their first definitive treatment within a maximum of 62 days

1.5 DELIVERY OF TARGETS

1.5.1 The waiting time targets are based on the “worst case” i.e. they reflect the minimum standards with which every Trust must comply.

1.5.2 The expectation is that these targets are factored into plans at Trust Board, divisional, specialty and departmental levels as part of the normal business

and strategic planning processes. Divisional, specialty and departmental managers will be expected to have produced implementation plans setting out the key steps they need to take to ensure the delivery of the Trust and Departmental protocol objectives within the area(s) of their responsibility. Trusts will manage implementation through a regular review of "local" divisional, specialty and departmental plans for the implementation of waiting and booking targets.

1.5.3 It is expected that Trusts will develop robust information systems to support the delivery of these targets. Daily management information should be available at both managerial and operational level so that staff responsible for selecting patients are working from up to date and accurate information. Future developments should also look towards a clinic management system which will highlight the inefficiencies within the outpatient setting.

1.6 CAPACITY

1.6.1 It is important for Trusts to understand their baseline capacity, the make-up of the current cohort of patients waiting and the likely changes in demand that will impact on their ability to treat patients and meet the Departmental Targets.

1.6.2 To manage at specialty and departmental level it is anticipated that managers will have, as a minimum, an overview of their core capacity including:

- Number of clinic and theatre sessions
- Session length
- Average procedure / slot time
- Average length of stay

1.6.3 It is expected that similar information will be available at consultant level. For inpatients this is at procedure level, and for outpatients and diagnostics at service level.

1.6.4 This information will enable Trusts to evaluate its waiting/booked lists in terms of theatre sessions (time in hours) and length of stay (time in bed days).

1.6.5 Each specialty should understand its elective bed requirements in terms of both inpatients and daycases, setting challenging daycase and LOS targets and agreeing plans to deliver them. In addition, systems must be developed to ensure assessment can be made of available capacity and flexible working arrangements developed accordingly.

1.6.6 Theatre sessions should be seen as corporate resources and used flexibly to ensure the delivery of waiting list and waiting time targets across consultants within the same specialty and specialties within the same Trust. This ties in with the Real Capacity Paper which also requires commissioners to demonstrate that they have used capacity flexibly across Trusts. The expectation is that divisions and/ or specialties will be able to demonstrate that they have optimised the use of existing capacity to maximise the treatment of patients within existing resources.

1.6.7 Trusts will treat patients on an equitable basis across specialties and managers will work together to ensure consistent waiting times for patients of the same clinical priority.

1.6.8 Trusts will set out to resource enough capacity to treat the number and anticipated casemix of patients agreed with commissioners. The Real Capacity Planning exercise will support this process locally.

1.6.9 Divisions/specialties will monitor referrals and additions to lists in terms of their impact on clinic, theatre time, bed requirements and other key resources e.g. ICU facilities, to ensure a balance of patients in the system and a balance between patients and resources.

1.6.10 When the balance in the system is disturbed to the extent that capacity is a constraint, divisional/specialty managers will be expected to produce plans

to expedite solutions and agree these through the accountability review process.

1.6.11 It is important for all services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.

1.6.12 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.

1.6.13 In summary, the intention is to link capacity to the Service and Budget Agreement i.e. to agree the plan, put in place the resources to achieve the plan, monitor the delivery of the plan and take corrective action in the event of divergence from the plan proactively. The existing arrangements whereby patients are added to waiting lists irrespective of whether Trusts have the capacity to treat them must change.

1.7 BOOKING PRINCIPLES

1.7.1 These booking principles have been developed to support all areas across the elective pathway where appointment systems are used.

1.7.2 Offering the patient choice of date and time is essential in agreeing and booking appointments with patients. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them. This takes away the uncertainty of not knowing how long the wait will be as patients are advised of their expected wait. Advanced booking in this way also gives patients notice of the date so that they can make any necessary arrangements, such as child care or work arrangements.

1.7.3 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place.

1.7.4 Booking development work within Trusts should be consistent with regional and local targets, which provide a framework for progress towards ensuring successful and consistent booking processes across the health community in Northern Ireland.

1.7.5 All booking processes should be underpinned with the relevant local policies and procedures to provide clarity to operational staff of the day to day requirements and escalation route, for example: management of patients who cancel / DNA their appointment, process for re-booking patients, and monitoring of clinical leave and absence.

1.7.6 Trusts should ensure booking processes are continually reviewed and updated as required to reflect local and regional requirements at an operational level.

1.7.7 The definition of a booked appointment is:

a) The patient is given the choice of when to attend.
b) The patient is advised of the total waiting time during the consultation between themselves and the healthcare provider / practitioner or in correspondence from them.
c) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment
d) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within 2 weeks if cancer is suspected.
e) The patient may choose to agree a date outside the range of dates offered or defer their decision until later

1.7.8 Booking Process

1.7.9 There are 3 main patient appointment types to be booked. Booking systems for these appointments should be designed around an agreed patient pathway and accepted clinical practice. They are:

a) New Urgent patients (including suspected cancer)
b) New Routine patients
c) Review patients

1.7.10 Clinic templates should be constructed to ensure that sufficient capacity is carved out to meet the local and maximum waiting time guarantees for new patients, and the clinical requirements of follow-up patients.

1.7.11 Principles for booking Cancer Pathway patients

a) All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral
b) Dedicated registration functions for red flag and suspected cancer referrals should be in place within centralised HROs
c) Clinical teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients
d) Patients will be contacted by telephone twice (morning and afternoon)
e) If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum of 3 days of receipt of referral
f) Systems should be established to ensure the Patient Tracker / MDT Co-ordinator is notified of the suspected cancer patient referral, to allow them to commence prospective tracking of the patient

1.7.12 Principles for booking Urgent Pathway patients

a) Local agreements should be in place with consultants to determine the timeframe within which urgent patients should be booked, and made explicit to booking teams

b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation
c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP's classification of urgency
d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.
e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.7.13 Principles for booking Routine Pathway patients

a) Patients should be booked to ensure appointment within the maximum waiting time guarantees for routine appointments
b) Referrals will be received, registered within one working day at HRO's and forwarded to consultants for prioritisation
c) Patients will receive an acknowledgement from the Trust indicating their expected length of wait and information on the booking process they will follow
d) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified
e) Patients should be selected for booking in chronological order from the PTL
f) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment

1.7.14 Principles for Booking Review Patients

a) Patients who need to be reviewed within 6 weeks will agree their appointment before they leave the clinic

b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list
c) Patients will be added to the review waiting list with an indicative date of treatment and selected for booking according to this date
d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment

1.7.15 It is recognised that some groups of patients may require booking processes that have additional steps in the pathway. These should be designed around the principles outlined to ensure choice and certainty as well as reflecting the individual requirements necessary to support their particular patient journey. Examples of this include:

a) midwives contacting patients directly by telephone to arrange their appointment
b) clinical genetics services where family appointments are required
c) mental health or vulnerable children's services where patients may need additional reminders or more than one professional contacted if patients fail to make an appointment.

SECTION 2

GUIDANCE FOR MANAGEMENT OF ICATS SERVICES

2.1 INTRODUCTION

2.1.1 The administration and management of ICATS referrals and ICATS requests for diagnostics must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

2.1.2 ICATS services are managed in accordance with the Data Definitions and Guidance Document for Monitoring of ICATS Services Sept 2007 **(Appendix 1).**

2.1.3 The level of functionality available on the Electronic Referral Management System to support the administration of patients in an ICATS setting is developmental. Achievement of the standards outlined will be where functionality permits.

2.1.4 Referrals will be managed through a centralised registration process in the nominated Hospital Registration Offices (HRO's) within Trusts to receive, register and process all ICATS referrals. The Trust should ensure that a robust process is in place to ensure that referrals received outside the HRO are date stamped, forwarded to the HRO and registered onto ERMS according to the date received by the Trust.

2.1.5 All new patients should be able to book their appointment in line with the guidance outlined in Booking Principles Section 1.7 The expectation is that follow up patients should also be offered an opportunity to choose the date and time of their appointment.

2.2 KEY PRINCIPLES

2.2.1 Where ICATS is in place for a specialty, all referrals should be registered and scanned onto Electronic Referral Management System (ERMS) within 24 hours of receipt.

2.2.2 Each ICATS must have a triage rota to ensure that every referral is triaged and the appropriate next step is confirmed, according to the clinically agreed

rules, within three working days of receipt in any Hospital Registration Office (HRO). Triage rotas must take multi-site working into account. A designated officer in ICATS should oversee the triage arrangements.

2.2.3 The outcome of the triage will be confirmed by letters to the GP and patient within a further two working days of triage (five working days in total from receipt).

2.2.4 ICATS clinical staff will be aware of all exclusions that prevent patients from being assessed or treated within the ICATS setting.

2.2.5 Patients of equal clinical priority will be selected for booking in chronological order in order to meet the maximum waiting time guarantee for patients and local access standards.

2.2.6 All patients deemed appropriate will be offered an ICATS appointment within six weeks from the triage date.

2.2.7 Data collection should be accurate, timely, complete and subject to regular audit and validation.

2.2.8 Staff should be supported by appropriate training programmes.

2.3 CALCULATION OF THE WAITING TIME

2.3.1 The waiting time clock for ICATS starts after the triage decision has been taken that an appointment in ICATS clinic is the appropriate next step.

2.3.2 The ICATS clock stops when the patient attends for first appointment or when the patient has been discharged from ICATS.

2.3.3 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the

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

2.3.4 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

2.3.4 No patient should have his or her appointment cancelled. If the ICATS service cancels a patient's appointment, the patient's waiting time clock will not be reset and the patient should be offered another appointment, ideally at the time of the cancellation, and which is within six weeks of the original appointment date.

2.4 NEW REFERRALS

2.4.1 All ICATS referrals will be registered and scanned onto ERMS within 24 hours of receipt. All referrals forwarded for ICATS triage must be triaged or assessed to make a clear decision on the next step of a referral within three working days of the referral being logged by the HRO onto ERMS.

2.4.2 Within five working days of the referral being recorded onto ERMS, the GP and patient must be issued with written confirmation of the next stage of the patient's treatment.

2.4.3 Where there is insufficient information for the professional to make a decision, they have the option to either return the referral to the referrer requesting the necessary information or contact the referrer in the first instance to access the necessary information. If this cannot be gained, the referral should be returned to the referrer requesting the necessary information and a new referral may be initiated.

2.4.4 Those patients identified for outpatients and diagnostic services following triage will be managed in line with the relevant sections of this IEAP.

Flowcharts illustrating the Triage Outcomes Process can be found in **Appendix 2.**

2.5 BOOKING

2.5.1 All patients requiring an appointment in an ICATS will have the opportunity to agree the date and time of their appointment, in line with the booking principles outlined in Section 1.7.

2.5.2 If a patient requests an appointment beyond the six week ICATS standard the patient will be discharged and told to revisit their GP when they are ready to be seen at the ICATS clinic. This will ensure that all patients waiting for an ICATS appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate recalculation of the patient's waiting time and to facilitate booking the patient into the date they requested.

2.5.3 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

2.6 REASONABLE OFFERS

2.6.1 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the second appointment date declined.

2.6.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

2.6.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date the service was notified of the cancellation, as the patient has entered into an agreement with the Trust.

2.6.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3.**

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

2.7.1 If a patient DNAs their first ICATS appointment the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

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

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.

- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

2.7.3 If a patient has been referred back to their referring clinician and the referrer still wishes a patient to be seen in ICATS, a new referral is required.

2.7.4 The Implementation Procedure for the Management of Patients who DNA or Cancel can be found in **Appendix 4.**

2.8 MAXIMUM WAITING TIME GUARANTEE

2.8.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their GP when they are ready to be seen. This will ensure that all patients waiting for an appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

2.9 COMPLIANCE WITH TRUST LEAVE PROTOCOL

2.9.1 It is essential that leave/absence of ICATS practitioners is organised in line with Trusts' notification of leave protocol. It is also necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of ICATS clinics.

2.9.2 The protocol should require a minimum of six weeks' notification of intended leave. A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

2.10 CLINIC OUTCOME MANAGEMENT

2.10.1 There are a number of locations within Trusts where patients present for their ICATS consultation. This protocol applies to all ICATS locations. It is the responsibility of the ERMS user managing the attendance to maintain data quality.

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

2.10.3 When the assessment has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on ERMS.

2.11 REVIEW APPOINTMENTS

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

2.11.2 As previously stated, the Booking Centres will be responsible for partially booking all new appointments. Booking Centres will also book review appointments that are required to be more than 6 weeks in the future. ICATS administration staff will make bookings directly with the patient at the clinic for any further appointments needing to occur within 6 weeks.

2.12 TEMPLATE CHANGES

2.12.1 Templates should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

2.12.2 Templates will identify the number of slots available for new and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated to each appointment slot.

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

2.12.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for management of Clinic Template Changes can be found in **Appendix 5.**

2.13 VALIDATION

2.13.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. Trusts should ensure that all relevant data fields are completed in ERMS. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce.

2.13.2 The data validation process will apply to both new and follow up appointments. The Implementation Procedure for data validation can be found in **Appendix 6.**

SECTION 3

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

3.1 INTRODUCTION

3.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of outpatient services.

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

3.1.3 There will be dedicated Hospital Registration Offices (HROs) within Trusts to receive, register and process all outpatient referrals. The HROs will be required to register and scan referrals (where appropriate) onto the Electronic Referrals Management System (ERMS) and PAS.

3.1.4 There will be dedicated booking functions within Trusts and all new and review outpatients should have the opportunity to book their appointment. The booking process for non-routine groups of outpatients or those with additional service needs should be designed to identify and incorporate the specific pathway requirements of these patients.

3.2 CALCULATION OF THE WAITING TIME

3.2.1 The starting point for the waiting time of an outpatient new referral is the date the clinician's referral letter is received by Trusts. All referral letters, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received into the organisation.

3.2.2 In cases where referrals bypass the dedicated HRO's, (e.g. sent directly to a consultant), the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the HRO and registered at the date on the date stamp.

3.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who

refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

3.2.3 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

3.3 KEY PRINCIPLES

3.3.1 Referrals into Trusts should be pooled where possible within specialties. Referrals to a specific consultant by a GP should only be accepted where there are specific clinical requirements or stated patient preference. As a minimum, all un-named referrals should be pooled.

3.3.2 All referrals, appointments and waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list, allocated according to urgency of the treatment. Trusts will manage patients in 2 streams, i.e. urgent and routine. Templates should be constructed to ensure enough capacity is available to treat each stream within agreed maximum waiting time guarantees. The Implementation Procedure for Template Redesign can be found in **Appendix 7.**

3.3.3 The regional target for a maximum OP waiting time is outlined in Section 1.4. Maximum waiting times for urgent patients should be agreed locally with clinicians.

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

3.3.5 Patients of equal clinical priority will be selected for booking in strict chronological order. Trusts must ensure that Department waiting and booking targets and standards are met.

3.3.6 Data collection should be accurate, timely, complete and subject to regular audit and validation.

3.3.7 Trusts should provide training programmes for staff which include all aspects of this IEAP and its Implementation Procedures. It is expected that training will be cascaded at and by each clinical, managerial or administrative tier within Trusts, providing the opportunity where required, for staff to work through operational scenarios.

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

3.4 NEW REFERRALS

3.4.1 All outpatient referrals sent to Trusts will be received at the dedicated HRO's and registered within one working day of receipt. GP priority status must be recorded at registration.

3.4.2 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and which are not returned can be identified.

3.4.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for referrals to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.

3.4.5 All outpatient referrals letters will be prioritised and returned to the HRO within 3 working days. It will be the responsibility of the health records

manager or departmental manager to monitor this performance indicator. Monitoring will take place by consultant on a monthly basis. Following prioritisation, referrals must be actioned on PAS and appropriate correspondence issued to patients within 1 working day.

3.4.6 Where clinics take place, or referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby GP prioritisation is accepted in order to proceed with booking urgent patients.

3.4.7 Inappropriate and inadequate referrals should be returned to the referral source. A minimum referral criteria dataset has been agreed and is outlined in **Appendix 8**

3.4.8 An Effective Use of Resources Policy is in place for some services and Trusts should ensure that this is adhered to. The policy is included for reference in **Appendix 9.**

3.5 URGENT AND ROUTINE APPOINTMENTS

3.5.1 All consultant led outpatient appointments where the patient attends the Trust should be booked. The key requirements are that the patient is directly involved in negotiating the appointment date and time, and that no appointment is made more than six weeks into the future.

3.5.2 All routine patients must be booked within the maximum waiting time guarantee. Urgent patients must be booked within the maximum wait agreed locally with clinicians, from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.

3.5.3 Acknowledgment letters will be sent to routine patients within five days of receipt of the referral. The estimated length of wait, along with information on

how the patient will be booked, should be included on the acknowledgement letter.

3.5.4 A minimum of three weeks' notice should be provided for all routine patients. This does not prevent patients being offered earlier appointment dates. Patients refusing short notice appointments (i.e. less than three weeks' notice) will not have their waiting time reset, in line with guidance on reasonable offers.

3.5.5 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

3.6 BOOKING

3.6.1 All new and review consultant led outpatient clinics should be able to book their appointment. This will entail patients having an opportunity to contact the hospital and agree a convenient date and time for their appointment. The use of the Patient Choice field on PAS is mandatory. The only fields that should be used are 'Y' to indicate that the appointment has been booked or 'N' to indicate that an appointment has not been booked. No other available field should be used as compliance with booking requirements will be monitored via the use of the Patient Choice field. For non-ISOFT and manual administration systems, Trusts should ensure that they are able to record and report patients who have been booked.

3.7 REASONABLE OFFERS

3.7.1 For patients who have been able to book their appointment, a reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

3.7.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

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

3.7.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3.**

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

3.8.1 If a patient DNAs their outpatient appointment, the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

3.8.2 There may be instances for review patients where the clinician may wish to review notes prior to any action to remove a patient because of DNA or failure to respond to partial booking invitation letters. Trusts should ensure that robust and locally agreed rules and processes are in place so that booking clerks are clear about how to administer these patients.

3.8.3 In a transition period where fixed appointments are still being issued, patients should have two opportunities to attend.

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

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.

- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

3.8.5 Following discharge, patients will be added to the waiting list at the written request of the referring GP and within a four week period from the date of discharge. Patients should be added to the waiting list at the date the written request is received.

3.8.6 The Implementation Procedure on DNAs and Cancellations can be found in **Appendix 4.**

3.9 MAXIMUM WAITING TIME GUARANTEE

3.9.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their GP when they are ready to be seen in the Outpatient Clinic. This will ensure that all patients waiting for an outpatient appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

3.10 COMPLIANCE WITH LEAVE PROTOCOL

3.10.1 Capacity lost due to cancelled or reduced clinics at short notice has negative consequences for patients and on the Trust's ability to successfully

implement booking processes. Clinic cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

3.10.2 It is essential that planned medical and other clinical leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments. There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.

3.10.3 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed HR policies.

3.10.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit. The Implementation Procedure for Compliance with Leave Protocol can be found in **Appendix 10.**

3.11 CLINIC OUTCOME MANAGEMENT

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

3.11.2 All patients will have their attendance registered on PAS upon arrival in the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS and the medical records.

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

3.11.4 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic. The implementation procedure for the Management of Clinic Outcomes can be found in **Appendix 11.**

3.12 REVIEW APPOINTMENTS

3.12.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the consultant. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative month of treatment and take the necessary action to ensure capacity is available for this cohort.

3.12.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the department and PAS updated. Patients requiring an appointment outside six weeks will be placed on a review waiting list, with the indicative appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

3.13 CLINIC TEMPLATE CHANGES

3.13.1 Clinic templates should be agreed between the consultant and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement and ensure that there is sufficient capacity allocated to enable each appointment type to be booked in line with clinical requirements and maximum waiting time guarantees for patients.

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

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

3.13.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for the management of Clinic Template Changes can be found in **Appendix 5.**

3.14 VALIDATION

3.14.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a weekly basis and continually reviewed as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times. The Implementation Guidance for Data Validation can be found in **Appendix 6.**

3.14.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

3.14.3 For patients in specialties that are not yet booked, they will be contacted to establish whether they will still require their appointment.

3.15 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

3.15.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to Independent Sector Providers. Transfers should not be a feature of an effective scheduled system.

3.15.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly. The Implementation Procedure and Technical Guidance for Handling Outpatient Transfers can be found in **Appendix 15a.**

SECTION 4

PROTOCOL GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

4.1 INTRODUCTION

4.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of diagnostic waiting lists. Where possible, the principles of good practice outlined in the Outpatient and Elective Admissions Section of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.

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

4.1.3 There will be a centralised registration process within Trusts to receive, register and process all diagnostic referrals. It is expected that this will be in a single location, where possible.

4.1.4 The Trust should work towards introducing choice of the date and time of tests to all patients. The Booking Principles outlined in Section 1 of this document should be considered in the development of this strategy.

4.2 CALCULATION OF THE WAITING TIME

4.2.1 The starting point for the waiting time of a request for a diagnostic test is the date the clinician's request is received into the department, in line with the guidance on Completing Diagnostic Waiting Times Collection (Definitions Document), September 2007. This can be found in **Appendix 14.** All referral letters and requests, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received.

4.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the service was informed of the cancellation.

4.2.3 Patients who refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

4.2.4 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

4.3 KEY PRINCIPLES

4.3.1 Trusts must have in place arrangements for pooling all referrals unless there is specific clinical information which determines that the patient should be seen by a particular consultant with sub-specialty interest.

4.3.2 All diagnostic requests, appointments and waiting lists should be managed according to clinical priority. A clinical priority must be identified for each patient on a waiting list, and patients managed in 2 streams, i.e. urgent and routine. Session or clinic templates should be constructed to ensure enough capacity is available to treat each stream within the maximum waiting time guarantees outlined in Section 1.4. Maximum waiting times for urgent patients should be agreed locally with clinicians.

4.3.3 Data collection should be accurate, timely, complete and subject to regular audit and validation.

4.3.4 Staff should be supported by appropriate training programmes.

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

4.4 NEW DIAGNOSTIC REQUESTS

4.4.1 All diagnostic requests sent to Trusts will be received at a single location within the specialty Department. Trusts should explore the setting of one centralised diagnostic registration centre.

4.4.2 All requests will be registered on PAS / relevant IT system within one working day of receipt. Only authorised staff will have the ability to add, change or remove information in the outpatient module of PAS or other diagnostic system.

4.4.3 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system and that letters sent for prioritisation and not returned can be identified. Trusts should consider the introduction of clinical tracking systems similar to that used in patient chart tracking.

4.4.4 All requests must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for requests to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.

4.4.5 All requests will be prioritised and returned to the central registration point within 3 working days. It will be the responsibility of the health records manager or departmental manager to monitor this performance indicator. Monitoring on a consultant level will take place by consultant on a monthly basis. Following prioritisation, requests must be actioned on PAS / IT system and appropriate correspondence issued to patients within 1 working day.

4.4.6 Where clinics take place, or requests can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby the GP's priority is accepted in order to proceed with booking urgent patients.

4.4.7 Inappropriate and inadequate requests should be returned to the referral source. Minimum referral criteria is being developed to ensure the referral process is robust.

4.5 URGENT AND ROUTINE APPOINTMENTS

4.5.1 All requests must be booked within the maximum waiting time guarantee. The key requirement is that the patient is directly involved in negotiating the date and time of the appointment and that no appointment is made more than six weeks in advance.

4.5.2 Urgent requests must be booked within locally agreed maximum waits from the date of receipt. It is recognised that there will be exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.

4.5.3 All routine patients must be booked within the maximum waiting time guarantee. Acknowledgement letters will be issued to routine patients within 5 working days of receipt of request. The estimated wait, along with information on how the patients will be booked should be included on the acknowledgement letter.

4.5.4 A minimum of three weeks notice should be provided for all routine patients. This does not prevent patients being offered earlier appointment dates. Patients who refuse short notice appointments (i.e. less than three weeks notice) will not have their waiting time reset in line with guidance on reasonable offers.

4.5.5 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

4.6 CHRONOLOGICAL MANAGEMENT

4.6.1 Patients of equal clinical priority will be selected for appointment in chronological order and Trusts must ensure that regional standards and targets in relation to waiting times and booking requirements are met. The process of selecting patients for diagnostic investigations is a complex activity. It entails balancing the needs and priorities of the patient and the Trust against the available resources.

4.6.2 It is expected that Trusts will use two prioritisation categories; urgent and routine.

4.7 BOOKING METHODS

4.7.1 Booking will enable patients to have an opportunity to contact the service and agree a convenient time for their appointment. As outlined in paragraph 4.1.4, booking strategies should be developed in line with these Booking Principles. In the interim period, while fixed appointments are being issued, Trusts should ensure that the regional guidance is followed in the management of patients.

4.8 REASONABLE OFFERS

4.8.1 For patients who have been able to book their appointment, a reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

4.8.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

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

4.8.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3.**

4.9 PATIENT CANCELLATIONS (CNAS) AND DID NOT ATTENDS (DNAS)

4.9.1 If a patient DNAs their diagnostic test, the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.
- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

4.9.2 There may be instances for follow-up patients where the clinician may wish to review notes prior to any action to remove a patient because of DNA or failure to respond to booking invitation letters. Trusts should ensure that robust and locally agreed rules and processes are in place so that booking clerks are clear about how to administer these patients.

4.9.3 In a transition period where fixed appointments are still being issued, patients should have two opportunities to attend.

4.9.4 If a patient cancels their appointment, the following process must be implemented.

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.
- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

4.9.5 Following discharge, patients will be added to the waiting list at the written request of the referring GP and within a four week period from the date of discharge. Patients should be added to the waiting list at the date the written request is received.

4.10 TRANSFERS BETWEEN HOSPITALS

4.10.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals. Transfers should not be a feature of an effective scheduled system.

4.10.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly.

4.11 COMPLIANCE WITH TRUST LEAVE PROTOCOL

4.11.1 One of the major issues regarding the operation of healthcare services is the capacity lost due to cancelled or reduced clinics at short notice. This has negative consequences for patients and on the ability to successfully implement booking requirements. Clinic or session cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

4.11.2 It is therefore essential that leave/absence is organised in line with the Trust's Human Resources leave protocol. It is necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of diagnostic sessions and the work associated with the rebooking of appointments. Where cancelling and rebooking is unavoidable the procedures used must be equitable and comply with clinical governance principles.

4.11.3 The local absence/leave protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed policies.

4.11.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

4.12 SESSION OUTCOME MANAGEMENT

4.12.1 There are a number of locations within Trusts where patients present for their diagnostic tests. This protocol applies to all diagnostic services. It is the responsibility of the PAS / relevant system user administrating the clinic to maintain data quality.

4.12.2 All patients will have their attendance registered on PAS / IT system upon arrival at the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS / IT system and the medical record.

4.12.3 Changes in the patient's details must be updated on PAS / IT system and the medical record on the date of clinic.

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

4.13.1 DIAGNOSTIC TEST OUTCOME

4.13.1 The outcome of the diagnostic test must be available to the referrer without undue delay. A standard for the reporting turnaround time of tests will be introduced during 2008 and Trusts will be expected to monitor and report compliance to the standard.

4.14 FOLLOW UP APPOINTMENTS

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

4.14.2 Where follow up appointments are not booked, patients who require a review within six weeks will negotiate the date and time of this appointment before leaving the department and PAS / IT system updated. Patients requiring an appointment outside six weeks will have their appointment managed through a 'hold and treat' system. They will be managed on a review waiting list, with an indicative date of treatment and sent a letter confirming their appointment date six weeks in advance.

4.15 TEMPLATE CHANGES

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

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

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

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

4.16 VALIDATION

4.16.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times.

4.16.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

4.16.3 For patients in specialties which still issue fixed appointments, they will be contacted to establish whether they require their appointment.

4.16.4 Until follow-up and planned appointments are booked, the validation process will apply to follow up appointments.

4.17 PLANNED PATIENTS AND DIAGNOSTICS TESTS CLASSIFIED AS DAY CASES

4.17.1 Trusts should ensure that the relevant standards in the Elective Admissions section of this document are adhered to.

4.18 PLANNED PATIENTS

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

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

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

4.19 HOSPITAL INITIATED CANCELLATIONS

4.19.1 No patent should have his or her admission cancelled. If Trusts cancel a patient's admission, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity, which should must be within the maximum waiting time guarantee.

4.19.2 Trusts should aim to have processes in place to have the new proposed admission date arranged before that patient is informed of the cancellation.

4.19.3 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.

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

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

4.19.6 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment as a result of hospital initiated reasons, i.e. equipment failure, a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

4.20 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

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

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

4.20.3 Where a patient requires more than one test carried out on separate occasions by different (or the same) clinician, the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.

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

SECTION 5

GUIDANCE FOR MANAGEMENT OF ALLIED HEALTH PROFESSIONAL (AHP) SERVICES

5.1 INTRODUCTION

5.1.1 Allied Health Professionals work with all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors. This guidance provides an administrative framework to support the management of patients waiting for AHP services.

5.1.2 Although it is written primarily for services provided in Trusts, it is recognised that there are a number of AHPs who provide services for children with physical and learning disabilities within special schools and with special educational needs within mainstream schools. Operational practices in these settings should be in line with the principles of the IEAP and provide consistency and equity for patients. Trusts should collaborate with colleagues within the Department of Education and the relevant schools to harmonise practices and ensure that children are able to access services equitably and within the maximum waiting time guarantees. A robust monitoring process will be required.

5.1.3 For the purposes of this section of the protocol, the generic term 'clinic' will be used to reflect AHP activity undertaken in hospital, community or domiciliary settings as it is recognised that AHPs provide patient care in a variety of care locations.

5.2 KEY PRINCIPLES

5.2.1 Trusts should ensure that there is a systematic approach to modernising AHP services which will help to improve access to services and quality of care for patients. This section should be read within the overall context of both the IEAP and the specific section governing the management of hospital outpatient services.

5.2.2 When looking at the experience of the patient it is important to consider the whole of their journey, with both the care and administrative pathways designed to support the patient's needs at each stage. The wait to receive outpatient therapy is likely to be one of many they experience in different parts of the system. It is the responsibility of all those involved to ensure that the patient wastes as little time as possible waiting and is seen by the right person as quickly as possible.

5.2.3 Booking will enable patients to have an opportunity to contact the hospital and agree a convenient time for their appointment. As outlined in paragraph 4.1.4, booking strategies should be developed in line with these Booking Principles. In the interim period, while fixed appointments are being issued, Trusts should ensure that the regional guidance is followed in the management of patients.

5.3 CALCULATION OF THE WAITING TIME

5.3.1 The waiting time clock for an AHP referral commences on the date the referral letter is received by the AHP service within the Trust. All referral letters, including faxed, emailed and electronically received referrals, will be date stamped on the date received.

5.3.2 The waiting time clock stops when the first definitive AHP treatment has commenced or when a decision is made that treatment is not required. Further information on definitions and sample patient pathways is contained in the Data Definitions and Guidance Document for AHP Waiting Times and can be found in **Appendix 12.**

5.3.3 As booking systems are introduced, patients should be made a reasonable offer, where clinically possible. Patients who refuse a reasonable offer of treatment, or fail to attend an AHP appointment, will have their waiting time clock re-set to the date the service was informed of the cancellation (CNAs) or the date the patient failed to attend (DNAs).

5.4 NEW REFERRALS

5.4.1 All AHP referrals will be registered on the relevant information system within 1 working day of receipt.

5.4.2 Trusts should work towards a system whereby all AHP referrals sent to the Trust are received at a dedicated registration function (s). Trusts should ensure that adequate systems are in place to deal with multiple referrals for the same patient regarding the same condition from a number of sources.

5.4.3 All referrals must be triaged or assessed to make a clear decision on the next step of a referral and clinical urgency (urgent or routine) clearly identified and recorded. All referrals will be prioritised and returned to the registration point with 3 working days.

5.4.4 Trusts must ensure that protocols are in place to prevent unnecessary delay from date stamping / logging of referrals to forwarding to the AHP department responsible for referral triage and/or initiation of treatment. It will be the responsibility of the relevant manager to monitor this performance indicator.

5.4.5 A robust system should be in place to ensure that cover is provided for referrals to be read and prioritised during practitioners' absence. A designated officer should oversee this and a protocol will be required for each service.

5.4.6 Where referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with AHPs whereby the referrer's prioritisation is accepted in order to proceed with booking patients.

5.4.7 Following prioritisation, referrals must be updated on the relevant information system and appropriate correspondence issued to patients within 1 working day. Where there is insufficient information for the AHP to make a decision, they should contact the originating referrer in the first instance to access the

necessary information. If this cannot be gained, the referral should be returned to the referral source.

5.4.8 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and letters which are not returned can be identified.

5.4.9 If at the referral stage the patient / client is identified as being clinically or socially unfit to receive the necessary service the referral should not be accepted (not added to a waiting list) and returned to the originating referrer with a request that they re-refer the patient / client when they are clinically or socially fit to be treated.

5.5 URGENT AND ROUTINE APPOINTMENTS

5.5.1 All routine patients should be appointed within the maximum waiting time guarantee. Urgent patients must be booked within locally agreed maximum waits from the date of receipt. Local booking process should be based upon the principles outlined in Section 1.7.

5.5.2 For routine waiting list patients, an acknowledgement letter will be sent to patients within 5 working days of receipt of the referral, which should provide information to patients on their anticipated length of wait and details of the booking process.

5.5.3 A minimum of three weeks' notice should be provided for all routine patients. This does not prevent patients being offered an earlier appointment. Patients refusing short notice appointments (i.e. less than three weeks notice) will not have their waiting time clock reset, in line with guidance on reasonable offers.

5.5.4 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

5.6 CHRONOLOGICAL MANAGEMENT

5.6.1 Patients, within each clinical priority category, should be selected for booking in chronological order, i.e. based on the date the referral was received. Trusts should ensure that local administrative systems have the capability and functionality to effectively operate a referral management and booking system that is chronologically based.

5.7 CAPACITY PLANNING AND ESCALATION

5.7.1 It is important for AHP services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.

5.7.2 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.

5.8 REASONABLE OFFERS

5.8.1 As booking systems are introduced, patients should be offered reasonable notice, where clinically possible. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused. To ensure a verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

5.8.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

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

5.8.3 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above.

5.9 AHP SERVICE INITIATED CANCELLATIONS

5.9.1 No patent should have his or her appointment cancelled. If Trusts cancel a patient's appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable appointment date, ideally at the time of cancellation, and no more than 6 weeks in advance. The Trust must ensure that the new appointment date is within the maximum waiting time guarantee.

5.9.2 The patient should be informed of the reason for the cancellation and the date of the new appointment. This should include an explanation and an apology on behalf of the Trust.

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

5.9.4 AHP service initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment as a result of AHP service initiated reasons, i.e. equipment failure, staff sickness, a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

5.10 MAXIMUM WAITING TIME GUARANTEE

5.10.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their referrer when they are ready to be seen. This will ensure that all patients waiting for an AHP appointment / treatment are fit and ready to be seen.

5.10.2 There will undoubtedly be occasions and instances where local discretion is required and sensitivity should be applied when short periods of time are involved; for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

5.11 COMPLIANCE WITH LEAVE PROTOCOL

5.11.1 Capacity lost due to cancelled or reduced clinics or visits at short notice has negative consequences for patients and on the Trust's ability to successfully implement robust booking processes. Clinic cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

5.11.2 It is therefore essential that AHP practitioners and other clinical planned leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of AHP clinics and the work associated with rebooking patient appointments. There should be clear practitioner agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient and comply with clinical governance principles.

5.11.3 The protocol should require a minimum of six weeks' notification of planned leave, in line with locally agreed HR policies.

5.11.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

5.12 CLINIC OUTCOME MANAGEMENT

5.12.1 All patients will have their attendance recorded or registered on the relevant information system upon arrival for their appointment. The patient must verify their demographic details on every visit. The verified information must be cross-checked on information system and the patient records. Any changes must be recorded and updated in the patient record on the date of the clinic.

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

5.13 REVIEW APPOINTMENTS

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

5.13.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the service and PAS / information system updated. Patients requiring an appointment outside six weeks should be managed on a review waiting list, with the indicative date recorded when appointment is required and booked in line with the booking principles outlined.

5.13.3 If domiciliary review appointment is required within 6 weeks, the appointment date should be agreed with the patient and confirmed in writing by the booking office. Where a domiciliary review appointment is required outside 6 weeks, the patient should be managed on a review waiting list, within the indicative date recorded, and booking in line with the booking principles outlined.

5.14 CLINIC TEMPLATE MANAGEMENT

5.14.1 Clinic templates should be agreed between the practitioner and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

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

5.14.3 All requests for template and temporary clinic rule changes will only be accepted in writing to the relevant service manager. A minimum of six weeks notice will be provided for clinic template changes.

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

5.15 ROBUSTNESS OF DATA / VALIDATION

5.15.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a weekly basis and continually reviewed as waiting times reduce. This is essential to ensure Primary Targeting Lists are accurate and robust at all times.

5.15.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

5.15.3 For patients in AHP services that are not yet booked, they will be contacted to establish whether they will still require their appointment.

SECTION 6 PROTOCOL GUIDANCE FOR MANAGEMENT OF ELECTIVE ADMISSIONS

6.1 INTRODUCTION

6.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of elective waiting lists.

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

6.2 COMPUTER SYSTEMS

6.2.1 To ensure consistency and the standardisation of reporting with Commissioners and the Department, all waiting lists are to be maintained in the PAS system.

6.2.2 Details of patients must be entered on to the computer system within two working days of the decision to admit being made. Failure to do this will lead to incorrect assessment of waiting list size when the daily / weekly downloads are taken.

6.2.3 As a minimum 3 digit OPCS codes should be included when adding a patient to a waiting list. Trusts should work towards expanding this to 4 digit codes.

6.3 CALCULATION OF THE WAITING TIME

6.3.1 The starting point for the waiting time of an inpatient is the date the consultant agrees with the patient that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is medically fit to undergo such a procedure.

6.3.2 The waiting time for each inpatient on the elective admission list is calculated as the time period between the original decision to admit date and the date

at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

6.3.3 Patients who refuse a reasonable offer of treatment, or fail to attend an offer of admission, will have their waiting time reset to the date the hospital was informed of the cancellation (CNAs) or the date the patient failed to attend (DNAs). Any periods of suspension are subtracted from the patients overall waiting time.

6.4 STRUCTURE OF WAITING LISTS

6.4.1 To aid both the clinical and administrative management of the waiting list, lists should be sub-divided into a limited number of smaller lists, differentiating between active waiting lists, planned lists and suspended patients.

6.4.2 Priorities must be identified for each patient on the active waiting list, allocated according to urgency of the treatment. The current priorities are urgent and routine.

6.5 INPATIENT AND DAY CASE ACTIVE WAITING LISTS

6.5.1 Inpatient care should be the exception in the majority of elective procedures. Trusts should move away from initially asking “is this patient suitable for day case treatment?” towards a default position where they ask “what is the justification for admitting this patient?” The Trust’s systems, processes and physical space should be redesigned and organized on this basis.

6.5.2 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient they are fit, ready, and able to come in.

6.5.3 All decisions to admit will be recorded on PAS within two working days of the decision to admit being taken.

6.5.4 Robust booking and scheduling systems will be developed to support patients having a say in the date and time of their admission. Further guidance will be provided on this.

6.5.5 Where a decision to admit depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure the result of the investigation is timely and in accordance with the clinical urgency required to admit the patient.

6.5.6 The statements above apply to all decisions to admit, irrespective of the decision route, i.e. direct access patients or decisions to directly list patients without outpatient consultation.

6.6 COMPLIANCE WITH TRUST HR LEAVE PROTOCOL

6.6.1 Trusts should have in place a robust protocol for the notification and management of medical and clinical leave and other absence. This protocol should include a proforma for completion by or on behalf of the consultant with a clear process for notifying the theatre scheduler of leave / absence.

6.6.2 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed consultant's contracts.

6.6.3 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

6.7 TO COME IN (TCI) OFFERS OF TREATMENT

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

6.7.2 Patients should be made reasonable offers to come in on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.

6.7.3 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of admission, irrespective of provider, that gives the patient a minimum of three weeks' notice and two TCI dates. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the refused admission.

6.7.4 If the patient is offered an admission within a shorter notice period and it is refused, the waiting time cannot be recalculated.

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

6.7.6 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above.

6.8 SUSPENDED PATIENTS

6.8.1 A period of suspension is defined as:

- A patient suspended from the active waiting list for medical reasons, or unavailable for admission for a specified period because of family commitments, holidays, or other reasons i.e. a patient may be suspended during any periods when they are unavailable for treatment for social or

medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc).

- A maximum period not exceeding 3 months.

6.8.2 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or social reasons. These patients should be suspended from the active waiting list until they are ready for admission. All patients who require a period of suspension will have a personal treatment plan agreed by the consultant with relevant healthcare professionals. One month prior to the end of the suspension period, these plans should be reviewed and actions taken to review patients where required.

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

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

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

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

6.8.7 No patient should be suspended from the waiting list without a review date. All review dates must be 1st of the month to allow sufficient time for the patient to be treated in-month to avoid breaching waiting times targets.

6.8.8 No more than 5% of patients should be suspended from the waiting list at any time. This indicator should be regularly monitored.

6.8.9 Trusts should ensure that due regard is given to the guidance on reasonableness in their management of suspended patients.

6.9 PLANNED PATIENTS

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

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

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

6.9.4 Ideally, children should be kept under outpatient review and only listed when they reach an age when they are ready for surgery. However, where a child has been added to a list with explicit clinical instructions that they cannot have surgery until they reach the optimum age, this patient can be classed as planned. The Implementation Procedure for Planned Patients can be found in **Appendix 13.**

6.10 CANCELLATIONS AND DNA'S

6.10.1 Patient Initiated Cancellations

Patients who cancel a reasonable offer will be given a second opportunity to book an admission, which should be within six weeks of the original admission date. If a second admission offer is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

6.10.2 Patients who DNA

If a patient DNAs their first admission date, the following process must be implemented:

- Where a patient has had an opportunity to agree the date and time of their admission, they will not normally be offered a second admission date.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second admission. The second admission date must be agreed with the patient.

6.10.3 In a period of transition where fixed TCIs are still being issued, patients should have two opportunities to attend.

6.10.4 Following discharge patients will be added to the waiting list at the written request of the referring GP and within a four week period from date of discharge. Patients should be added to the waiting list at the date of the written request is received.

6.10.5 It is acknowledged that there may be exceptional circumstances for those patients identified as being 'at risk' (children, vulnerable adults).

6.10.6 No patient should have his or her operation cancelled prior to admission. If Trusts cancel a patient's admission/operation in advance of the anticipated TCI date, the waiting time clock (based on the original date to admit) will not be reset and the patient will be offered an alternative reasonable guaranteed future date within a maximum of 28 days.

6.10.7 Trusts should aim to have processes in place to have the new proposed admission date arranged before the patient is informed of the cancellation.

6.10.8 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.

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

6.10.10 Where patients are cancelled on the day of surgery as a result of not being fit for surgery / high anaesthetic risk, they will be suspended, pending a clinical review of their condition either by the consultant in outpatients or by their GP. The patient should be fully informed of this process.

6.10.11 Hospital-initiated cancellations will be recorded and reported to the relevant department on a monthly basis.

6.11 PERSONAL TREATMENT PLAN

6.11.1 A personal treatment plan must be put in place when a confirmed TCI date has been cancelled by the hospital, a patient has been suspended or is simply a potential breach. The plan should:

- Be agreed with the patient
- Be recorded in the patient's notes
- Be monitored by the appropriate person responsible for ensuring that the treatment plan is delivered.

6.11.2 The listing clinician will be responsible for implementing the personal treatment plan.

6.12 CHRONOLOGICAL MANAGEMENT

6.12.1 The process of selecting patients for admission and subsequent treatment is a complex activity. It entails balancing the needs and priorities of the patient and the Trust against the available resources of theatre time and staffed beds.

6.12.2 The Booking Principles outlined in Section 1.7 should underpin the development of booking systems to ensure a system of management and monitoring that is chronologically as opposed to statistically based.

6.12.3 It is expected that Trusts will work towards reducing the number of prioritisation categories to urgent and routine.

6.13 PRE-OPERATIVE ASSESSMENT

6.13.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-operative assessment. This can be provided using a variety of methods including telephone, postal or face to face assessment. Please refer to the Design and Deliver Guide 2007 for further reference.

6.13.2 Pre operative assessment will include an anaesthetic assessment. It will be the responsibility of the pre-operative assessment team, in accordance with protocols developed by surgeons and anaesthetists, to authorise fitness for surgery.

6.13.3 If a patient is unfit for their operation, their date will be cancelled and decision taken as to the appropriate next action.

6.13.4 Only those patients that are deemed fit for surgery may be offered a firm TCI date.

6.13.5 Pre-operative services should be supported by a robust booking system.

6.14 PATIENTS WHO DNA THEIR PRE OPERATIVE ASSESSMENT

6.14.1 Please refer to the guidance outlined in the Outpatient section.

6.15 VALIDATION OF WAITING LISTS

6.15.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis, and ideally on a weekly basis as waiting times reduce. This is essential to ensure the efficiency of the elective pathway at all times.

6.15.2 As booking processes are implemented and waiting times reduce, there will no longer be the need to validate patients by letter. For patients in specialties that are not yet booked, they will be contacted to establish whether they will still require their admission.

6.15.3 Involvement of clinicians in the validation process is essential to ensure that waiting lists are robust from a clinical perspective. Trusts should ensure an ongoing process of clinical validation and audit is in place.

6.16 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

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

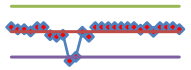
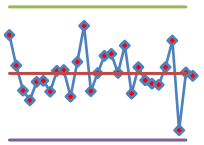
6.16.2 Where different clinicians working together will perform more than one procedure at one time the patient should be added to the waiting list of the clinician for the priority procedure with additional clinician procedures noted.

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

6.17 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

6.17.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to Independent Sector Providers. Transfers should not be a feature of an effective scheduled system.

6.17.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly. The Implementation Procedure and Technical Guidance for Handling Inpatient Transfers can be found in **Appendix 15b.**

Themes	Directorate	Title	OGI	Baseline (2017/18)	OGI (2018/19)	Cumulative 2018/19 Performance	Trend Graph	TDP assessment	Cumulative 2019/20 Performance	Narrative
Cancer	**ASD**	**Cancer Pathway (31 days)**	During 2018/2019, at least 98% of patients diagnosed with cancer should receive their 1st treatment within 31-days of a decision to treat.	97.0%	98%	99.5%		**Amber**	**99.8%**	Cumulatively at the end of July 2019 there has been 1 breach against the 31-day pathway target within skin cancer which was impacted by surgical capacity.
Cancer	**ASD**	**Cancer Pathway (62 days)**	During 2018/2019, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62-days.	74.3%	95%	74.4%		**Red**	**72.1%**	During 2019/2020 as at July 2019, 99 patients have waited more than 62-days to commence their first treatment with the majority of breaches occurring within Urology. The longest completed wait was a Urology patient at 328 days. Reasons for breaches include insufficient capacity for assessment, delays to diagnostics tests and referrals between Trusts as well as complex diagnostic pathways. Average Regional performance is 54%. Further detailed analysis is being undertaken to explore capacity and demand.
Z Trajectory - Non-OGI	**ASD**	**Cancer 62-Day (Summary)**	**NON-OGI Summary Trajectory**: At least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62-days	74.3%	2019/2020 Operational Trajectory 56.4%	74.4%		**NON-OGI**	**72.1%**	Cumulative performance at July 2019 is 72.1% is +16% above the projected 2019/2020 end of year performance of 56.4%.
ZS Trajectory - Non-OGI	**ASD**	**Urology (Inpatient/Day Case) (Sub-Specialty)**	**NON-OGI** Reduce the percentage of funded activity associated with elective care services that remains undelivered.	4,694 Variance 12%	2019/2020 Trajectory volume 4,501	4,717		**NON-OGI**	**1,653**	At the end of July 2019, there was a +21% variance in the cumulative performance against trajectory volume
ZS Trajectory - Non-OGI	**NON-OGI**	**Urology (New Outpatient) (Sub-Specialty)**	**NON-OGI** Reduce the percentage of funded activity associated with elective care services that remains undelivered	3,797 Variance 6%	2019/2020 Operational Trajectory 3,866	3,841		**NON-OGI**	**1,060**	At the end of July 2019, there was -13% variance in the cumulative performance against trajectory volume. Significant underperformance was demonstrated in May and June. A Consultant vacancy from the end of April with no locum cover to be in place until late July 2019 and the reduction of some OPD sessions to ensure all IPDC theatre sessions are fully utilised have contributed to underperformance. Performance against the trajectory improved again in July, however, the service advise that it is likely to be October before this is back on track.

Southern Health and Social Care Trust

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BOARD REPORT SUMMARY SHEET

Meeting: **Date:**	SMT 17 September 2019
Title:	Monthly Corporate Performance Scorecard
Lead Director:	Aldrina Magwood, Director of Performance and Reform
Purpose:	For Approval

Key Strategic Aims:

- To provide information to the Trust Board in exercising its function of overseeing the delivery of planned results by monitoring performance against objectives and ensuring corrective actions are taken when necessary within agreed timelines.

Key Issues/Risks for Discussion

- **Draft Commissioning Plan**: The Trusts response to the Health and Social Care Board's draft Commissioning Plan for 2019/2020, the Trust Delivery Plan (TDP), has been drafted. This makes an indicative assessment of the anticipated level of performance that can be achieved against each Objective and Goal for Improvement (OGI). This includes 6 new objectives;

  - 1.7 - implementation of a regional prototype bariatric service,
  - 1.11- establishment of an Infant Mental Health Group and Action Plan consistent with the "Infant Mental Health Framework for Northern Ireland" 2016.
  - 4.3 – reduction in the number of unallocated family and children's social care cases by 20%.
  - 8.1- Contribution to delivery of Phase One of the single lead employer project by 31 July 2019
  - 8.8 - Review of the social work workforce will be progressed to inform future supply needs and commissioning of professional training (subject to resource availability).
  - 8.10 – Improvement in the take up in annual appraisal of performance during 2019/20 by 5% on previous year towards meeting existing targets (95% of medical staff and 80% of other staff).

- In the interim the Trust continues to report on the 2018/2019 OGIs.The **Corporate Performance Scorecard** attached provides a summary of actual performance against all OGIs and key Performance Improvement Trajectories (PITs), which now form part of new HSC performance management arrangements. Whilst the scorecard includes an assessment of actual performance against the objective sought on a Red, Amber and Green (RAG) basis to inform performance against targets, the performance trends are also included.

- **Key Risks** continue to relate to the challenges of increasing demand against capacity; the available capacity to meet red flag/urgent and unscheduled demands in a timely manner; and challenges in the ability to recruit and retain sufficient skilled workforce to ensure the provision of core service delivery.

  Key areas for focus include:

- 62-Day Cancer pathway;
- Diagnostic Services which support unscheduled; red flag/urgent and routine clinical pathways;
- Unscheduled care pathway considering pressures within GP OOHs; Emergency Department; and delayed complex discharges;
- Length of time patients are waiting beyond their clinically indicated timescale for review or repeat procedure; and
- Wait times for first assessment within Mental Health services.

- Key areas of statistical change on the corporate scorecard include:

  - **Imaging - Plain Film Reporting (Row 10)** –less unreported plain films were reported in the September snapshot position, 4,789 compared to 5,153 in mid-August; longest waiting chest x-ray unreported improved t0 33-days compared to 42-days at the last snapshot;
  - **In-Patients/Day Cases <13-weeks (Row 19) –** the % of patients that are waiting less than 13 weeks for treatment is reducing with 70% of patients on waiting lists now waiting more than 13 weeks.
  - **Out-Patients >52-weeks (Row 22)** – the volume of patients waiting over 52 weeks for first outpatient assessment at August 2019 (10,575) demonstrates +2,061 increase in patients >52-weeks in comparison to March 2019;
  - **Psychological Therapies (Row 28)** – the volume of patients waiting over 13 weeks for their first psychological therapies assessment has decreased for two consecutive months for the first time in over one year (July &August 2019) and whilst this is not a trend this is welcomed;
  - **Anti-Biotic Prescribing (Rows 36 to 38)** – August 2019 demonstrates continuing reduction in use of antibiotics, particularly Carbapenem, in comparison to March 2019. Use of WHO antibiotics from the Access Aware categories has also improved;
  - **Out-Patient Review Backlog (Row 45)** – August 2019 (29,111) demonstrates +4,274 increase in patients waiting beyond their clinically indicated timescale for review in comparison to March 2019 (24,837)
  - **Planned Backlog (Rows 47 and 48)** – August 2019 (2,285) demonstrates +163 increase in patients waiting beyond their clinically indicated timescale for repeat procedure in comparison to March 2019 (2,122).
  - **Complex Discharges >7-Days (Row 57)** – August 2019 (27) demonstrates an increase in patients that remained in acute hospital bed for more than 7-days after being identified as medical fit for discharge in comparison to July 2019 (16) reflecting complexity and challenges with discharge of those with complex issues.
  - **Non-Complex Discharges (Row 58**) – August 2019 (90.9%) also reflected a -1.4% reduction in the percentage of non complex patients discharged within 6 hours of being deemed medically fit, and demonstrates variation close to the lower control limit (LCL).

- Risks are managed in line with the Performance Management Framework

Summary of SMT Discussion:

- Assurance re escalation arrangements for surge management in Emergency Department and continued focus on unscheduled care with assurance regarding on-going work for resilience planning including the review of Regional learning;
- Assurance regarding direction of capacity to Red Flag and Urgent demand, in the first instance, in light of on-going reduced core and additional capacity;
- Assurance regarding tracking/monitoring and management of patients on the cancer pathway, including ongoing review of exception waits at an individual patient and tumour site level, to optimise journey times and reduce waits;
- Review of impact of reduced uptake of additional sessions to facilitate increased capacity by

clinical staff;
- Focus on actions to manage and stratify any emergent risk in caseloads/reviews for patients waiting to be seen beyond clinically indicated timescales and actions to improve via development of Review Improvement plans; this area is identified on the corporate risk register, and
- Development of Diagnostic Improvement plans.

Human Rights/Equality:

The equality implications of actions taken are considered and equality screening is carried out on individual actions as appropriate.

Equality screening and rural proofing to be undertaken on all transformational schemes in line with IPT processes.

20190913
Q12.103 A3

From: Leeman, Lesley [redacted]
Sent: 13 September 2019 22:00
To: Carroll, Ronan; McVey, Anne; Conway, Barry; Boyce, Tracey; Carroll, Anita
Cc: Lappin, Lynn; McClements, Melanie
Subject: FW: SMT - Monthly peformance Report
Attachments: 20190913_CorporateCPDScorecard(AugustforSeptember)SMT_V2.xlsx; 20190913_PerformanceScorecardCoversheetSMT_AugustforSeptember_V0_2.docx

See attached monthly performance report issued to SMT. Fyi note the following areas in report which you might want to validate and provide update to Melanie on prior to Trust Board meeting

62 day cancer pathway reporting 328 day urology wait
Planned patient backlogs reflect Aug 16 for urol/cardiology and October 16 for endoscopy
Hips low in June (9 breaches – Friday Sat admissions mainly)
Cancer tumour sites reported for first time – red area gynae, head and neck, other and upper GI – some low volumes

Lesley

Lesley Leeman
Assistant Director Performance Improvement
Southern Health and Social Care Trust
68 Lurgan Road Portadown Craigavon Co Armagh BT63 5QQ

[redacted]
Directline: [redacted]
Mobile: [redacted]

From: Leeman, Lesley
Sent: 13 September 2019 21:55
To: Devlin, Shane; Magwood, Aldrina; Trouton, Heather; O'Neill, Helen; Toal, Vivienne; Morgan, Paul; McClements, Melanie; Beattie, Brian; McNeany, Barney; OKane, Maria [redacted]
Cc: Wright, Elaine; PADirectorofP&RSHSCT; Willis, Lisa; Gilmore, Sandra; Trouton, Heather; Alexander, Ruth; Stinson, Emma M; Taylor, Karen; Griffin, Tracy; Weir, Lauren; Rutherford, Alison; McKimm, Jane; Lappin, Lynn; Brodison, Julie; Murphy, Elaine; Judt, Sandra; McCormick, Susan
Subject: SMT - Monthly peformance Report

See attached corporate scorecard and cover page for monthly performance report for your review at SMT; this has not been uploaded to minute pad

Note the scorecard includes reporting for trajectories at tumour site level for the first month ; note only summary level information is shared with Board members

Any comments or amendments to Lynn Lappin Head of Performance by close of play Thursday please to facilitate finalisation for distribution

Regards
Lesley

Lesley

Lesley Leeman
Assistant Director Performance Improvement
Southern Health and Social Care Trust
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Personal Information redacted by the USI

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

Southern Health and Social Care Trust

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SMT COVER SHEET

Meeting/Date	SMT Tuesday, 28 June 2022	
Accountable Director	Lesley Leeman Interim Director of Performance and Reform	
Title	Non-Recurrent Funding 2022/2023 Elective 'Waiting List Initiative' Additionality	
Report Author	Name	Lynn Lappin
	Contact details	[redacted]
This paper is presented for: *Approval*		

Links to Trust Corporate Objectives	√	Promoting Safe, High Quality Care
	√	Supporting people to live long, healthy active lives
	√	Improving our services
	√	Making best use of our resources
	√	Being a great place to work – supporting, developing and valuing our staff
	√	Working in partnership

This report cover sheet has been prepared by the Accountable Director.

Its purpose is to provide SMT with a clear summary of the paper being presented, with the key matters for attention and the ask of SMT.

It details how it impacts on the people we serve.

Context

- In 2021/2022 the Southern Trust was allocated £9,584,356 non-recurrently for spend related to additional elective activity; provided in-house, via predominantly 'waiting list initiative' sessions and purchased in the independent sector.
- At year end the actual spend equated to £9,271,807 leaving an underspend of £313,174.
- New principles for the management of Elective Funding have been issued by SPPG (24 June 2022) which require robust management of the provision of planned activity against spend.
  - If the DoH's (SPPG) assessment is that the Trust should have had plans in place to deliver the agreed activity but a **lower level of activity has been delivered, an amount at least equal to the non-pay element of the marginal cost will be retracted for reallocation.**
  - Consideration will also be given to retraction of elements of the pay budget.
  - In certain circumstances **where activity is assessed as significantly below agreed plans the full marginal cost may be retracted**. This will be agreed and discussed with Trust Officers. It is accepted that in some circumstances this may create a deficit issue for the Trust which will require management, however it is expected that these circumstances will be exceptional.
- It is of note that the Performance Team had to manage the veering and movement of circa £8,000,000 from the original purpose of allocation to alternative use in liaison with Operational leads. The year-end information graphic is attached for your information.
- SPPG have confirmed that for Q1/2 we are to work within the same funding envelope as Q1/2 in 2021/2022. Elective Care Non-Recurrent Funding will be allocated on a quarterly basis circa to the allocation received last.

Bids for 2022/2023

- The current costed bid is £8,245,136.46 (see Appendix 1); this includes the full projected cost of c£1.9m for a regional contract that the Trust is holding for all Trusts to utilise. There is an estimated value of c£1m associated with projected costs for other Trusts included in the £8,2m; any spend against this amount will not be incurred by the Southern Trust.
- The allocation for the Southern Trust for Q1 and Q2 is £4.8m; in keeping with the actual spend in 2021/2022. Therefore at this stage there is a planning gap of c£2.4m where the Trusts bid is above the regional allocation at this stage.
- Operational Teams have front loaded their bids to try and minimise the impact of Winter pressures and to utilise available capacity in the Independent Sector.
- There is potential for a further projected spend of c£1m for additional urology capacity in IS. Again the trust will hold this contract for the region and estimates it will be assigned 60% of the activity. This has not been included in the bid above yet as still subject to costing.

Area of Concern

- The Trust's bid for additional activity to be undertaken in Q1/2 is in excess of our Q1/2 allocation to date by c£2.4m.

  As such the Trust is required to either:

  a. **Re-prioritise the bids received and agree which bids will not proceed; or**
  b. **To proceed at risk on the basis that funding received in Autumn/Winter for Q3/4 can be used to offset this underspend in Q1/2. This is on the assumption that the Trust will receive as a minimum c£10m in total for the year in keeping with 2021/22**

SMT is asked to consider option B above. To proceed at risk to facilitate the Trust working ahead in this Summer period to undertake additional elective activity. This will utilising the secured capacity in the early part of the year

Risk – No funding has been confirm yet for Q3/Q4.

Southern Trust Q1 & Q2 Bid 2022/23 **£8,245,136.46**

APPENDIX 1

									2022/23 Q1 &2 Allocation and Volume		
Directorate	**Division**	**HOS**	**Specialty**	**Appointment Type**	**Activity Type**	**Category**	**Funding Allocation Period**	**Recording Methodology**	**Volume to be delivered (Patients / Sessions)**	**Current Total Funding Allocated**	**Current Cost per Patient**
OPPC	AHP	Mandy Gilmore	Dietetics	AHP	New	Urgent	Q1/2	IHA	200	£73,188.00	£365.94
OPPC	AHP	Mandy Gilmore	Dietetics	AHP	Review	Urgent	Q1/2	IHA	180	£8,089.20	£44.94
CYPS	AHP	Joan McMahon	Dietetics	AHP	New	Urgent	Q1/2	IHA	108	£6,530.76	£60.47
CYPS	AHP	Joan McMahon	Dietetics	AHP	Review	Urgent	Q1/2	IHA	225	£13,605.75	£60.47
ASD	CCS	Denise Newell	CT Colongraphy	Diagnostic	Diagnostic	Red Flag/Urgent	Q1/2	IS	24	£8,400.00	350
ASD	CCS	Denise Newell	CT Cardiac	Diagnostic	Diagnostic	Red Flag/Urgent	Q1/2	IS	77	£36,575.00	475

ASD	CCS	Denise Newell	CT General	Diagnostic	Diagnostic	Red Flag/Urgent	Q1/2	IS	2040	£316,200.00	155
ASD	CCS	Denise Newell	Fluroscopy & MRI (Dual Examination)	Diagnostic	Diagnostic	Urgent	Q1/2	IS	84	£64,680.00	770
ASD	CCS	Denise Newell	MRI	Diagnostic	Diagnostic	Red Flag/Urgent	Q1/2	IS	1600	£480,000.00	300
ASD	CCS	Denise Newell	NOUS - Sonographer/Radiologist Led	Diagnostic	Diagnostic	Red Flag/Urgent	Q1/2	IHA	300	£42,372.00	141.24
ASD	CCS	Clair Quinn	Haematology - Nurse Led	Outpatient	New/Review	Red Flag/Urgent	Q1/2	IHA	60	£9,309.00	155.15
ASD	CCS	Geoff Kennedy	Pathology Sessions	Laboratory	Testing	Red Flag/Urgent	Q1/2	IHA	66	£68,218.92	1033.62
ASD	CCS	Denise Newell	Dexa	Diagnostic	Diagnostic	Routine	Q1/2	IS	915	£128,100.00	140
ASD	CCS	Denise Newell	General CT (Reporting Only MPH)	Diagnostic	Diagnostic	Red Flag/Urgent	Q1/2	IS	600	£31,800.00	53
ASD	CCS	Denise Newell	NOUS (Friends)	Diagnostic	Diagnostic	Red Flag/Urgent	Q1/2	IS	2085	£469,125.00	225
ASD	CCS	Denise Newell	Plain Film Reporting - Reporting Radiographer	Diagnostic	Diagnostic	Urgent	Q1/2	IHA	5100	£34,305.58	6.73

ASD	CCS	Denise Newell	Reassessment of hearing aid plus kit	Outpatient	Review	Urgent	Q1/2	IHA	690	£68,890.77	99.84
ASD	CCS	Denise Newell	CT Scanning & Reporting - DHH Modular Scanner	Diagnostic	Diagnostic	Red Flag/Urgent/Routine	Q1/2		2140	£354,919.00	165.85
ASD	AHP	Denise Newell	Orthoptics	AHP	New		Q1/2	IHA	68	£1,830.64	£26.92
ASD	AHP	Denise Newell	Orthoptics	AHP	Review		Q1/2	IHA	0	£7,291.25	
ASD	IMWH	Wendy Clarke	Truclear Blades for Hysteroscopy	Outpatient	Procedure	Red Flag/Urgent	Q1/2	IHA	102	£58,717.32	575.66
ASD	IMWH	Wendy Clarke	Colposcopy	Outpatient	Procedure	Red Flag/Urgent	Q1/2	IHA	70	£10,860.50	155.15
ASD	IMWH	Wendy Clarke	Gynae	Outpatient	New/Review	Red Flag/Urgent	Q1/2	IHA	68	£10,550.20	155.15
ASD	IMWH	Wendy Clarke	Bulkamid	Outpatient	Procedure	Urgent	Q1/2	IHA	8	£6,420.00	802.5
ASD	IMWH	Wendy Clarke	Botox Injection	Outpatient	Procedure	Urgent	Q1/2	IHA	6	£4,815.00	802.5
OPPC	AHP	Denise Russell	Podiatry	AHP	New	Urgent	Q1/2	IHA	240	£9,024.00	£37.60

OPPC	AHP	Denise Russell	Podiatry	AHP	Review	Urgent	Q1/2	IHA	2100	£78,960.00	£37.60
CYPS	AHP	Hilary McFaul	Speech and Language Therapy - Paediatrics	AHP	Review	Urgent	Q1/2	IHA	340	£17,098.60	£50.29
OPPC	Orthopaedic ICATS	Elaine Mulligan	MSK	Outpatient	New	Urgent	Q1/2		76	£4,568.56	£60.11
ASD	ATICS & SEC	Wendy Clayton	Urology	Outpatient	Review	Red Flag/Urgent	Q1/2	IHA	10	£1,679.90	£167.99
ASD	ATICS & SEC	Wendy Clayton	Urology	Virtual	Review	Red Flag/Urgent	Q1/2	IHA	11	£635.58	£57.78
ASD	ATICS & SEC	Wendy Clayton	ENT	Outpatient	Review	Urgent	Q1/2	IHA	66	£7,697.58	£116.63
ASD	ATICS & SEC	Wendy Clayton	Urology Mega Clinic (Pre Assessment)	Outpatient	New	Urgent	Q1/2	IHA	54	£6,529.14	£120.91
ASD	ATICS & SEC	Wendy Clayton	Regional Urology - Hermitage	Inpatient/Daycase	New	Urgent	Q1/2	IS	150	£0.00	
ASD	ATICS & SEC	Wendy Clayton	Urology - 352	Outpatient	New	Red Flag/Urgent	Q1/2	IS	2400	£570,096.00	£237.54
ASD	ATICS & SEC	Wendy Clayton	Urology Washthrough - 352	Washthrough	Radiology	Washthrough	Q1/2	IS	1600	£248,192.00	£155.12

ASD	ATICS & SEC	Wendy Clayton	Urology Washthrough - 352	Washthrough	Day Case	Washthrough	Q1/2	IS	800	£1,076,024.00	£1,345.03
ASD	ATICS & SEC	Brigeen Kelly	Orthopaedics - Hips & Knees - Hermitage	Inpatient/Daycase	Inpatient/Daycase	Urgent	Q1/2	IS	105	£1,323,000.00	£12,600.00
ASD	ATICS & SEC	Brigeen Kelly	Orthopaedics - Other Minor Hand Surgery	Inpatient/Daycase	Inpatient/Daycase	Urgent	Q1/2	IS	24	£30,000.00	£1,250.00
ASD	ATICS & SEC	Brigeen Kelly	Orthopaedics - Shoulders	Inpatient/Daycase	Inpatient/Daycase	Urgent	Q1/2	IS	22	£132,000.00	£6,000.00
ASD	ATICS & SEC	Brigeen Kelly	Orthopaedics - Carpal Tunnel	Inpatient/Daycase	Inpatient/Daycase	Urgent	Q1/2	IS	51	£76,500.00	£1,500.00
ASD	ATICS & SEC	Brigeen Kelly	CTOP foot and Ankle	Outpatient	New	Urgent	Q1/2	IHA	451	£68,544.24	£151.98
ASD	ATICS & SEC	Brigeen Kelly	CTOP foot and Ankle - Physio cover	Outpatient	New	Urgent	Q1/2	IHA	72	£7,920.00	£110.00
ASD	ATICS & SEC	Brigeen Kelly	CTOP foot and Ankle - Podiatry Cover	Outpatient	New	Urgent	Q1/2	IHA	72	£7,920.00	£110.00
ASD	ATICS & SEC	Brigeen Kelly	Orthopaedics (Hermitage Dublin 2020/2021 roll-over)	Inpatient/Daycase	In-Patients	Urgent	Q1/2	IS	11	£138,600.00	£12,600.00
ASD	ATICS & SEC	Helena Murray	Pain Management	Outpatient	New	Urgent	Q1/2	IHA	26	£6,036.94	£232.19

ASD	ATICS & SEC	Helena Murray	Pain Management - NWIH	Outpatient	New	Urgent	Q1/2	IS	34	£38,451.96	£1,130.94
ASD	ATICS & SEC	Sarah Conway	Breast Screening Assessment	Outpatient	New	Urgent	Q1/2	IHA	40	£6,634.00	£165.85
ASD	ATICS & SEC	Amie Nelson	Endoscopy	Diagnostic	Day Case	Red Flag/Urgent	Q1/2	IHA	660	£426,368.25	£646.01
ASD	ATICS & SEC	Amie Nelson	General Surgery	Virtual	New	Red Flag/Urgent	Q1/2	IHA	300	£11,556.00	£38.52
ASD	ATICS & SEC	Amie Nelson	General Surgery	Outpatient	New	Red Flag/Urgent	Q1/2	IHA	60	£9,437.40	£157.29
ASD	ATICS & SEC	Amie Nelson	General Surgery	Outpatient	Review	Red Flag/Urgent	Q1/2	IHA	217	£28,094.99	£129.47
ASD	ATICS & SEC	Amie Nelson	General Surgery	Virtual	Review	Red Flag/Urgent	Q1/2	IHA	418	£16,101.36	£38.52
ASD	ATICS & SEC	Amie Nelson	Breast Symptomatic	Outpatient	New	Red Flag/Urgent	Q1/2	IHA	75	£12,438.75	£165.85
ASD	ATICS & SEC	Amie Nelson	Breast Symptomatic - Monday PM except Breast Surgeons	Outpatient	New	Red Flag/Urgent	Q1/2	IHA	300	£46,545.00	£155.15

ASD	ATICS & SEC	Amie Nelson	Admin Validation of Inpatient and Outpatient WLs	Validation	New/Review		Q1/2	IHA	0	£59,533.25	
ASD	ATICS & SEC	Amie Nelson	NIWH - Endoscopy Colons	Day case	Day Case	Red Flag/Urgent	Q1/2	IS	40	£59,960.00	£1,499.00
ASD	ATICS & SEC	Amie Nelson	NIWH - Endoscopy Flex Sigs	Day case	Day Case	Red Flag/Urgent	Q1/2	IS	60	£59,940.00	£999.00
ASD	ATICS & SEC	Wendy Clayton	TP Biopsies - 352	Inpatient/Daycase	Inpatient/Daycase	Red Flag/Urgent	Q1/2	IS	110	£178,200.00	£1,620.00
ASD	ATICS & SEC	Wendy Clayton	Flexible Cystoscopies - 352	Inpatient/Daycase	Inpatient/Daycase	Red Flag/ Urgent	Q1/2	IS	90	£116,100.00	£1,290.00
OPPC	AHP	Julie Smyth	Occupational Therapy - ICT Community	AHP	New/Review	Urgent	Q1/2	IHA	350	£71,452.50	£204.15
CYPS	AHP	Sarah Fisher	Occupational Therapy - Paediatrics	AHP	Review	Urgent	Q1/2	IHA	166	£11,674.78	£70.33
ASD	MUSC	Kay Carroll	Cardiac Investigations - TTEs (CP's)	Diagnostic	Diagnostic	Urgent	Q1/2	IHA	142	£19,296.38	£135.89
ASD	MUSC	Kay Carroll	Cardiac Investigations - TOEs	Diagnostic	Diagnostic	Urgent	Q1/2	IHA	21	£11,616.99	£553.19

ASD	MUSC	Kay Carroll	Cardiac Investigations - DSEs	Diagnostic	Diagnostic	Urgent	Q1/2	IHA	60	£26,001.00	£433.35
ASD	MUSC	Kay Carroll	AVS clinical validation / updating spreadsheet	Validation	New/Review	Urgent	Q1/2	IHA	350	£7,593.24	£21.69
ASD	MUSC	Kay Carroll	TTEs (SET IHA)	Diagnostic	Diagnostic	Urgent	Q1/2	IHA	100	£13,589.00	£135.89
ASD	MUSC	Kay Carroll	Pacing (Pacemaker implant/ Pacemaker box change/ Loop explants)	Inpatient/Daycase	Day Case	Urgent	Q1/2	IHA	40	£11,342.00	£283.55
ASD	MUSC	Kay Carroll	Angiograms	Inpatient/Daycase	Day Case	Urgent	Q1/2	IHA	104	£56,196.40	£540.35
ASD	MUSC	Kay Carroll	Cardiology	Outpatient	New	Urgent	Q1/2	IHA	200	£29,318.00	£146.59
ASD	MUSC	Kay Carroll	Cardiology Virtual	Virtual	New/Review	Urgent	Q1/2	IHA	966	£35,143.08	£36.38
ASD	MUSC	Patricia Loughan	Dermatology	Outpatient	New	Red Flag / Urgent & RFR	Q1/2	IHA	175	£28,087.50	£160.50
ASD	MUSC	Patricia Loughan	Dermatology	Outpatient	Review	Red Flag / Urgent & RFR	Q1/2	IHA	46	£7,383.00	£160.50
ASD	MUSC	Patricia Loughan	Dermatology	Virtual	New	Red Flag / Urgent & RFR	Q1/2	IHA	174	£10,440.00	£60.00
ASD	MUSC	Louise Devlin	Rheumatology	Outpatient	Review	Clinically Urgent review	Q1/2	IHA	76	£13,499.12	£177.62

ASD	MUSC	Louise Devlin	Rheumatology - Injection Session	Inpatient/Daycase	Day Case	Urgent	Q1/2	IHA	14	£4,089.54	£292.11
ASD	MUSC	Louise Devlin	Gastroenterology	Outpatient	Review	Urgent Review	Q1/2	IHA	30	£4,815.00	£160.50
ASD	MUSC	Louise Devlin	Neurology	Outpatient	New	Red Flag / Urgent	Q1/2	IHA	48	£7,704.00	£160.50
ASD	MUSC	Louise Devlin	Neurology	Outpatient	Review	Urgent Review	Q1/2	IHA	54	£8,667.00	£160.50
ASD	MUSC	Kay Carroll	Sleep Studies	Diagnostic	Diagnostic	Urgent Reviews	Q1/2	IHA	660	£134,099.19	£203.18
ASD	MUSC	Kay Carroll	Respiratory Investigations	Diagnostic	Diagnostic	Urgent	Q1/2	IHA	360	£73,145.01	£203.18
ASD	MUSC	Louise Devlin	Diabetology	Outpatient	Review	Urgent	Q1/2	IHA	96	£15,408.00	£160.50
CYPS	SCHD	Joan McMahon	Community Paediatrics	Outpatient	New	Urgent	Q1/2	IHA	11	£4,378.44	£398.04
CYPS	SCHD	Bernie McGibbon	Acute Paediatric	Outpatient	New/Review	Urgent	Q1/2	IHA	70	£9,750.48	£139.29
CYPS	SCHD	Sarah Foy	Dental Extraction	Inpatient/Daycase	Day Case	Urgent	Q1/2	IHA	108	£53,042.04	£491.13

MHD	MHD	John McEntee	Primary Mental Health Care (East London Foundation Trust) - Subject to contract negotiation	Outpatient	New	Urgent	Q1/2	IS	0	£140,664.00	
OPPC	AHP	Wendy Taggart	SLT- Adult Learning Disability	AHP	New	Urgent	Q1/2	IHA	5	£535.00	£107.00
OPPC	AHP	Wendy Taggart	SLT- Adult Learning Disability	AHP	Review	Urgent	Q1/2	IHA	6	£642.00	£107.00
OPPC	AHP	Wendy Taggart	SLT- OPPC	AHP	New	Urgent	Q1/2	IHA	90	£8,667.00	£96.30
OPPC	AHP	Wendy Taggart	SLT- OPPC	AHP	Review	Urgent	Q1/2	IHA	90	£8,667.00	£96.30
ASD	ATICS & SEC	Amie Nelson	Breast Clinic - Tuesday morning - Consultant only - 7 sessions	Outpatient	New/Review	Red Flag	Q1/2	IHA	225	£21,667.50	£96.30
CYPS	SCHD	Sarah Foy	Dental - Paediatric Day Surgery	Inpatient/Daycase	Day Case	Urgent	Q1/2	IS	120	£183,355.20	£1,527.96
CYPS	SCHD	Joan McMahon	Paediatric - Community	Outpatient	New	Urgent	Q1/2	IHA	20	£4,743.60	237.18
CYPS	SCHD	Joan McMahon	Paediatric - Community	Outpatient	Review	Urgent	Q1/2	IHA	56	£13,282.08	237.18
ASD	ATICS & SEC	Wendy Clayton	ENT	Day case	New/Review	Urgent	Q1/3	IHA	10	£0.00	

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3827	19/08/2016	Safe, High Quality and Effective Care		Due to the move down from level 6 to outpatient department to the current OPD accommodation is not suitable to sustain numbers.	Risk of late diagnosis and treatment. Health and Safety and fire risk to patients and staff.	Reduction in the number of fracture patients that can attend each clinic to be reduced.	12/11/21 Refurbishment in DHH for fracture clinic will not take place within financial year 2021/2022. Await confirmation of funding for 2022/2023. 08/09/2021- accommodation for refurb not available as yet. 28/06/2021- remains a risk. Investigating refurbishing Phase 1 OPD in DHH for fracture clinic. Plans developed at a cost of £60k. Waiting to here if funding is to be approved before commencing work. 15/02/2021- remains a risk. Due to the Covid 19 pandemic DHH fracture clinics remain in CAH however still risk due to no social distancing. One DHH clinic has moved to an evening clinic from November 2020. Requested fracture accommodation in STH, unfortunately no capacity to date. 11/12/2020 - remains a risk. DHH fracture clinics remain in CAH however still risk to no social distancing. One DHH clinic moving to evening clinic from Nov 2020. Requested fracture accommodation in STH, unfortunately no capacity to date. 20/10/2020 - remains a risk. DHH fracture clinics remain in CAH however still risk to no social distancing. One DHH clinic moving to evening clinic from Nov 2020. Requested fracture accommodation in STH 10/8/2020 - Remain on risk register. DHH fracture clinic transferred to CAH due to covid pandemic. Need new accommodation in DHH to transfer service back large number of patients going through CAH on a Mon and Tuesday, CAH is not suitable for 2 consultant led clinics. 18.09.19 Remain on Register until capital allocation 24.06.19 - DHH T&O accomodation is priority 1 on the Trust's capital allocation list. To remain on the RR until new accomodation is complete. This will move the fracture clinic from level 2 SAU. 28/3/19 - fracture clinic in DHH continues to be located on level 3 DHH (SAU room), therefore numbers remain reduced. Remains on the capital allocation list 6/2/19 - as below no change to risk	HIGH	DIV
4018	15/10/2016	Provide safe, high quality care		Inpatient / Daycase Planned Backlog	Delay in review of patients planned for screening/repeat procedures presenting adverse clinical risk.	INDC planned backlog in the following surgical specialties: urology, general surgery, ortho and chronic pain.	19/11/21 ICU beds are currently sitting at 12.WIthin Elective Theatres there are 16 urgent bookable sessions in CAH and 5 urgent bookable sessions in DHH 16/09/2021- OSL update- continues to monitor backlog. Due to Covid 19 pressures there are reduced theatre sessions and therefore the focus is on red flag. 08/09/2021- Due to the increase in Covid ICU patients, theatres have decreased sessions down to 3 all day urgent bookable in CAH and one AM session per day in DHH. This will result in ongoing backlog in planned and surveillance surgical patients. 28/06/2021- OSL continues to monitor planned IPDC backlog. Theatres sessions has increased with DHH restarting 14/06/2021 with 15 theatre sessions. Only RF and urgent at present. Validating top 10 longest waiters each month. 15/02/2021- Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to Covid. Currently one 1 urgent bookable list per day Mond to Friday. clinically urgent and priority 2 patients being scheduled. The Trust is currently facing the 3rd surge. No urgent bookable in DHH. 11/12/2020 - Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to COVID pandemic. Currently only clinically urgent and priority 2/3 patients being scheduled. The Trust is currently facing the 2nd COVID surge. 1 urgent bookable each day in CAH and 3 days in DHH 20/10/2020- Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to COVID pandemic. Currently only clinically urgent and the red flag priority 2 patients being scheduled. The Trust is currently facing the 2nd COVID surge unsure if elective surgery will continue 10/8/2020 - Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present.	HIGH	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
4019	15/10/2016	Provide safe, high quality care		Inpatient / Daycase Planned Backlog for Endoscopy	Delay in review of patients for planned screening/repeat procedures presenting adverse clinical risk.	Endoscopy planned backlog. Papers written and submitted to Director re risk. Requested HSCB funding for planned backlog clearance.	19/11/21 Currently only clinical urgent and red flag priority 2 patients are being scheduled for endoscopy. Planned backlog continues to increase as no planned patients are being booked. Validation of planned endoscopy patients is still ongoing. Endoscopy capacity has decreased due to Covid 19 pressures, the redeployment of theatre based workforce continues to impact on capacity within South Tyrone Hospital (STH). The day clinical centre was redeployed to STH day procedure admission ward during the pandemic which still remains in day procedure. This was a 14 bedded ward historically used to run two endoscopy lists 5 days a week simultaneously. Until they return to CAH it is not possible for STH to return to a 19 planned endoscopy list per week. 16/09/2021- Planned endoscopy backlog validation is still in progress 28/06/2021- planned endoscopy backlog is currently being validated by the Gastro and General Surgical Team. 15/02/2021- Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March due to the COVID pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. as no planned endoscopy patients are being scheduled. Validation of planned endoscopy patients has commenced. 20/10/2020- Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March due to the COVID pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. Colon patients being sent Qfit test then prioritised for their colon. Still working on IS contract 10/8/2020 - Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. In process of securing contract to bring IS into the Trust for weekend endoscopy additional	HIGH	DIV
4021	12/04/2019	Provide safe, high quality care		Access Times (Outpatients) - General (not inclusive of visiting specialties)	Increase in access times associated with capacity gaps and emergent demand - Capacity gapin RF, urgent and routine.	ATICs/SEC specialties with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain	19/11/21 OSL update SEC, New regional guidance has been approved for Outpatient admin validation this will be for ENT, Urology and Trauma and Orthopaedics. From April 19 admin validation has been ongoing, new regional technical guidance has been approved and will commence Jan 2022 and the validation team admin support will increase, recruitment in progress.Capacity reduced due to Covid 19 social distancing guidance which is decreasing the number of booked clinics. IPC guidance is continually reviewed and updated. 160921 OSL update- Within outpatients admin validation is ongoing within the following areas: ENT, BFH and orthopaedics. OSL progressing decision with IPC if clinic sizes can be increased. 08/09/2021 - Currently only red flag and some urgent patients are being booked however demand is still greater than capacity. Redeployment of DSU and Theatre staff to ICU for surgery reduces theatre capacity on CAH, STH and DHH sites. Six urgent bookable sessions in CAH, fourteen trauma sessions and five urgent bookable sessions in DHH with cancellation of day surgery and endoscopy. 28/06/2021- OSL and HOS continue to monitor longest waiters. Currently due to social distancing reduced numbers continue and only red flag and urgent patients being booked. Agreed to contact IPC to see if we can increase numbers at clinics. Admin validation to commence. 15/02/2021New Outpatients backlog waiting times continues as a clinical risk. All outpatient cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present. The trust is facing a 3rd surge at present. All outpatients cancelled again and outpatient staff redeployed. 0/10/2020 - New Outpatients backlog waiting times continues as a clinical risk. All outpatient cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present.	HIGH	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
4022	12/04/2019	Provide safe, high quality care		Access Times (In-patient/Day Case) - General	Increase in access times associated with capacity gaps and emergent demand.	ATICs/SEC specialties with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain	19/11/21 OSL and HOS continue to monitor outpatient stragglers >52 weeks. we are currently booking P2 priority patients due to Covid 19 patients. 16/09/21 OSL update- OSL and HOS continue to monitor top ten longest waiters for inpatient/day case. 08/09/2021 - Due to increase in Covid 19 ICU patients, theatres have decreased sessions down to three all day urgent bookable in CAH and one am session per day in DHH. This will result in ongoing backlog in planned and surveillance surgical patients. 28/06/2021- OSL and HOS continue to monitor. Top 10 longest waiters to be validated on a monthly basis. Theatres sessions have increased with DHH restarting 14.06.2021 with 15 theatre sessions. Only priority 2 elective surgery on CAH site. 15/02/2021- New outpatient long waiting times continues as a clinical risk. Reduced outpatient capacity due to covid. Still only RF and urgent patients being scheduled. Surge 3 all outpatients have been cancelled and staff redeployed to support the Wards 11/12/2020 - New outpatients long waiting times continues as a clinical risk. Reduced outpatient capacity due to covid. Only RF and urgent patients being scheduled. Outpatient accommodation increased slightly from 14/12/2020 but not to full capacity. To continue with reduced numbers due to social distancing 20/10/2020 - New outpatients long waiting times continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag new and review patients being booked at present. Reduced capacity due to outpatient rooms being utilised for new covid processes, reduced patients per clinics for social distancing. New referrals have been reduced from March to June 2020 due to covid pandemic. 10/8/2020 - New outpatients long waiting times continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag new and review patients	HIGH	DIV
4131	03/12/2020	Safe, High Quality and Effective Care	Trustwide	Reduction in elective capacity due to covid restrictions-Urology ENT, Gen Surgery, Gynae and Orthopaedics	With the Covid-19 pandemic SEC ability to accommodate commissioned levels of activity is not being achieved resulting in increases in waiting times and volumes of patients on the elective and planned waiting list. As a result of increased waiting times and reduced capacity consequently patients may come to harm, increased levels of pain and discomfort and reduced quality of life	Mon-Friday 1x all day Urgent bookable on both sites CAH and DHH Due to limited elective capacity consultants clinically prioritise patients for surgery using the FSSA royal college guidelines, priority to cancer patients. Regional cancer rest meeting working towards equalising waiting times across the province. In house additionally from January 2021 on DHH site Endoscopy- weekend additional sessions in LV	12/11/2021ICU beds are currently sitting at 12.WIthin Elective Theatres there are 16 urgent bookable sessions in CAH and 5 urgent bookable sessionsin DHH. 08/09/2021 - Due to increase in Covid 19 ICU patients, theatres have decreased sessions down to three all day urgent bookable in CAH and one am session per day in DHH. THis will result in ongoing backlog in planned and surveillance surgical patients. Only priority 2 for CAH and DHH sites. 28/06/2021- DHH recommenced elective theatres x 15 sessions on the 07/06/2021. CAH elective sessions continue with reduced theatres- currently 2-3 urgent bookable per staff however this is staff dependent. Agency staff have taken leave July/August 21. 9/6/2021 the ongoing workforce issues will affect our ability to provide core operating sessions. Primarily for in patient theatres. The action in respect to recruitment is in place. advertisements are going out in June and 9 new registered nurses are due to commence work between June and Sept for CAH in patient theatres. we are currently working with the nurse bank and agency to attract theatres nurses and Dps from agency across mainland UK. 15/02/2021- ICU remains open to 16 patients, surge staff from day surgery and theatres/recovery remain in-situ. Currently in surge 3 03/12/2020- full de-escalation of CCaNNi critical care surge plan- this is currently medium surge and difficult to predict. Commencement of in house additionally from Jan 2021 for endoscopy and surgical specialties and the January sessions are currently being agreed. Increase urgent bookable theatre sessions	HIGH	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3802	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Nurse Recruitment for Adult and Paed theatres	Risk of being unable to cover all required theatre sessions with appropriately skilled theatre staff, therefore, there is a risk of sessions not being scheduled or being cancelled if insufficient skilled Theatre staff are not available.	We continue to use the Nursing Team in ATICs across all theatre departments. This includes cross site working, to ensure that we make the best use of our resources to cover the core confirmed sessions.	19/11/2021- no further update. 20/09/2021- Rolling nurse recruitment for Band 6 for paeds theatre is at advert. No paediatric surgery at present due to surge- redeployment of staff to ICU. 28/06/2021- Jan/Feb 2021x8 band 5 staff nurses recruited through peri-operative workstream. June 2021 band 5 applications closed, approx 8 band 5 have been recruited. Waiting on checks and start dates. Delivering of care x 1 Band 7 and 10 x Band 6's funding secured. ATICS going out to advertisement (3x CEPs Band 7- 1 funded and 2 at risk). 15/02/2021- regional peri operative recruitment drive closing date 05/02/2021, awaiting confirmation of applicants and interviews to be processed. ATICS remain with larger number of vacant adult and paediatric theatre nursing posts. 11/12/2020 - request through E&G for a commissioned paediatric nursing course for 21/22. Regional recruitment plans ongoing. HOS ATICS remains on group 20/10/2020 - regional recruitment plans ongoing. HOS ATICS sits on the group. 10/8/2020 - Since the covid-19 pandemic Paediatric theatre presently being used for outpatient ENT AGPs. No paediatric surgery currently on the DHH site. Only 2 paediatric nurses Band 6 at present, out for recruitment with BSO. Continues as risk. Continuing with recruitment drives for adult theatre nursing staff. Vacancies still remain. For retention Band 5 uplift to Band 6 successfully completed. 3/9/19 - only 3 paed nurses at present (1 is 16 hours only). Further nursing gap highlighted to AD and Director - paper attached 18/6/19 - Unfortunately continued high level of vacancies in ATICS. Theatre nursing paper has been submitted to the Acute Director. Continue to run main theatres in CAH and DHH at 30% reduction. Risk remains high. 28/3/19 - Continued high level of vacancies in theatres and risk to staffing main theatre sessions. Continue to run at 30% less theatre sessions for April 2019.	MOD	DIV
3804	27/05/2016	Safe, High Quality and Effective Care	Outpatients Dept	Pre Op Assessment	Pre-op assessment is currently under resourced to provide the number of assessments required and deal with the increase in demand to the service	Staffing has been structured within pre-op to cover the key areas ensuring the best use of the limited resources. We are currently proactively working to change the existing pre-op processes to ensure that patients are pre-assessed and passed fit before ever being scheduled for surgery. This impacts on the need for additional staffing as we are working to change the processes while having to continue with existing processes.	20/09/2021- Pre-op staffing currently matches the requirements for urgent bookable. Recruitment required. Will update as necessary. 28/06/2021- remains unchanged will discuss way forward with AD. 15/02/2021- remains unchanged. 11/12/2020 - remains unchanged. Internal audit completed and addressing recommendations 2010/2020 - remains unchanged 10/8/2020 - Pre-op assessment demand continues outweigh capacity. Out for recruitment BSO band 6. Requested planners to complete a business case to enhance pre-op service. 10/8/2020 - Pre-op assessment demand continues outweigh capacity. Out for recruitment BSO band 6. Requested planners to complete a business case to enhance pre-op service. 18/9/19 - Lead nurse is interviewing this week for new pre-op nursing staff. Pre-op is one of the projects submitted under demography monies. 18/6/19 - Ongoing works pressures continue in pre-op due to demand. Group met to progress pre-op paper however planners will be not support without confirmed funding stream. To remain on RR. 28/3/19 - Risks continue as below and additionality continues. Agency band 2 part time to start end of April 19 to support the B5/6 nursing staff. 6/2/19 - High sickness rate in pre-assessment at present. Additional hours offered to keep up with demand. Discuss additional admin B2 to be recruited as risk to support the B5/6	MOD	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3800	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Anaesthetic cover for maternity services	We currently fail to meet the standards regard to anaesthetic cover for maternity theatres. There is a risk to the Maternity patients from having inadequate cover. The staff is approximately 2.0wte. The nursing levels do not meet the national guidelines. Risk of failing anaesthetic accreditation, currently do not meet the standards.	A paper is being completed with regard to sorting the deficit in both anaesthetic and nursing cover.	19/11/2021- no change 20/09/2021- no change 28/06/2021- no change 15/02/2021- risk remains the same 11/12/2020 - risk remains unchanged, however, in DHH elective c-sections are performed in the main theatres. 20/10/2020 - risk remains unchanged, however, in DHH elective c-sections are performed in the main theatres. 10/8/2020 - no further update. Risk continues. 18.09.19 - HOS & LN's have met and are meeting again in the next month to go through figures for the nursing requirement 18/6/19 - meeting was held between gynae and ATICs, business case to be progressed. To be kept on RR 28/3/19 - Next ATICS business meeting arranged for 19/4/19, await update from Dr Scullion. 6/2/19 - discussed at ATICS business meeting. Dr Scullion investigating the transfer of IMWH maternity theatres	MOD	DIV
3727	01/09/2015	Make the best use of resources	Anaesthetics, Theatres & Intensive Care Services	No equipment store available in Day Surgery Unit CAH	Currently there is a 2 bedded side room unable to be used for patients as it stores the equipment for this unit. This can impact on the availability of beds for the daycase list, particularly when lists are occurring simultaneously. Potential for harm; Potential delay of access to day surgery beds. Limited availability of segregation for patients for IPC reasons and also male/female.	Try to maximise the use of the existing 12 bed spaces. Continues to use the 2-bedded side room for equipment as this reduces the risk to patients and staff of equipment being stored in corridors, this would also be a fire hazard.	19/11/2021- no change 28/06/2021- remains unchanged no funding. 15/02/2021- remains unchanged still no capital funding 11/12/2020 - remains unchanged 20/10/2020 - remains unchanged, no capital funding identified. 10/8/2020 - Still no capital funding, risk remains the same. 18.09.19 Still no capital funding risk remains the same 18/6/19 - still no capital funding identified, risk remains the same. 28/3/19 - as below, risk remains as no capital funding identified. 6/2/19 - no capital funding, therefore risk remains the same.	MOD	DIV
4095	02/06/2020	Provide safe, high quality care a great place to work	Trustwide	Mishandling of Patient handover resulting in an Information Governance breach	There is a risk that the handover with patients details could be mislaid anywhere on site or in the community. Patient detail not being managed in a confidential manner thereby reveling the patient's private business and exposing the Trust to a breach in public confidence.	All disciplines of staff have been informed of the recent breaches in Information Governance and the consequence of same. All wards and departments have bins with clearly visible signage indicating they are for the disposal of the confidential handover prior to the end of their shift Regular reminders at patient safety briefings to adhere to Trust governance protocols Representative in Acute have met and agreed the content on the handovers. Incident and meeting note shared with OPPC, Peads and MH directorates.	12/11/20212 An Information Governance audit has taken place and results are pending to ascertain compliance with non identifiable patient from handovers.To await report to ascertain compliance to inform if this risk should remain on register. 20/09/2021- AD to confirm is this can be removed from risk register 28/06/2021- Additional confidential waste bins at doffing, exits and signs were erected re disposing confidential waste appropriately. 24/02/2021- continuously monitored 02/06/2020 Staff regularly reminded of necessity to adhere to Trust governance protocols.	LOW	DIV
750	28/07/2008	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	STH Theatres and Day Procedure Unit requires UPS/IPS syste,	Theatres and Day Procedure Unit at STH currently does not have any form of backup electrical supply other than the emergency generator; in the event of a power failure all power supplies to socket outlets will drop out for approx. 15 seconds until the generator comes on line.	Battery backup exists on the anaesthetic machine only.	12/11/2021- no change 20/09/2021- UPS/IPS need an injection of £200k. Estates are costing. 29/06/2021- less than 50% of the required installation has been completed. I have liaised with estates to advise of the next priorities if a phased approach for installation of further UPS/IPS is being considered when funding becomes available. I have listed the areas below detailing completed works in Green and the work that remains outstanding in red: Theatre 1 pendants Completed Theatre 2 pendants Completed Recovery area main theatre 6 bed spaces and defib plug Not completed DPU recovery 6 bed spaces and defib plug in reception Not completed DPU 1 procedure room pendants Not completed DPU 2 procedure room pendants Not completed DPU Decontamination unit (2 drying cabinets completed and 2 endoscope washers not completed) 15/02/2021- covid remains a priority for estates no change to risk 11/12/2020 - still with estates, priority to covid 20/10/2020 - no change and remains with estates. Priority being given to covid 10/8/2020 - no change, remains a risk. Helena to e-mail Estates re plan to address IPS/UPS. 18.09.19 No change	HIGH	HOS

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3801	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	JAG Accreditation	Due to the waiting times for patients having endoscopy procedures, we cannot achieve timeliness of appointments, and therefore, cannot achieve JAG accreditation. This is a regional issue and JAG are aware of same.	JAG is working with HSCB and the Trusts with regard to the revised JAG standards and the potential for 2 levels of accreditation.	12/11/2021 No ATICS business meeting interface 15/09/2021- unchanged. 28/06/2021- unchanged. 15/02/2021- priority given to covid pandemic. Significantly reduced capacity available on all day surgery sites. 11/12/2020 - remains the same, priority being given to covid pandemic 20/10/2020 - Due to covid pandemic remains unchanged, currently going into 2nd surge 10/8/2020 - Dr P Murphy is the Interim Endoscopy lead. Endoscopy waiting times continue to be an issue in achieving JAG accreditation. 18.09.19 Require a led for JAG 28/3/19 - next ATICS Business meeting Fri 19/4/19, to discuss taking JAG off the RR. 6/2/19 - Consider taking off Directorate RR to be discussed at next ATICS Business meeting.	MOD	HOS

Surgery and Elective Care Division
Division, HOS and Team Risk Register - Updated May 2019

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
4018	15/10/2016	Provide safe, high quality care		Inpatient / Daycase Planned Backlog	Delay in review of patients planned for screening/repeat procedures presenting adverse clinical risk.	INDC planned backlog in the following surgical specialties: urology, general surgery, ortho and chronic pain.	28/3/19 - continue to monitor IPDC planned backlog by HOS and OSL. Validation of strugglers to ensure they are true waiters or appoint. No routine planned capacity currently on the CAH site 6/2/19 - Continue monitoring and discussed at HOS meetings 20/11/18 - IPDC planned backlog continues to be high risk to the Trust. Monthly monitoring continues and discussed at HOS performance meeting and monthly Director performance meeting 15/10/18 - Risk assessment paper written and submitted to Director for discussion at SMT. Validation of long waiters being undertaken in Gen Surgery and Ortho	HIGH	DIV
4021	12/04/2019	Provide safe, high quality care		Access Times (Outpatients) - General (not inclusive of visiting specialties)	Increase in access times associated with capacity gaps and emergent demand - Capacity gapin RF, urgent and routine.	ATICs/SEC specialties with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain	28/3/19 - continued capacity gap in all surgical specialties. regional discussions in ongoing re urology. Q1 2019/20 in house additionality received for breast symptomatic, chronic pain and general surgery additionality for both in house and IS 6/2/19 - Waiting times are monitored by OSL and HOS, and discussed at HOS weekly meetings. Risks highlighted at monthly performance meetings 20/11/18 - new outpatient waits continue to grow on a monthly basis. Additionality secured for general surgery and chronic pain. high risk of incidental cancers from long new waiters 15/10/18 - Clear capacity gap. Request for HSCB funding when IHA capacity available to do additional sessions. Ongoing RF capacity issues discussed at monthly cancer performance meeting	HIGH	DIV
4022	12/04/2019	Provide safe, high quality care		Access Times (In-patient/Day Case) - General	Increase in access times associated with capacity gaps and emergent demand.	ATICs/SEC specialties with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain	28/3/19 - 30% reduced theatre capacity to continue into April 2019. Access times continue to grow for routine and urgent waits. HOS and OSL continues to monitor and validate long waiters 6/2/19 - IPDC waiting times continue to grow. Winter plan in place from Dec 18 to March 19 with 30% reduced theatre capacity. No routines to be scheduled on CAH site, capacity for RF and urgent only 20/11/18 - IPDC waiting times continue to grow. Winter plan in place from Dec 18 to March 19 with 30% reduced theatre capacity. No routines to be scheduled on CAH site, capacity for RF and urgent only 15/10/18 - Clear capacity gap. Request for HSCB funding when IHA capacity available to do additional sessions. Ongoing RF capacity issues discussed at monthly cancer performance meeting	HIGH	DIV

Cancer and Clinical Services Division
Divisional, Head of Service and Team Risk Register - 1 May 2019

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3191	03/09/2012	Safe, High Quality and Effective Care		62 Day Cancer Performance	Trust fails to meet performance standard due to increase in red flag, capacity issues, inability to downgrade and Regional issues.	Daily monitoring of referrals of patients on the 62 day pathway. Escalations to HoS/AD when patients do not meet milestone on pathway. Continuous communication with Regional with regard to patients who require PET and ITT patients for Thoracic Surgery, 1st oncology appointment. Monthly performance meetings with AD/HoS and escalations of all late triaging	14.11.17 Cancer work plan under development, Cancer trajectories in place, Weekly monitoring continues 6.6.17 Difficulty achieving 62 day performance due to delay in 1st apt, investigation and external pressures including PET scan lung/cru oncology 28/06/2016-achievement of the 62 day pathway continues to be a risk due to external factors and internal factors such as delay in first appointments, increase in red flag referrals from GPs, Reporting of diagnostics . May performance 76%. • Breast screening and assessment, Breast 2ww - currently unable to achieve this target due to increase in demand and reduction in Radiologists and Surgeons to cover this service. Routine symptomatic breast service.	MOD	DIV
3728	01/09/2015	Provide safe, high quality care	Trustwide	Serious concerns following June 2015 Cancer Peer Review	Serious concerns for skin, urology and H&N following assessment against the cancer peer review standards. Potential for Harm; The highlighted serious concerns may result in risk to patients who are/should be on the cancer pathway.	Recognised capacity gaps exist, consultation with HSCB ongoing with IPTs submitted where appropriate and participate and await the outcome of the Regional outpatient reform exercise. With regards to CNS's await outcome of the Regional CNS prioritisation project.	22.1.18 No longer serious concerns. Awaiting new Risk Assessment with accurate update. There are now action plans in place for each cancer MDT. 14.11.17 Ongoing process. Working closely with cancer MDT's to ensure compliance against standards 6/6/17 Clinical Nurse Spec workforce expansion on a 5 year period agreed by HSCB. Skin & other CNS under recruitment. 24/10/16 Fiona Reddick to provide an update 6/1/16 - The Urology & skin task/finish groups continue to meet to address peer review issues.	MOD	DIV

Southern Health and Social Care Trust

3 South Short Stay 19/20 Budget v Spend Report

	Budget	Cumulative Expenditure	Variance	Staffing Level Current Year		
	M12 £	M12 £	M12 £	FSL	WTE	VAR
Payroll						
Nursing & Midwifery	1,769,135	3,067,062	-1,297,927	47.19	43.15	4.04
Allied Health Professionals	0	0	0	0.00	0.00	0.00
General Administration	0	44,171	-44,171	0.00	1.97	-1.97
Total Payroll	**1,769,135**	**3,111,233**	**-1,342,098**	**47.19**	**45.12**	**2.07**
Goods & Services						
Diagnostic Imaging / Radiography	0	2,280	-2,280			
Laboratory	0	4,910	-4,910			
Administration	1,781	7,732	-5,951			
Postage	0	0	0			
Travelling & Subsistence	101	9,726	-9,625			
Staff Uniforms	906	4,472	-3,566			
Transport & Moveable Plant	88	536	-448			
General Services	1,560	23,556	-21,996			
Computer Services	0	0	0			
Staff Training	0	260	-260			
Medical & Surgical Supplies & Equip	55,044	154,316	-99,272			
Patient / Client Appliances	1,163	305	858			
Patient / Client Clothing	3,565	4,249	-684			
Bedding & Linen	2,217	6,092	-3,875			
Catering	0	2,449	-2,449			
Cleaning	1,923	16,837	-14,914			
Laundry	0	221	-221			
Total Goods & Services	**68,348**	**237,941**	**-169,593**			
Income						
Other operating income	0	0	0			
Total Income	**0**	**0**	**0**			
Total Income & Expenditure						
Grand Total	**1,837,483**	**3,349,174**	**-1,511,691**			

Southern Health and Social Care Trust

3 South Short Stay 20/21 Budget v Spend Report

	Budget	Cumulative Expenditure	Variance	Staffing Level Current Year		
	M12 £	M12 £	M12 £	FSL	WTE	VAR
Payroll						
Nursing & Midwifery	1,833,693	2,812,908	-979,215	47.19	58.90	-11.71
Allied Health Professionals	0	0	0	0.00	0.00	0.00
General Administration	0	55,688	-55,688	0.00	3.00	-3.00
Total Payroll	**1,833,693**	**2,868,596**	**-1,034,902**	**47.19**	**61.90**	**-14.71**
Goods & Services						
Diagnostic Imaging / Radiography	0	4,170	-4,170			
Laboratory	0	5,208	-5,208			
Administration	1,781	5,201	-3,420			
Postage	0	50	-50			
Travelling & Subsistence	101	-1,049	1,150			
Staff Uniforms	906	1,914	-1,008			
Transport & Moveable Plant	88	-398	486			
General Services	1,560	19,557	-17,997			
Computer Services	0	0	0			
Staff Training	0	260	-260			
Medical & Surgical Supplies & Equip	55,044	90,720	-35,676			
Patient / Client Appliances	1,163	2,982	-1,819			
Patient / Client Clothing	3,565	4,741	-1,176			
Bedding & Linen	2,217	5,275	-3,058			
Catering	0	2,176	-2,176			
Cleaning	1,923	11,713	-9,790			
Laundry	0	142	-142			
Total Goods & Services	**68,348**	**152,661**	**-84,313**			
Income						
Other operating income	0	0	0			
Total Income	**0**	**0**	**0**			
Total Income & Expenditure						
Grand Total	**1,902,041**	**3,021,257**	**-1,119,216**			

Southern Health and Social Care Trust

3 South Short Stay 21/22 Budget v Spend Report

	Budget	Cumulative Expenditure	Variance	Staffing Level Current Year		
	M12 £	M12 £	M12 £	FSL	WTE	VAR
Payroll						
Nursing & Midwifery	1,915,054	2,974,942	-1,059,888	47.19	52.87	-5.68
Allied Health Professionals	0	2,016	-2,016	0.00	0.00	0.00
General Administration	0	70,546	-70,546	0.00	4.00	-4.00
Total Payroll	**1,915,054**	**3,047,504**	**-1,132,450**	**47.19**	**56.87**	**-9.68**
Goods & Services						
Diagnostic Imaging / Radiography	0	3,628	-3,628			
Laboratory	0	6,744	-6,744			
Administration	1,781	6,409	-4,628			
Travelling & Subsistence	101	-23	124			
Staff Uniforms	906	2,342	-1,436			
Transport & Moveable Plant	88	61	27			
General Services	1,560	8,648	-7,088			
Computer Services	0	0	0			
Staff Training	0	390	-390			
Medical & Surgical Supplies & Equip	55,044	98,031	-42,987			
Patient / Client Appliances	1,163	3,078	-1,915			
Patient / Client Clothing	3,565	6,312	-2,747			
Bedding & Linen	2,217	6,195	-3,978			
Catering	0	2,641	-2,641			
Cleaning	1,923	11,163	-9,240			
Laundry	0	126	-126			
Total Goods & Services	**68,348**	**155,745**	**-87,397**			
Income						
Other operating income	0	0	0			
Total Income	**0**	**0**	**0**			
Total Income & Expenditure						
Grand Total	**1,983,402**	**3,203,250**	**-1,219,848**			

Southern Health and Social Care Trust

Urology 19/20 Budget v Spend Report

	Budget	Cumulative Expenditure	Variance	Staffing Level Current Year		
	M12 £	M12 £	M12 £	FSL	WTE	VAR
Payroll						
Medical						
Nursing & Midwifery						
Total Payroll						
Goods & Services						
Laboratory	0	460	-460			
Administration	5,539	1,821	3,718			
Travelling & Subsistence	9,423	4,439	4,984			
Staff Uniforms	110	385	-275			
General Services	908	1,556	-648			
Computer Services	146	0	146			
Staff Training	0	2,831	-2,831			
Medical & Surgical Supplies & Equip	57,413	64,928	-7,515			
Patient / Client Appliances	2,451	0	2,451			
Patient / Client Clothing	230	284	-54			
Bedding & Linen	1,279	3,054	-1,775			
Catering	0	110	-110			
Cleaning	1,475	1,357	118			
Laundry	0	3	-3			
Total Goods & Services	**78,974**	**81,227**	**-2,253**			
Income						
Other operating income	-17,260					
Total Income						
Total Income & Expenditure						
Grand Total	**2,190,343**	**2,183,420**	**6,923**			

Southern Health and Social Care Trust

Urology 20/21 Budget v Spend Report

	Budget	Cumulative Expenditure	Variance	Staffing Level Current Year		
	M12 £	M12 £	M12 £	FSL	WTE	VAR
Payroll						
Medical						
Nursing & Midwifery						
Total Payroll						
Goods & Services						
Laboratory	0	110	-110			
Administration	5,539	2,258	3,281			
Travelling & Subsistence	9,423	1,219	8,204			
Staff Uniforms	110	822	-712			
Transport & Moveable Plant	0	152	-152			
General Services	908	491	417			
Computer Services	146	0	146			
Medical & Surgical Supplies & Equip	57,413	51,443	5,970			
Patient / Client Appliances	2,451	60	2,391			
Patient / Client Clothing	230	0	230			
Bedding & Linen	1,279	612	667			
Catering	0	62	-62			
Cleaning	1,475	209	1,266			
Total Goods & Services	**78,974**	**57,439**	**21,535**			
Income						
Other operating income	-51,500					
Total Income						
Total Income & Expenditure						
Grand Total	**2,209,155**	**2,285,519**	**-76,364**			

Southern Health and Social Care Trust

Urology 21/22 Budget v Spend Report

	Budget	Cumulative Expenditure	Variance	Staffing Level Current Year		
	M12 £	M12 £	M12 £	FSL	WTE	VAR
Payroll						
Total Payroll						
Goods & Services						
Laboratory	0	464	-464			
Administration	5,539	1,832	3,707			
Travelling & Subsistence	9,423	1,438	7,985			
Staff Uniforms	110	510	-400			
Transport & Moveable Plant	0	40	-40			
General Services	908	160	748			
Computer Services	146	0	146			
Staff Training	0	1,370	-1,370			
Medical & Surgical Supplies & Equip	57,413	130,853	-73,440			
Patient / Client Appliances	2,451	77	2,374			
Patient / Client Clothing	230	324	-94			
Bedding & Linen	1,279	2,021	-742			
Catering	0	66	-66			
Cleaning	1,475	749	726			
Total Goods & Services	78,974	139,907	-60,933			
Income						
Other operating income	-39,500					
Total Income						
Total Income & Expenditure						
Grand Total	2,263,348	2,415,873	-152,525			

3 South Short Stay Ward Nursing Payroll Expenditure Analysis			
	19/20	20/21	21/22
	£	£	£
Agency	1,805,680	1,524,071	1,581,624
Bank	176,727	140,652	153,796
Overtime	4,559	1,667	4,736
Additional Hours	789	552	6
Total flexible payroll spend	**1,987,755**	**1,666,942**	**1,740,162**
Substantive	1,079,308	1,145,966	1,234,780
Grand Total	**3,067,062**	**2,812,908**	**2,974,942**

Southern Health and Social Care Trust

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Staffing Support Requirement for Serious Adverse Incident /Inquiry - Urology

3 December 2020

1.0 Introduction

There have been significant clinical concerns raised in relation to Consultant A which require immediate and coordinated actions to ensure patient safety is maintained. Comprehensive plans need to be put into place to undertake the following:

- Review of professional governance arrangements
- Liaison with professional bodies
- Review of patient safety and clinical governance arrangements
- Commencement of operational support activities including
  - Offering additional clinical activity
  - Provide complaints resolution
  - Media queries, Assembly Questions responses
  - Managing the volume of patients who require to be reviewed
  - Patient Support (Psychology / Telephone Support / Liaison)
  - Staff Support
  - Claim handling / medico-legal requests

This proposal identifies the staffing requirements and costs required to support the Serious Adverse Incident (SAI) Investigation/Inquiry for Urology in the Southern Trust.

This proposal will require revision as demands change over time.

2.0 Needs Assessment

A comprehensive review of patients who have been under the care of Consultant A will be required and this may likely number from high hundreds to thousands of patients.

Following discussions with the Head of Service the following clinics have initially been proposed and have been estimated in the first instance to continue for one year.

Clinics will commence in December 2020 and continue throughout 2021. A putative timetable has been included. We will require that consultants have access to records, have reviewed the contents and results and are familiar with each patient's care prior to face to face review where required. Each set of patient records will require 10-30 minutes to review depending on complexity. In addition, each of the patients reviewed will require 45 minute consultant urologist appointments to include time for administration/ dictation in addition to 15 mins preparation time on average. That is 8 patients require 8hrs Direct Clinical Contact (DCC) Programmed Activity (PA). 800 patients require 800 hours of Direct Clinical and so on. (Each consultant DCC PA is 4hrs).

The purpose of the clinical review is to ascertain if the:

1. diagnosis is secure
2. patient was appropriately investigated
3. Investigations, results and communications were requested in a timely fashion
4. Investigations, results and communications were responded to/ processed in a timely fashion
5. Patient was prescribed / is receiving appropriate treatment
6. Overall approach taken is reasonable
7. Patient has, is or likely to suffer harm as a result of the approach taken.

In addition, it will be expected that where there are concerns in relation to patient safety or inappropriate management that these will be identified and a treatment plan developed by the assessing consultant and shared with the urology team for ongoing oversight or with the patient's GP.

Table 2-1 Suggested timetable

Day	Clinic Session	Number of Patients
Monday	AM	8
Monday	PM	8
Tuesday	AM	8
Tuesday	PM	8
To be confirmed	AM	8
To be confirmed	PM	8
Total no of patients per week		48

3.0 Staffing Levels Identified

3.1 Information Line – First Point of Contact

An information line will be established for patients to contact the Trust to speak with a member of staff regarding any concerns they may have and will operate on Monday to Friday from 10am until 3pm. A call handler will receive the call and complete an agreed Proforma (appendix 1) with all of the patient's details and advise that a colleague will be in contact with them. The PAS handler will take the information received and collate any information included on PAS/ECR and this will be examined in detail by the Admin/Information Handler. The following staff have been identified as a requirement for this phase. It must be noted that the WTE is an estimate and will be adjusted dependent on the volume of calls received. Costs are included in Appendix 1.

Table 3-1 – Information Line Initial Staffing Requirements

Title	Band	WTE
Call Handlers	4	2
Admin Support for identifying notes/ looking up NIECR etc	4	2
Admin/Information Handler	5	1

3.2 Clinic Requirements

To date a clinical process audit has been carried out in relation to aspects of the Consultant's work over a period of 17 months.

In addition to this 236 urology oncology patients are being rapidly and comprehensively reviewed in the private sector. (Patients returned with management plan are included in Table 3.2/Table 3.4)

A further 26 urology oncology patients have been offered appointments or reviewed in relation to their current prescription of Bicalutamide.

Given the emerging patterns of concerns from these reviews and Multi-Disciplinary Meetings (MDMS) which have resulted in 9 patients' care meeting the standard for SAI based on this work to date, it is considered that a comprehensive clinical review of the other patients is required. The Royal College of Surgeons has advised that this includes 5 years of clinical activity in the first instance.

The numbers and clinical prioritisation will be identified collectively by the Head of Service, Independent Consultant and the Clinical Nurse Specialist either face to face or via virtual clinics. The volume of patients is 2327 for 18 months in the first instance and the number of DCC PA has been identified as **. The staffing required to operate these clinics is detailed below. This work will be additionality and should not disrupt usual current urology services. It must be noted that again this is an estimate and will be dependent on the volume of patients involved. .

Clinic Requirements Staffing – 6 sessions as detailed in Section 2. Costs are included in Appendix 1.

Table 3-2 – Clinic Staffing Requirements

Title	Band	WTE
Outpatient Manager	7	0.7
Medical Secretarial Support	4	0.5
Booking clerk	3	0.7
Audio Typist	2	0.7
Medical Records	2	0.7
Nursing staff	5	0.7
Nurse Clinical Specialist	7	0.7
Health Care Assistant	3	0.7
Receptionist	2	0.7
Consultant		DCC
Pharmacist	8a	0.7
Psychology Band 8B and above		1 present per clinic
Domestic Support	2	0.7

3.3 Procedure Requirements

If the outcome of the patient review by the Independent consultant urologist is that the patient requires further investigation, this will be arranged through phlebotomy, radiology, day procedure, and pathology / cytology staff. The provision will be dictated by clinical demand. The following staffing levels have been identified as below for each 1 day sessions. Costs are included in Appendix 1.

Table 3-3 – Procedure Staffing Requirements

Title	Band	WTE
Secretary	4	
Reception	2	
Nurses	5	0.64

Title	Band	WTE
Health Care Assistant	3	0.22
Sterile Services	3	0.22
Consultant - locum		2 PAs
Anaesthetic cover		1 PA
Domestic Support	2	0.22

3.4 Multi-Disciplinary Weekly Meetings Requirements

In order to monitor and review the number of patients contacting the following multi-disciplinary team has been identified as a requirement. Costs are included in Appendix 1.

Table 3-4 -–Staffing Requirements for Multi-Disciplinary Meetings (weekly)

Title	Band	WTE
Cancer Tracker	4	0.4
Nurse Clinical Specialist	7	0.1
Consultant Urologist x 2		2 PAS
Consultant Oncologist		1 PA
Consultant Radiologist		1 PA
Consultant Pathologist		1 PA

3.5 Serious Adverse Incident Requirements

Work has commenced on 9 SAI's and the following staff have been identified as a requirement to support the SAI and the Head of Service to enable investigative work to take place and to enable current provision to continue. Costs are included in Appendix 1.

Table 3-5 -Additional staffing and Services required to support SAI

Title	Band	WTE
Head of Service (Acute) – SAI backfill	8b	1
Chair of Panel	N/A	sessional
Band 5 admin support	5	1
Governance Nurse/ Officer	7	2
Admin support to the panel	3	1
Psychology support	Inspire	sessional
Family Liaison SLA	7	1

3.6 Inquiry Requirements

Costs are included in Appendix 1.

Table 3-6 - Additional staffing and Services required to Support Inquiry

Title	**Band**	**WTE**
Head of Service Backfill	8b	1
Clinical Nurse Specialist	7	1
Admin Support for HOS	4	1
Admin Support to respond and collate requests for information for inquiry team	5	2
Health records staff to prepare notes for Inquiry Team	2	4
Urology Experts – WL Initiative Funding £138 per hour	Consultant	Sessional
Media queries, Assembly Questions responses	8a (uplift from Band 7's)	2
Admin Support for media queries/Assembly questions	4	1

3.7 Professional and Clinical Governance Requirements to Support the SAI/ Inquiry

Investigations involving senior medical staff are resource intensive due to the many concerns about patient safety, professional behaviours, demands on comprehensive information and communications with multiple agencies. In particular this case has highlighted the need for clinical and professional governance processes across clinical areas within the Trust, to develop these systems and to embed and learning from the SAIs and Inquiry. This work should be rigorous and robust and develop systems fit for the future.

This strand will have responsibility for undertaking activities to ensure embedding of learning, improvement and communication of Trust response to the Urology incidents. This includes providing assurance that improvement efforts are benchmarked outside the Trust from both a service development and national policy perspective and the acquired learning process and may include:

- Revision of Appraisal and Revalidation processes
- Quality Assurance of information processes in relation to Appraisal and Revalidation
- Development of systems and processes that marry professional and clinical governance
- Embedding and providing assurance regarding learning, improvement and communication
- Provide support on Trust communications regarding incident response
- Support triangulation of clinical and social care governance and professional governance information to improve assurance mechanisms
- Support the benchmarking of Trust service developments against regional and national perspectives
- Support liaison and communications with PHA / HSCB and Department of Health on matters relating to the urology incidents
- Support for corporate complaints department

Costs are included in Appendix 1.

Table 3-7 - Professional Governance, Learning and Assurance

Title	Band	WTE
AD Professional Governance, Learning and Assurance	8c	1
Project Lead	7	1
Administrative Support	4	1

Table 3-8 – Claims Management / Medico – Legal Requests (DLS 20%)

It is anticipated that the number of medico-legal requests for patient records and the number of legal claims will significantly increase as a result of the patient reviews and SAIs. This will require support for claims handling, responses to subject access requests and redaction of records.

Title	Band	WTE
Head of Litigation (uplift from band 7)	8a (uplift from band 7)	1
Specialist Claims Handler	7	1
Claims Administrative Support	4	1
Medico – Legal Admin Support	3	1
Service admin support – redaction	4	1
Support Health Professional for redaction – Clinical Nurse Specialist	7	1
2 x Solicitor Consultants (DLS)	sessional	

4.0 Identified Risks

Risk Identified	Mitigation Measure
• Recruitment of experienced staff –	• Complete recruitment documentation as soon as possible • Liaise with Human Resources
• Staff Backfill	• Complete recruitment

Risk Identified	Mitigation Measure
	documentation as soon as possible • Liaise with Human Resources
• Securing Funding	• Liaise with PHA and HSCB regarding additional funding required to support the SAI/Inquiry.
• Volume of calls received by the information line will exceed expectations leading to further complaints	• Monitoring of call volumes • Extending the operational hours to receive calls • Increasing the number of call handlers
• Number of clinics is insufficient to cope with the demand for review appointments	• Monitoring the number of review appointments required • Monitoring clinics and virtual clinics • Increasing the number of virtual clinics
• Current Service Provision will be impacted by the additional clinics being taken forward and Waiting Lists will continue to grow.	• Current provision continues • Utilise independent resources • Provide evening/weekend clinics
• Red flag appointments will not be seen within the required timeframe	• Monitor all current referrals and red flag appointments
• Reputation of Trust	• Provide a response within an agreed timeframe

5.0 Monitoring

Monitoring and reporting will continue throughout the investigation period and will be provided on a weekly basis. Meetings are scheduled on a weekly basis.

Business Case Template	REVENUE FUNDING £250k - £1m

REVENUE BUSINESS CASE PROFORMA COVER

(To be submitted with every business case)

Name of Organisation	Southern Health and Social Care Trust, Craigavon Area Hospital
HSCB Representative	David McCormick
Project Title	Expansion of Southern Trust Urology Team (7th Consultant Urologist & staff infrastructure))
Total Cost	**£869,314 FYE, £434,657 CYE (2020/21)**
Project Start Date*	01 October 2020
Completion Date	Recurrent

Project start date is the date at which the business case is approved and the project starts to incur costs. No expenditure should be committed until all approvals are in place. You should ensure that the actual start date is entered NOT the planned start date.

Complete this section if bid is for new funding

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	***Y***
How much total funding required?	***£869,314 FYE***
How much funding required per year?	***£869,314 FYE, £434,657 CYE (2020/21)***
Is this funding to be made recurrent?	***Y***

Complete this section if funding available within existing allocation

Funding available within existing allocation (Y/N)	***N***
Total cost of proposal	
Cost of proposal per year	
Is this cost within recurrent allocation?	

Is this business case	***Y/N***
(a) Standard	***Y***
(b) Novel	***N***
(c) Contentious	***N***
(d) Setting a precedent	***N***
If "yes" to (b) or (c) or (d), requires Departmental & DFP approval ***Is Departmental / DFP approval required***	

Approvals & submissions

Prepared by: Susan Devlin, Planner (Band 6) and Martina Corrigan, Head of ENT, Urology, Ophthalmology and Outpatients, Craigavon Area Hospital **Name Printed (signed)** **Date**

Approved by: Melanie McClements, Interim Director of Acute Services, Southern Health and Social Care Trust **Name printed Melanie McClements (signed)** **Grade / Title: Interim Director of Acute Services** **Date** **Insert more boxes if further approvals are required by officials** **Please tick the box below to confirm that expenditure has not been committed until the necessary approvals are in place.** √ **(To be completed by the business case approver within the provider organisation).** **If expenditure has been committed before the necessary approvals are in place, please provide explanation below.**
<u>Trust Director of Finance Signature</u> (required) **Name printed: Helen O'Neill (signed)** **Date**
<u>Trust Chief Executive Signature</u> (required) **Name printed: Shane Devlin (signed)** **Date**

Complete this section if Department / DOF approval required

Date submitted to Department **Department/ DOF approval (y/n)** **Date approved**

SECTION 1(a): Commissioner Specification to include strategic context and need (to be completed by the Commissioner).

Commissioner Statement

In 2008/09 A Regional Review of (Adult) Urology Services was undertaken by a multi-disciplinary and multi-organisational Steering Group in response to service concerns regarding the ability to manage growing demand and maintain quality standards. The regional review was followed in 2013/14 by a stock-take to assess progress to date.

Over the last 10 years there have been significant changes in the way urology services are delivered, with increased focus on e-triage, enhanced roles for specialist nurses, one stop service provision and new patient pathways. This change in clinical practice, coupled with the different levels of implementation across Trusts has resulted in significant variations in waiting times across the region.

Since the completion of the stocktake, the HSCB has met with Trusts to explore how service redesign could help address the key challenges facing the service. These challenges include:

- There are regional variations in pathways for both new outpatient assessments and treatments, including cancer;
- There are regional variations in waiting times for outpatients and surgical procedures, with significant numbers of patients waiting for core urology procedures;
- There has been a significant change in referral patterns. The total number of urology referrals have increased by 7.5% since 2015, with red flag and urgent referrals increasing by 26% and 15% respectively. This has a direct impact on the cancer waiting times and those referrals classified as routine;
- A regional capacity gap across both outpatient assessments and treatments which continues to grow as demand increases;
- Across the region there are continued challenges for the recruitment and retention of clinical staff at all levels;
- There are infrastructure constraints and in particular limited access to operating theatre sessions which has resulted in excessive waiting times for routine core urology procedures;

The following IPT aims to make the urology service more sustainable by expanding the urology workforce in the Southern Trust

The Trust is asked to submit a proposal to help reduce the current waiting times for urology assessments and treatments. The proposal must demonstrate how key elements of best practice will be introduced to improve productivity.

Background and Strategic Context (Trust)

The Southern Trust was established on 1st April 2007 following the amalgamation of Craigavon Area Hospital Group, Craigavon & Banbridge Community, Newry & Mourne and Armagh & Dungannon Health and Social Services Trusts. It is one of six organisations that provide a wide range of health and social care services in Northern Ireland. The Trust is responsible for the delivery of high quality health and social care to a resident population of approximately 380,000 and employs 13,000 staff.

The Trust's Hospital network comprises two acute hospitals (Craigavon Area Hospital and Daisy Hill Hospital) with a range of local services provided at South Tyrone and Lurgan Hospitals. The hospitals work together to co-ordinate and deliver a broad range of services to the community.

Both acute hospitals provide a range of medical, surgical and maternity specialties including emergency departments, elective/non-elective inpatient medicine and surgery,

maternity and paediatrics. Craigavon Area Hospital is the larger of the two acute hospitals hosting much of the more complex care. A range of day, outpatient and diagnostic services are offered locally at South Tyrone and Lurgan Hospitals.

The Department of Health (DOH asked the Medical Director/Director of Public Health for the Public Health Agency/Health and Social Care Board to take forward medical workforce planning for Northern Ireland for the period until 2019. The Urology Planning and Implementation Group which was led by the Health and Social Care Board (HSCB) and Public Health Authority (PHA) and included clinicians and senior managers from all Trusts with representatives from both NIMDTA and BMA. In May 2017 the HSCB/PHA issued a Urology Medical Workforce Planning Report (NI) 2017-2024. The work included:

- The identification of a set of principles and standards for urology, based on the Royal College of Surgeons and the British Association of Urological Surgeons (BAUS) standards
- A stocktake of the urology medical workforce at all grades working in hospitals in Northern Ireland
- The determination of the medical workforce required to deliver the service in line with the agreed principles and standards
- An analysis of the impacts (where possible) of modernisation work-streams and strategic service change
- Analysis of information on trainee numbers, recent trends in recruitment of trainees, attrition rates and numbers of trainees exiting per year with CCT accreditation

The subsequent Report (dated May 2017) detailed the number of additional consultants needed to meet the population needs in 2024, a total number of .13 which includes filling both the current vacant posts and the posts vacated through retirement.

The report recommended the need to fund an additional four trainees as a first phase and then to review the need for an additional two trainees once the modernisation work has been further progressed.

Whilst the current service model has urological surgical inpatient procedures delivered in only four hospitals, there are outpatient clinics and day procedures delivered in the local hospitals across NI to provide improved access for the population. The modernisation or urology services is an important element of the work of the Urology Planning and Implementation Group, including exploring the role of the Clinical Nurse Specialist. Clinical pathways for common conditions and reviews for patients with cancer are also being agreed and implemented. While these developments are expected to have an impact on the current workload of doctors, it is not yet possible to quantify the actual impacts with certainty. It will also take several years to fully implement the role of Clinical Nurse Specialists with training and mentoring requirements. If this impact is not materialised then additional trainees may be required to meet the projected population need.

There continues to be supply and demand challenges in relation to the Consultant workforce. Whilst the Trust has made progress in a number of specialties, particular challenges continue within Emergency Medicine, General Medicine, Paediatrics and Urology.

The Southern Trust continues to work to analyse and improve recruitment and advertising strategies, with the aim of reaching a wider pool of potential medical staff across the UK and further afield, with a focus on hard-to-fill posts. The Trust continues to engage with the ongoing regional International recruitment campaigns and is keen to secure the appointment of additional Consultant Urology support as subsequently detailed in this paper.

SECTION 1(b): DEMONSTRATE THE NEED FOR THE PROJECT

Current Urology Service at SHSCT

The urology service provided at Craigavon Area Hospital encompasses the entire spectrum of urological investigation and management, with the main exceptions of radical pelvic surgery, renal transplantation and associated vascular access surgery, which are provided by the Regional Transplantation Service in Belfast. Neonatal and infant urological surgery is provided by the Regional Paediatric Surgical Service in Belfast.

Craigavon Area Hospital has been designated as a Cancer Unit, with its Urological Department being designated the Urological Cancer Unit for the Area population of 425,000 (+65,000 Fermanagh) total 490,000. A wide spectrum of urological cancer management has been provided for some time. Cancer surgery includes orthotopic bladder reconstruction in the management of bladder cancer. Cancer management also includes intravesical chemotherapy for bladder cancer. Immunotherapy for renal cell carcinoma is also performed.

The Trust has a purpose built Urology outpatient facility located in the Thorndale Unit, main outpatient department at Craigavon Area Hospital. It is run by three Clinical Nurse Specialists. Outpatient services include urodynamics, ultrasound, intra-vesical therapy, prostate biopsy and flexible cystoscopy.

Outreach outpatient clinics are currently provided in Armagh, Banbridge, South Tyrone Hospital and the South West Acute Hospital in Enniskillen. Due to the recent retirement of a General Surgeon with an interest in Urology in Daisy Hill Hospital the team are currently making arrangements to move some of the urological services to Daisy Hill Hospital in order to allow the continuation of urology at Daisy Hill Hospital.

A fixed site ESWL lithotripter with full facilities for percutaneous surgery is also accommodated in Craigavon Area Hospital and the department also has a holmium laser.

Flexible cystoscopy services are undertaken by Specialist Registrars and Clinical Nurse Specialist on the Craigavon/Daisy Hill and South Tyrone sites.

The official statistics on cancers diagnosed in Northern Ireland during 1993-2017 were published on 23/3/2019. There were 9,401 patients diagnosed with cancer each year during 2013-2017 (excluding non-melanoma skin cancer, (NMSC)). Prostate cancer was one of the most common cancers diagnosed between 2013 and 2017.

The most common cancers diagnosed for this period were:

- Prostate cancer (24% of all male cancers ex NMSC), lung cancer (14%) and bowel cancer (14%) among men.
- Breast cancer (30% of all female cancers ex NMSC), lung cancer (13%) and bowel cancer (11%) among women.

Cancer risk was strongly related to age with 62% of cases occurring in people over the age of 65 years and incidence rates greatest for those aged 85-89 years. The likelihood of developing cancer by the age of 75 was 1 in 3.5 men and 1 in 3.7 for women. Over the last ten years the number of cancers (excluding NMSC) has increased by 15% from 8,269 cases in 2008 to 9,521 in 2017. These increases are largely due to our ageing population.

The table below gives the population projections for Northern Ireland and the Southern Trust area for all ages and also for the 65 and over age group. The figures demonstrate a significant projected increase with a higher increase for the Southern Trust area than Northern Ireland as a whole, in total population numbers and also in the 65 years and older population. The older population tends to be the most reliant age group on hospital care.

Northern Ireland Population Projections[1]

[1] Northern Ireland Statistics and Research Agency (NISRA) 2014 Based Population Projections, Published 2016

	2017	2020	2023	2026	2029	2032	2035	2039	% Increase 2017- 39
All Ages									
NI	1,873,502	1,903,663	1,930,407	1,954,144	1,974,120	1,990,810	2,005,005	2,021,322	**7.9%**
SHSCT	381,731	393,503	404,753	415,559	425,826	435,623	445,149	457,686	**19.9%**
Age 65 and Over									
NI	304,302	325,025	350,448	379,629	411,899	443,646	471,014	498,528	**63.8%**
SHSCT	55,427	59,798	65,003	70,998	77,832	84,632	90,973	98,104	**77.0%**

'The British Association of Urological Surgeons (BAUS) recommends a consultant workforce ratio of 1 wte per 60,000 population' which would indicate a recommended consultant workforce of 8.00 WTE for the SHSCT (including Fermanagh population)

Current Staffing Urology:

The following staff complement supports the Urology Service:

- 6.00 WTE Consultant Surgeons
- 3.00 WTE Specialist Registrars
- 0.50 WTE Specialty Doctor (currently vacant)
- 1.50 WTE Specialty Doctor

Supported by:

- 4 Nurse Practitioners - 1 funded by Macmillan for a 3 year period, (currently in year 2) to be subsequently funded by the Trust.
- An IPT was submitted to the HSCB on 21/9/19 to seek funding for a further 2 Nurse Practitioners.

The following table details the actual Urology Activity between 2017/18 compared to 2019/20:

Year	Activity Type	SBA	Activity	% Variance	Variance
2017/2018	NOP	3591	3797	+6%	+206
	IP/DC	4198	4699	+12%	+501
2018/2019	NOP	3591	3841	+7%	+250
	IP/DC	4198	4717	+12%	+519
2019/2020 (April to July)	NOP	1197	1060	-11%	-137
	IP/DC	1399	1653	+18%	+254
2019/2020 (April to September)	NOP	1796	1685	-6%	-111
	IP/DC	2099	2501	+19%	+402

The figures show an underperformance of 111 new patients, -6% in 2019/20 to date for outpatients. At the end of June a Consultant Urologist left the Trust (to go on a one year fellowship). A Locum has been covering some opd activity however priority was given to inpatient/daycase activity which had a significant impact on outpatient activity.

Changes to the NHS pension tax regime are resulting in consultants requesting reduction in their hours, considering retiring earlier than they originally planned and/or being unable to undertake any additional clinical work. This will have a significant impact on all specialties in the future including urology.

The numbers of patients waiting for a new outpatient appointment, in particular the urgent referrals are unacceptably high as shown below:

As at the **1st August 2019** there were **4107 new patients on the Urology Outpatient waiting list**.

New Outpatients:

- 859 Urgent referrals with 14 waiting over 52 weeks and the longest wait is 87 weeks
- 3,248 referrals waiting with 2,168 of these waiting over 52 weeks (the longest wait is 184 weeks)

Daycase:

- **Total patients on the waiting list 690**
- 349 Urgent cases with the longest wait 258 weeks. 90 patients waiting over 52 weeks
- 341 Routine cases with the longest wait 274 weeks. 156 patients waiting over 52 weeks

Inpatients:

- **Total on the inpatient waiting list 959**
- 675 Urgent cases with the longest wait 259 weeks. 346 patients waiting over 52 weeks
- 284 Routine cases with the longest wait 260 weeks. 212 patients waiting over 52 weeks

The backing for this service expansion is driven by the need to support the reduction in the current waiting times for urology assessments and treatments. The figures demonstrate a clear need to secure additional consultant capacity.

Key Elements of Best Practice to enhance productivity

When the Red Flag referral is received the Consultant triages this and indicates on the letter what preparations/diagnostics etc are needed for the patients visit, e.g. bloods/ Urinalysis, flexible cystoscopy, biopsy, ultrasound, CT etc. this is then processed through the Red Flag team and the patient appointed appropriately to the next available New Outpatient clinic. The wait for the appointment is within 8-14 days (as opposed to previously over 30 days).

When the patient is invited to attend the clinic they are advised that they may have to be present for a number of hours and they may require to have a number of tests carried out during their appointment.

The whole team meet before the clinic starts to discuss and make a plan for each patient. The nursing staff greet the patient and do any bloods urinalysis etc. the patient is seen for a consultation with the Consultant/Registrar who explains what other tests they may need done and the reasons why. The Nurse at this consultation accompanies the patient to have their further tests done, e.g. Flexible Cystoscopy/TRUS Biopsy/Ultrasound. Clinical Nurse Specialists (CNS) do these tests (this Trust is the only place in N. Ireland where nurses do biopsies). The Consultant/Registrar continues seeing patients but are available for the CNS if needed whilst carrying out the procedures. Once the procedure is completed the Consultant then discusses any results and the next steps (if any) with the patient. For most patients they will get an outcome from the consultation and will either be discharged, sent for further tests, e.g. MRI scan or will be added to a waiting list for surgery. All consultants keep slots free on their theatre sessions for 'red flags', patients who are seen for the majority of the time within the 62-day target. If a patient needs to come back to discuss their tests the consultant will have protected timeslots to see the patient again avoiding delay.

The Trust has been advised by the HSCB that elective baseline funding will be recurrent to appoint an additional consultant urologist and has requested submission of this IPT which sets out associated activity/implementation plan.

SECTION 2(a): OBJECTIVES

Project Objectives	Measurable Targets
1. Increase outpatient capacity for urology referrals by April 2021	**Baseline Urology OPD:** 2019/20 - SBA Baseline 3591 As at 1st August 2019 there were **4107** new patients on the waiting list. **Target:** Increase capacity by: • 299 New Outpatients • 798 Review Outpatients **Please note to achieve a reduction in waiting times a non-recurrent exercise will be required**
2. Increase daycase capacity for urology patients by April 2021	**Baseline Urology Daycase:** 2019/20 - SBA Baseline 3142 As at 1st August 2019 there were **690** patients on the waiting list **Target:** Increase capacity by: • **140 Daycases and** • **350 Flexible Cystoscopy** **Please note to achieve a reduction in waiting times a non-recurrent exercise will be required**
3. Increase inpatient capacity for urology patients by April 2021	**Baseline Urology Inpatients:** 2019/20 – SBA Baseline 1056 As at 1st August 2019 there were 959 patients on the waiting list **Target:** Increase capacity by: • **175 Elective In-patients** **Please note to achieve a reduction in waiting times a non-recurrent exercise will be required**
4. Reduce the time patients wait for their first outpatient appointment by April 2021	**Baseline:** At the 31 July 2019 there were 2179 waiting longer than 52 weeks. The longest wait was 184 weeks. **Target:** By March 2021 50% of patients should be waiting no longer than 9 weeks for an outpatient appoint and no patient waits longer than 52 weeks. The Trust cannot commit to a reduction in first outpatient appointment with this investment but will increase capacity for new outpatients and will continue to direct capacity to red flag and urgent waits in the first instance.

SECTION 2(b): CONSTRAINTS

Constraints	Measures to address constraints
1. Availability of Funding	The Health and Social Care Board has identified a conditional allocation pending submission of a robust Investment Proposal. This IPT sets out the volumes of activity to support the appointment of 1.00 WTE Consultant Urologist and staff support to expand the Urology Team at the Southern Trust.
2. Availability of trained Consultant staff and nursing support	The Trust continues to promote local and international recruitment campaigns to encourage trained nurses to apply for positions in the Trust. There may also be applicants who would be interested in relocating from the UK.

SECTION 3: IDENTIFY AND SHORTLIST OPTIONS

Option Number/ Description	Shortlisted (S) or Rejected (R)	Reason for Rejection
1. Status Quo - continue with existing arrangements	**S**	
3. Appoint an Additional Consultant Urologist (see below for detail)	**S**	
4. Appoint an additional 2.00 wte Consultant Urologists (see below for detail)	**S**	

Option 1 Status Quo

There would be no additional resources appointed/or additional capacity with the Status Quo.

Option 2 Appoint an additional Consultant Urologist

Option 2 involves funding a 7th Consultant Urologist. The indicative job plan and associated activity would be as follows:

Indicative job plan:

- 1 New OP clinic per week 299 pts
- 2 Review clinics OP 798 pts
- 2 In-patient lists 175 pts
- 1 x Day Case 140 pts
- 1 x Flexible Cystoscopy session 350 pts

(All of the above elective activity/elective theatre activity and opd activity is calculated x 35 weeks due to Urology Surgeon of the Week commitments).

To deliver this activity the necessary support staff and goods and services will also be required.
Additional staff resources are detailed at Appendix A

Option 3 Appoint two additional Consultant Urologists

Option 3 involves funding a 7th and 8th Consultant Urologist. The indicative job plan and associated activity would be as follows:

- 2 New OP clinic per week = 598 pts
- Review OP 1,596 pts
- 4 In-patient lists 350 pts
- 2 x Day Case 280 pts
- 2 x Flexible Cystoscopy session 700 pts

(All of the above elective activity/elective theatre activity and opd activity is calculated x 35 weeks due to Urology Surgeon of the Week commitments).

To deliver this activity the necessary support staff and goods and services will also be required.
Additional staff resources are detailed at Appendix B

SECTION 4: MONETARY COSTS AND BENEFITS OF OPTIONS

Option 1: Status Quo	Year 0 20/21 £ 000	Year 1 21/22 £ 000	Year 2 22/23 £ 000	Year 3 23/24 £ 000	Year 4 24/25 £ 000	Year 5 25/26 £ 000	Totals £ 000
Capital Costs							
(a) Total Capital Cost	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Revenue Costs							
Revenue Baseline	1,939.8	1,939.8	1,939.8	1,939.8	1,939.8	1,939.8	11,638.8
(b) Total Revenue Cost	**1,939.8**	**1,939.8**	**1,939.8**	**1,939.8**	**1,939.8**	**1,939.8**	**11,638.8**
(c) Total Cost = (a) + (b)	**1,939.8**	**1,939.8**	**1,939.8**	**1,939.8**	**1,939.8**	**1,939.8**	**11,638.8**
(d) Disc Factor @ 3.5%pa	*1.0000*	*0.9662*	*0.9335*	*0.9019*	*0.8714*	*0.8420*	
(e) NPC = (c) x (d)	**1,939.8**	**1,874.2**	**1,810.8**	**1,749.5**	**1,690.3**	**1,633.3**	**10,697.9**

COST ASSUMPTIONS:

Finance Assumptions:

1. Year 0 is 2020/21 Financial Year.
2. The baseline costs for this case is the 2019/20 recurring revenue budget for the HoS Urology (CA7830) in the DAS directorate of SHSCT.
3. No other revenue or capital costs are associated with this option
4. A discount factor @3.5% pa has been applied to calculate the NPC.
5. Please note all figures above have been rounded to thousands and shown to one decimal place.
6. Total Net Present Cost (NPC) equates to £10,697.9k for this option

Option 2: Appoint an additional Consultant Urologist (7th) & support infrastructure	**Year 0 20/21 £ 000**	**Year 1 21/22 £ 000**	**Year 2 22/23 £ 000**	**Year 3 23/24 £ 000**	**Year 4 24/25 £ 000**	**Year 5 25/26 £ 000**	**Totals £ 000**
Capital Costs							
Computers	4.9	0.0	0.0	0.0	0.0	0.0	4.9
(a) Total Capital Cost	**4.9**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**4.9**
Revenue Costs							
Revenue Baseline	1,939.8	1,939.8	1,939.8	1,939.8	1,939.8	1,939.8	11,638.8
Payroll	344.3	688.5	688.5	688.5	688.5	688.5	3,786.8
Unsocial allowances, On-Call and excess travel	23.2	46.4	46.4	46.4	46.4	46.4	255.2
Payroll related G&S	24.8	49.5	49.5	49.5	49.5	49.5	272.3
Additional G&S Costs	42.4	84.8	84.8	84.8	84.8	84.8	466.4
(b) Total Revenue Cost	**2,374.5**	**2,809.0**	**2,809.0**	**2,809.0**	**2,809.0**	**2,809.0**	**16,419.5**
(c) Total Cost = (a) + (b)	**2,379.4**	**2,809.0**	**2,809.0**	**2,809.0**	**2,809.0**	**2,809.0**	**16,424.4**
(d) Disc Factor @ 3.5%pa	*1.0000*	*0.9662*	*0.9335*	*0.9019*	*0.8714*	*0.8420*	
(e) NPC = (c) x (d)	**2,379.4**	**2,714.1**	**2,622.2**	**2,533.4**	**2,447.8**	**2,365.2**	**15,062.1**

COST ASSUMPTIONS:

Finance Assumptions:

1. Year 0 is 2020/21 Financial Year.
2. The baseline costs for this case is the 2019/20 recurring revenue budget for the HoS Urology (CA7830) in the DAS directorate of SHSCT.
3. The cost of the staff identified in Section 3 and Appendix A is calculated as per General Costing 2019.20 DRAFT 16.09.19. This includes an allowance for employee related G&S and appropriate allowances for unsocial hours payments.
4. The medical staff costs include an allowance for excess travel and an on-call provision for their rota. This also includes the cost of 11 APA's for each 1.00 WTE.
5. A provision has been made for additional G&S for the additional activity. This based on 10% of the average 2018/19 TFR cost for each procedure adjusted by 2.6% for inflation to 2019/20 Rates.
6. The G&S cost of a Flexible Cystoscopy is assumed to be the same as a day case (£122.82).
7. This work is expected to start on 01/10/2020 so a 6 month effect is included for 2020/21.
8. Office accommodation will be required for both the Consultant and Secretary on the CAH site the provision of which should be covered in the 10% G&S .
9. A computer/laptop/home access and mobile phone will be required for the Consultant Urologist and a desktop computer for the Secretary. A further laptop will be needed by the Consultant Anaesthetist. The Capital costs identified in this case is 2 * Laptops @ £1,700 plus 1 * desktop @ £1,500.
10. A discount factor @3.5% pa has been applied to calculate the NPC.
11. Please note all figures above have been rounded to thousands and shown to one decimal place.
12. Total Net Present Cost (NPC) equates to £15,062.1 for this option.

Option 3: Appoint 2.00 WTE Consultant Urologists (7th & 8th) and support infrastructure	**Year 0 20/21 £ 000**	**Year 1 21/22 £ 000**	**Year 2 22/23 £ 000**	**Year 3 23/24 £ 000**	**Year 4 24/25 £ 000**	**Year 5 25/26 £ 000**	**Totals £ 000**
Capital Costs							
Computers	8.3	0.0	0.0	0.0	0.0	0.0	8.3
(a) Total Capital Cost	**8.3**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**8.3**
Revenue Costs							
Revenue Baseline	1,939.8	1,939.8	1,939.8	1,939.8	1,939.8	1,939.8	11,638.8
Payroll	688.5	1,377.1	1,377.1	1,377.1	1,377.1	1,377.1	7,574.0
Unsocial allowances, On-Call and excess travel	46.4	92.9	92.9	92.9	92.9	92.9	510.9
Payroll related G&S	49.5	99.0	99.0	99.0	99.0	99.0	544.5
Additional G&S Costs	84.8	169.6	169.6	169.6	169.6	169.6	932.8
(b) Total Revenue Cost	**2,809.0**	**3,678.4**	**3,678.4**	**3,678.4**	**3,678.4**	**3,678.4**	**21,201.0**
(c) Total Cost = (a) + (b)	**2,817.3**	**3,678.4**	**3,678.4**	**3,678.4**	**3,678.4**	**3,678.4**	**21,209.3**
(d) Disc Factor @ 3.5%pa	*1.0000*	*0.9662*	*0.9335*	*0.9019*	*0.8714*	*0.8420*	
(e) NPC = (c) x (d)	**2,817.3**	**3,554.1**	**3,433.8**	**3,317.5**	**3,205.4**	**3,097.2**	**19,425.3**

COST ASSUMPTIONS:

Finance Assumptions:

1. Year 0 is 2020/21 Financial Year.
2. The baseline costs for this case is the 2019/20 recurring revenue budget for the HoS Urology (CA7830) in the DAS directorate of SHSCT.
3. The cost of the staff identified in Section 3 and Appendix B is calculated as per General Costing 2019.20 DRAFT 16.09.19. This includes an allowance for employee related G&S and appropriate allowances for unsocial hours payments.
4. The medical staff costs include an allowance for excess travel and an on-call provision for their rota. This also includes the cost of 11 APA's for each 1.00 WTE.
5. A provision has been made for additional G&S for the additional activity. This based on 10% of the average 2018/19 TFR cost for each procedure adjusted by 2.6% for inflation to 2019/20 Rates.
6. The G&S cost of a Flexible Cystoscopy is assumed to be the same as a day case (£122.82).
7. This work is expected to start on 01/10/2020 so a 6 month effect is provided in 2020/21.
8. Office accommodation will be required for both the two Consultants and their Secretary on the CAH site, the provision of which should be covered in the 10% employee related G&S.
9. A computer/laptop/home access and mobile phone will be required for the two Consultant Urologists and a desktop computer for their Secretary. Further laptops will be needed by the Consultant Anaesthetist and Consultant Radiologist. The Capital costs identified in this case is 4 * Laptops @ £1,700 plus 1 * desktop @ £1,500.
10. A discount factor @3.5% pa has been applied to calculate the NPC.
11. Please note all figures above have been rounded to thousands and shown to one decimal place.
12. Total Net Present Cost (NPC) equates to £19,425.3 for this option.

SECTION 5: NON MONETARY COSTS AND BENEFITS

Impact assessment

Non-Monetary Factor	Option 1 Status Quo	Option 2 Appoint a Consultant Urologist (7th) & infrastructure	Option 3 Appoint 2.00 wte Consultant Urologists & infrastructure
1. Increase outpatient capacity	There is limited potential to increase the current outpatient activity within the existing capacity available within the Status Quo.	Option 2 will provide additional new outpatient capacity for 299 new appointments for patients who are referred to a Consultant Urologist. To deliver the activity the necessary support staff and goods & services will be required.	Compared to Option 1 and Option 2 Option 3 will provide additional new outpatient capacity of 598 appointments. This would provide a significant improvement to the current outpatient capacity for patients referred to a Consultant Urologist. To deliver the activity the necessary support staff and goods & services will be required.
2. Increase daycase capacity	There is limited potential to increase the current daycase capacity with the Status Quo.	Option 2 will provide additional capacity for 140 day cases. To deliver the activity the necessary support staff and goods & services will be required.	Compared to Option 2 this option would provide capacity for an additional 280 day cases To deliver the activity the necessary support staff and goods & services will be required.
3. Increase inpatient capacity	There is very limited potential to increase the inpatient capacity within the current service model.	Option 2 will provide additional inpatient capacity for 175 patients. To deliver the activity the necessary support staff and goods & services will be required.	Compared to Option 2 Option 3 will provide 350 additional inpatient cases. To deliver the activity the necessary support staff and goods & services will be required.
4. Compliance with Ministerial OPD waiting time target	The Ministerial target states that by March 2020 – 50% of Patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks. As at July 2019 the longest wait was 184 weeks. There would be no improvement with the status quo as the existing Consultant complement could not achieve the stated compliance target. Waiting times and numbers of patients waiting would continue to increase.	Option 2 will increase the current funded consultant urology posts from 6 to 7. This will enable the team to reduce the number of patients waiting longer than 9 weeks and 52 weeks respectively. Option 2 will improve the waiting time target compared to Option 1. This will increase capacity by 299 outpatient appointments. However to effect a decrease in waiting times from the current level a non-recurrent exercise will be required.	Compared to both Options 1 and 2, Option 3 performs better. It will increase the current Consultant Urology posts from 6 to 8. This would provide additional scope for the Trust to achieve the Ministerial OPD waiting time target. This will increase capacity by 598 outpatient appointments. However to effect a decrease in waiting times from the current level a non-recurrent exercise will be required. However to effect a decrease in waiting times from the current level a non-recurrent exercise will be required.

SECTION 6: ASSESS RISKS AND UNCERTAINTIES

Risk Description	Likely impact of Risk L/M/H			State how the options compare and identify relevant risk management / mitigation measures
	Opt 1	Opt 2	Opt 3	
1. Reduction in current Consultant capacity (due to changes in pension tax regime)	H	H	H	Option 1, 2 and 3 all carry a high level of risk associated with the changes to pension. The changes to pension are prompting consultants and other senior medical staff to cut back on hours of work as they could obtain a significantly higher pension by cutting their hours. In relation to Northern Ireland the Permanent Secretary of Department of Health and Chief Executive of Health and Social Care for Northern Ireland are actively pursuing a way forward in respect of this issue.
2. Inability to appoint consultant/s	N/A	H	H	Option 1 involves no service change and therefore risk does not apply. This risk applies to options 2 and 3. It is deemed to be high for both options. There will be no-one completing training for the next 3 years. It may be possible that applicant/s may be interested in relocating from the UK. The Trust would however advertise for Locum staff. In the interim sessions could be considered as in-house additionality however there remains a risk with the current changes to tax regime. As noted at risk 1 above, once a doctor crosses a level of earnings the new rules come into play, this means that doctors are prompted to cut back on hours of work and it will be likely they will not wish to avail of additional working hours.
2. Inability to appoint nursing/key staff resources	N/A	H	H	Option 1 involves no service change and therefore risk does not apply. A high risk applies to options 2 and 3. There is a workforce deficit in nursing in Northern Ireland so recruiting to these posts will be a challenge. The Trust continues to progress a range of innovative approaches to recruitment including radio/ online/ social media campaigns, one-stop recruitment days, local, regional and national recruitment activities. There is also a risk with both option 2 & 3 that other key staff such as anaesthetic and radiology staff may not be appointed immediately. As with the urologist post the Trust would advertise again until posts are filled.

3. Availability of bed infrastructure	H	H	H	Due to emergency admissions the Trust continues to experience bed pressures. That said the Trust continually considers and implements new models of care/best practice and enhanced discharge planning processes with a view to alleviate bed pressures.
Overall Risk (H/M/L)	H	H	H	

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

Option 1 - Status Quo

This option will not make provision for any additional capacity within the Urology service. The waiting times for new patient referrals will continue to be a challenge for the Trust to achieve waiting time targets. The achievement of the project objectives will not be delivered.

Option 2 and Option 3 will deliver the desired benefits:

- Additional capacity will be provided for:
  - Outpatients
  - Day case patients
  - Inpatients
- Progress will be made towards compliance with the recommendations of the opd waiting time target that by March 2020 50% of patients should be waiting no longer than 9 weeks for an outpatient appointment and no patient waits longer than 52 weeks.

Option 3 would exceed option 2 in terms of delivery of benefits. However the risk of not being able to attract two consultants, due to the limited number available across the region, is significant. In addition the annual revenue cost of option 3 at **£1,738,628** is double that of Option 2 **£869,314.** Option 3 would exceed the funding envelope identified by the HSCB and therefore has not been identified as the preferred Option on this occasion.

The preferred Option is Option 2 – Appoint an Additional 7th Consultant Urologist and associated staff support. This option will meet the project objectives, enable additional capacity for urology patient referrals to the Trust and reduce the time patients wait for an appointment to see a Consultant Urologist.

There will remain a risk associated with changes to the NHS pension tax regime which will have a significant impact on all specialities in the future including urology. The Trust will actively advertise for both a Consultant Urologist and the necessary support staff with a view to expand the Urology Service at the Southern Trust.

SECTION 8: ASSESS AFFORDABILITY AND FUNDING ARRANGEMENTS

AFFORDABILITY STATEMENT	Year 0 20/21 £ 000	Year 1 21/22 £ 000	Year 2 22/23 £ 000	Year 3 23/24 £ 000	Totals £000's
Required:					
Capital	4.9	0.0	0.0	0.0	4.9
Resource	2,375.4	2,996.3	3,194.9	3,406.7	11,973.3
Depreciation	*1.0*	*1.0*	*1.0*	*1.0*	*4.0*
Existing Budget:					
Capital	0.0	0.0	0.0	0.0	0.0
Resource	1,939.8	2,068.4	2,205.5	2,351.7	8,565.4
Depreciation	*0.0*	*0.0*	*0.0*	*0.0*	*0.0*
Additional budget Required:					
Capital	4.9	0.0	0.0	0.0	4.9
Resource	435.6	927.9	989.4	1,055.0	3,407.9
Depreciation	*1.0*	*1.0*	*1.0*	*1.0*	*4.0*

Affordability narrative

Finance Assumptions:

1. Year 0 is 2020/21 Financial Year.
2. The baseline costs for this case is the 2019/20 recurring revenue budget for the HoS Urology (CA7830) in the DAS directorate of SHSCT.
3. The cost of the staff identified in Section 3 and Appendix A is calculated as per General Costing 2019.20 DRAFT 16.09.19. This includes an allowance for employee related G&S and appropriate allowances for unsocial hours payments.
4. The medical staff costs include an allowance for excess travel and an on-call provision for their Rota. This also includes the cost of 11 APA's for each 1.00 WTE.
5. A provision has been made for additional G&S for the additional activity. This based on 10% of the average 2018/19 TFR cost for each procedure adjusted by 2.6% for inflation to 2019/20 rates.
6. No Capital costs have been identified in this case.
7. Costs have been uplifted by 6.63% for inflation from 2020/21.
8. Please note all figures above have been rounded to thousands and shown to one decimal place.

SECTION 9: PROJECT MANAGEMENT (Please see additional activity detailed at Section 11)

It is proposed to implement the organisation and management of this project in accordance with the requirements of the Department of Finance and Personnel guidance relating to successful project management.

The following key roles have been identified:

- Project Owner – Mr Ronan Carroll (Assistant Director of Acute Services, Surgery & Elective Care & ATICS)
- Project Manager – Mrs Martina Corrigan, Head of ENT, Urology, Ophthalmology and Outpatients

A review of the project in relation to the stated objectives will be undertaken 12 months after full implementation.

Activity will be monitored on an ongoing basis via the Performance Management Team and submitted to the Health and Social Care Board.

SECTION 10: MONITORING AND EVALUATION

Who will manage the implementation? (please provide the name of the responsible individual where possible)	Ronan Carroll, Asst Director, Surgery and Elective Care and ATICs
Who will monitor and evaluate the outcomes? (please provide the name of the responsible individual where possible)	Acute Head of Service (independent to the project) will undertake post project evaluation
What other factors will be monitored and evaluated?	Appointment and commencement of Consultant Urologist and support staff
When will this take place? (preferably 4 to 12 months after project closure)	During the recruitment and commencement of the Consultant. A Post Project Evaluation will be undertaken 12 months after implementation.

SECTION 11: ADDITIONAL ACTIVITY

Specify the additional activity commensurate with the value of the Investment Proposal Template (expand as required where more service lines are involved.) Please ensure that any changes in activity arising from productivity and efficiencies associated with the investment are also recorded. See example.

				Activity From (previous SBA baseline)	Activity To (New SBA Baseline)		Please specify if activity relates to Investment or Productivity / Efficiency Gains
PoC	**Service line descriptor 1**	**Service line descriptor 2**	**Currency** use existing SBA currency e.g. (FCE / OP atts / Daycase / contacts / caseload / Occupied Beddays / Hours etc	**Full Year Effect Total**	**Current Year Effect Total**	**Full Year Effect Total**	**I - Investment** **P - Productivity**
Acute	Urology	Appointment of a 7th Consultant Urologist	New OP – 299 Review OP –798 Elective In-patients –175 Day cases –140 Flexible cystoscopy – 350	New OP – 3591 Review OP – 4489 Elective In-pts – 1056 Day cases – 3142 FCEs – 629 OP Procedures - 432	-	New OP – 3890 Review OP – 5287 Elective In-pts – 1231 Day cases – 3282 FCEs – 979	I

SECTION 11: MONITORING AND EVALUATION

Mr Ronan Carroll, Assistant Director of Acute Services, Surgery and Elective Care and ATICs will manage the implementation of this service expansion. Timescale for the implementation of the urology service expansion will primarily be dependent on the commencement date of the Consultant Urologist pursued as follows:

Task	Timescale
Approval of IPT by Trust SIC	February 2020
Approval of IPT by HSCB	March 2020
Confirmation of funding allocation	May 2020
Completion/approval of job plan to Specialty Advisor	May 2020
Advertisement of Consultant Post	July 2020
Advertisement of support staff	July 2020
New Consultant in Post	October 2020

A review of the project in relation to the stated objectives will be undertaken 12 months after full implementation of the proposal following the appointment of the new Consultant. The evaluation will be undertaken by a Head of Service independent to the Urology Team.

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

BENCHMARK

Craigavon Area Hospital has been designated as a Cancer Unit, with its Urological Department being designated the Urology Cancer Unit for the area population of 490,000 (including Fermanagh) A wide spectrum of urological cancer management has been provided for some time. Cancer surgery includes orthotropic bladder reconstruction in the management of bladder cancer. Cancer management also includes intravesical chemotherapy for bladder cancer. Immunotherapy for renal cell carcinoma is also performed.

'The British Association of Urological Surgeons (BAUS) recommends a consultant workforce ratio of 1 wte per 60,000 population' which would indicate a recommended consultant workforce for the Trust of 8.0 wte.

This IPT sets out evidence to support the need for a further Consultant Urologist in line with BAUS guidelines.

Consultant Urologist (7th) & Additonal Staffing - (Based at DHH) - APPENDIX A	
Costing Schedule provided at Appendix C	
OPTION 2	
1 New OP clinic per wk = 299 pts 2 Review OP 798 pts 2 In-patient lists 175 pts 1 x Day Case 140 pts 1 x Flexible scope session 350 pts (activity calculated x 35 weeks)	
Recurring	**WTE**
Medical Staff	
Consultant Urologist	1.00
Consultant Anaesthetist	0.62
Consultant Radiologist	0.50
Specialist Nursing	
Band 7	1.00
Pre-op Assessments	
Band 5	0.17
Band 6	0.15
Theatres Nurses	
Band 6	0.52
Band 5	1.60
Band 5 (Recovery)	0.52
Band 3 "	0.52
	3.16
Elective Admission Ward Nursing	
Band 5	1.00
Band 3	1.00
	2.00
Outpatients	
Band 5	0.40
Band 3	0.78
	1.18
Ultrasonographers Band 7	0.50
	0.50
Laboratory	
Consultant Pathologist	0.10
BMS Band 7	0.15
	0.25
Pharmacy	
Clinical Pharmacist Band 7	0.20
Pharmacy Technician Band 4	0.20
	0.40
CSSD	
ATO Band 2	0.33
	0.33
Admin Support	
PAS/Clinical Coding Band 4	0.10
Personal Secretary Band 4	0.50
Booking Clerk Band 3	0.55
Audio Typist Band 2	0.55
Health Records Band 2	0.51
	2.21
Hotel Services	
Band 2	0.30
Goods & services	
Outpatient attendances 299 new & 798 review	
Day case x 140	
Flexible scopes x 350	

Consultant Urologist (7th & 8th) & additional staff resources			APPENDIX B
(based at DHH)			
Costing Schedule provided at Appendix C			
Option 3			
2 New OP clinic per wk = 1,596 pts Review OP 1,596 pts 4 In-patient lists 350 pts 2 x Day Case 140 pts 2 x Flexible scope session 350 pts (activity calculated x 35 weeks)			
Recurring	**WTE**		
Medical Staff			
Consultant Urologist	2.00		
Consultant Anaesthetist	1.24		
Consultant Radiologist	1.00		
Specialist Nursing			
Band 7	2.00		
Pre-op Assessments			
Band 5	0.34		
Band 6	0.30		
Theatres Nurses			
Band 6	1.04		
Band 5	3.20		
Band 5 (Recovery)	1.04		
Band 3 "	1.04		
	6.32		
Elective Admission Ward Nursing			
Band 5	2.00		
Band 3	2.00		
	4.00		
Outpatients			
Band 5	0.80		
Band 3	1.56		
	2.36		
Ultrasonographers Band 7	1.00		
	1.00		
Laboratory			
Consultant Pathologist	0.20		
BMS Band 7	0.30		
	0.50		
Pharmacy			
Clinical Pharmacist Band 7	0.40		
Pharmacy Technician Band 4	0.40		
	0.80		
CSSD			
ATO Band 2	0.66		
	0.66		
Admin Support			
PAS/Clinical Coding Band 4	0.20		
Personal Secretary Band 4	1.00		
Booking Clerk Band 3	1.10		
Audio Typist Band 2	1.10		
Health Records Band 2	1.02		
	4.42		
Hotel Services			
Band 2	0.60		
Goods & services			
Outpatient attendances 299 new & 798 review			
Day case x 140			
Flexible scopes x 350			

Appendix C

Schedule of Costs for Option 2 and 3 (page 23)

Summary Costing schedule for Investment Decision Making Templates	Ref Number
Provider	SOUTHERN
Hospital Site or Community development	CRAIGAVON
Scheme Title	Elective Care 2020/21 - Expansion of Southern Trust Urology Team -7th Consultant Urologist
Pay and Price Levels	2019/20

Commissioner Use only
Sign and Date for TRAFFACS update

		Base Case - option 1				Option 2				Option 3			
Pay Costs	Description	months claimed	wte	fye	cye	months claimed	wte	fye	cye	months claimed	wte	fye	cye
				1,939,777	1,939,777			1,939,777	1,939,777			1,939,777	1,939,777
Specialist Nursing					0				0			0	0
Band 7	Nurse				0	6.00	1.00	50,744	25,372	6.00	2.00	101,488	50,744
Pre-op Assessments					0								
Band 5	Nurse				0	6.00	0.17	6,006	3,003	6.00	0.34	12,012	6,006
Band 6	Nurse				0	6.00	0.15	6,358	3,179	6.00	0.30	12,715	6,358
Theatre Nurses					0								
Band 5	Nurse				0	6.00	1.60	56,525	28,262	6.00	3.20	113,050	56,525
Band 6	Nurse				0	6.00	0.52	22,040	11,020	6.00	1.04	44,079	22,040
Band 5 (Recovery)	Nurse				0	6.00	0.52	18,371	9,185	6.00	1.04	36,741	18,371
Band 3	Nursing Assistant				0	6.00	0.52	12,849	6,425	6.00	1.04	25,698	12,849
Elective Admissions Ward					0								
Band 5	Nurse					6.00	1.00	35,328	17,664	6.00	2.00	70,656	35,328
Band 3	Nursing Assistant					6.00	1.00	24,710	12,355	6.00	2.00	49,420	24,710
Outpatients													
Band 5	Nurse					6.00	0.40	14,131	7,066	6.00	0.80	28,262	14,131
Band 3	Nursing Assistant					6.00	0.78	19,274	9,637	6.00	1.56	38,548	19,274
Band 7	Ultrasonographer					6.00	0.50	25,372	12,686	6.00	1.00	50,744	25,372
Laboratory													
Band 7	BMS					6.00	0.15	7,612	3,806	6.00	0.30	15,223	7,612
Pharmacy													
Band 7	Clinical Pharmacist					6.00	0.20	10,149	5,074	6.00	0.40	20,298	10,149
Band 4	Pharmacy Technician					6.00	0.20	5,786	2,893	6.00	0.40	11,572	5,786
Support Services													
Band 2	ATO - CSSD					6.00	0.33	7,465	3,732	6.00	0.66	14,930	7,465
Band 4	PAS Clinical Coding					6.00	0.10	2,893	1,447	6.00	0.20	5,786	2,893
Band 4	Personal Secretary					6.00	0.50	14,466	7,233	6.00	1.00	28,931	14,466
Band 3	Booking Clerk					6.00	0.55	13,591	6,795	6.00	1.10	27,181	13,591
Band 2	Audio Typist					6.00	0.55	12,442	6,221	6.00	1.10	24,883	12,442
Band 2	Health Records Clerk					6.00	0.51	11,537	5,768	6.00	1.02	23,073	11,537
Band 2	WBS				0	6.00	0.30	6,786	3,393	6.00	0.60	13,573	6,786
Non-AFC posts please detail below					0								
Medical	Consultant Pathologist - Cat A, No on-call, 11 APA					6.00	0.10	13,126	6,563	6.00	0.20	26,252	13,126
Medical	Consultant Urologist - Cat A on-call 1 in 7, 11 APA				0	6.00	1.00	137,885	68,943	6.00	2.00	275,770	137,885
Medical	Consultant Anaesthetist - Cat A on-call 1 in 8, 11 APA					6.00	0.62	85,489	42,744	6.00	1.24	170,977	85,489
Medical	Consultant Radiologist - Cat A on-call 1 in 16 11 APA				0	6.00	0.50	67,617	33,809	6.00	1.00	135,234	67,617
Allowances for posts noted above - please detail below					0								
Excess Travel													
Medical	£2k per 1.00 WTE					6.00		4,440	2,220	6.00		8,880	4,440
Unsocial Hours payments													
Theatre Nurses					0				0				0
Band 5	Nurse - 24 hr working - 23.09%				0	6.00		13,052	6,526	6.00		26,103	13,052
Band 6	Nurse - 24 hr working - 23.09%				0	6.00		5,089	2,544	6.00		10,178	5,089
Band 5 (Recovery)	Nurse - 24 hr working - 23.09%				0	6.00		4,242	2,121	6.00		8,484	4,242
Band 3	Nursing Assistant - 24 hr working - 28.47%				0	6.00		3,658	1,829	6.00		7,316	3,658
Ultrasonographers													
Band 7	Ultrasonographer - Weekend Working - 17.24%					6.00		4,374	2,187	6.00		8,748	4,374
Pharmacy													
Band 7	Clinical Pharmacist - Weekend Working - 17.24%					6.00		1,750	875	6.00		3,499	1,750
Band 4	Pharmacy Technician - Weekend Working - 17.24%					6.00		998	499	6.00		1,995	998
Support Services									0				0
Band 2	ATO - CSSD - Weekend Working - 21.45%					6.00		1,601	801	6.00		3,202	1,601
Band 4	PAS Clinical Coding - Weekend Working - 17.24%					6.00		499	249	6.00		998	499
Band 3	Booking Clerk - Weekend Working - 20.62%					6.00		2,802	1,401	6.00		5,605	2,802
Band 2	Health Records Clerk - Weekend Working - 21.45%					6.00		2,475	1,237	6.00		4,949	2,475
Band 2	WBS - Weekend Working - 21.45%				0	6.00		1,456	728	6.00		2,911	1,456
Salary Related G&S: /													
Band 2	Salary related G&S					6.00		2,942	1,471	6.00		5,885	2,942
Band 3	Salary related G&S					6.00		5,395	2,698	6.00		10,790	5,395
Band 4	Salary related G&S					6.00		1,762	881	6.00		3,523	1,762
Band 5	Salary related G&S					6.00		9,852	4,926	6.00		19,705	9,852
Band 6	Salary related G&S					6.00		2,134	1,067	6.00		4,268	2,134
Band 7	Salary related G&S					6.00		7,023	3,511	6.00		14,045	7,023
Medical	Consultant Pathologist					6.00		881	441	6.00		1,762	881
Medical	Consultant Urologist					6.00		9,250	4,625	6.00		18,500	9,250
Medical	Consultant Anaesthetist					6.00		5,735	2,868	6.00		11,470	5,735
Medical	Consultant Radiologist					6.00		4,537	2,269	6.00		9,074	4,537
	TOTAL PAY COSTS		**0.00**	**1,939,777**	**1,939,777**		**13.77**	**2,724,271**	**2,332,024**		**27.54**	**3,508,764**	**2,724,271**
Non-Pay Costs, Option 2 - please detail below													
Outpatient Attendences - 798 Review @ £22.46					0	6.00		17,923	8,962				
Outpatient Attendences - 299 new @ £22.46					0	6.00		6,716	3,358				0
Day Case * 140 @ £122.82						6.00		17,195	8,597				
Flexible Cystoscopy * 350 @ £122.82					0	6.00		42,987	21,494				0
									0				
Non-Pay Costs, Option 3 - please detail below													
Outpatient Attendences - 1,596 Review @ £22.46										6.00		35,846	17,923
Outpatient Attendences - 598 new @ £22.46										6.00		13,431	6,716
Day Case * 280 @ £122.82										6.00		34,390	17,195
Flexible Cystoscopy * 700 @ £122.82					0				0	6.00		85,974	42,987
					0				0				0
					0				0				0
	TOTAL NON-PAY COSTS			**0**	**0**		**13.77**	**84,820**	**42,410**		**27.54**	**169,641**	**84,820**
	GRAND TOTAL			**1,939,777**	**1,939,777**			**2,809,091**	**2,374,434**			**3,678,405**	**2,809,091**
								869,314	434,657			1,738,628	869,314
Phasing/Timescale		*(Can development be phased, if so provide details in this box)*				*(Can development be phased, if so provide details in this box)*				*(Can development be phased, if so provide details in this box)*			
PROGRAMME OF CARE		acute				acute				acute			
SUB-SPECIALTY INFORMATION eg inpatients, outpatients, daycases if known													
LCG													
If more than one LCG in option above please give details													
LGD													
If more than one LGD in option above please give details													

REVENUE BUSINESS CASE PROFORMA COVER

(To be submitted with every business case)

Name of Organisation	Southern Health & Social Care Trust
Project Title	Development of the Northern Ireland Stone Treatment Centre for provision of ESWL for the province.
Total Cost	£522,988 at 2021/22 rates or £535,610 after a 3% allowance for 2021/22 Pay increase
Start Date	01/04/2022
Completion Date	Recurrent funding requested

Complete this section if bid is for new funding

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	Yes
How much total funding required?	£522,988 at 2021/22 rates or £535,610 after a 3% allowance for 2021/22 Pay increase
How much funding required per year?	£522,988 at 2021/22 rates or £535,610 after a 3% allowance for 2021/22 Pay increase
Is this funding to be made recurrent?	Yes

Complete this section if funding available within existing allocation

Funding available within existing allocation (Y/N)	No
Total cost of proposal	
Cost of proposal per year	
Is this cost within recurrent allocation?	

Is this business case	***Y/N***
(a) Standard	Y
(b) Novel	N
(c) Contentious	N
(d) Setting a precedent	N
If yes to (b) or (c) or (d), requires Departmental & DoF approval Is Departmental/DOF approval required	n/a

Approval & submission by Trust

This section to be completed by Trusts for all submissions

Responsible Director Signature (required for all submissions)			
Name Printed	Melanie McClements	**(signed)**	
Grade/Title	Director of Acute Services	**Date**	

Trust Director of Finance Signature (required if bid is over £100k)		
Name printed	Catherine Teggart	**(signed)**
Date		

Trust Chief Executive Signature (required if bid is over £100k)		
Name printed	Shane Devlin	**(signed)**
Date		

Complete this section if Department /DOF approval required

Date submitted to Department	
Department/ DOF approval (Y/N)	**Date approved**

BUSINESS CASE TEMPLATE REVENUE FUNDING £50k - £250k

SECTION 1: PROJECT BACKGROUND, STRATEGIC CONTEXT & NEED

Introduction

This paper outlines a proposal associated with enhancing the Extra Corporeal Shockwave Lithotripsy & Generalised Stone Service within the Southern Health & Social Care Trust.

Associated costs of **£535,610** have been identified and approval is now being sought from Senior Management Team for the progression of this proposal.

Trust Senior Managers have been in discussion with regional Commissioners to advice a proposal is being developed and their support and approval of funding is greatly welcomed.

Craigavon Area Hospital (CAH) has the only fixed site lithotripter in Northern Ireland to provide stone treatments on a regular and predictable basis. NICE guidelines specifically focus on the delivery of ESWL as a primary method for treating suitable renal and ureteric stones. It is a recognized, cost effective method of day case treatment and has the ability to reduce the strain on elective and emergency theatre operating lists, and reduce the excessively long wait for stone treatments experienced currently by patients in Northern Ireland. This is both a cheaper and lower risk method of treating stones than expanding theatre capacity - between £1,248 - £2,235 per patient lower than expanding day case and inpatient Ureteroscopy.

GIRFT report (Getting it Right First Time expert UK report on distribution and funding of urological services)

'By contrast, only four providers treated more than 10% of emergency admissions with ESWL. While it is not always successful and is not appropriate for all patients and all stones, it offers the benefits that patients do not need a general anaesthetic and are usually mobile immediately after the procedure. During GIRFT visits, providers were asked why they did not provide definitive stone treatment with Ureterostomy or ESWL for more of their emergency stone patients. A range of reasons were given, from not having access to a suitable operating theatre to a lack of staff trained to use the stone laser or assist with emergency stone procedures. It was also clear that not all units offer emergency ESWL, even when a lithotripter is available in a neighbouring hospital. It should be possible to overcome all of these obstacles to effective care. **All hospitals that admit emergency urology patients should be able to provide the surgeon with facilities for Ureteroscopy and laser lithotripsy for acute cases. Access to acute ESWL should be available by liaising with the urology department in the region that has a lithotripter permanently on site.'**

Extra Corporeal Shockwave Lithotripsy (ESWL)

Definitive stone treatment can be provided by ESWL. This non-invasive technology uses a machine to send highly focused pressure pulses into the body in a way that will fragment a stone and allow passage of the resultant debris. ESWL is typically provided on an outpatient basis, often over two or more treatment episodes. Suitable patients are vetted by a stone multidisciplinary team, including Consultant Urologists, and the treatment delivered by trained radiographers. In the first instance, renal tract stones will be detected via the use of CT which will determine their size, density, location and potential suitability for ESWL with ultrasound or X-Ray confirming visibility for the treatment.

Patients within the Southern Trust area suitable for this treatment may attend on a day case elective basis or for emergency ESWL for ureteric stones if requiring inpatient admission. Treatment sessions last for approximately 40minutes.

Guidelines for the management of renal colic/renal and ureteric stones are documented in:-

- British Association of Urological Surgeons "**Standards for the Management of Acute Ureteric Colic" September 2017**
- National Institute for Health & Care Excellence guideline **"Renal & Ureteric Stones: Assessment and Management (consultation 20 January to 17 February 2017)"**

"Stone removal is recommended in the instance of persistent obstruction, failure of stone progression or increasing or unremitting colic. The choice of treatment to remove a stone depends on the size, site and

shape of the stone. Options include extra corporeal shockwave lithotripsy (ESWL) Ureteroscopy with laser, percutaneous nephrolithotomy or open surgery".

"Where suitable, ESWL offers a non-invasive treatment with lower complication rates and a shorter hospital stay".

In addition, the current standards associated with care for acute stone pain and use of ESWL (British Association of Urological Surgeons "***Standards for the Management of Acute Ureteric Colic" September 2017)*** states that "for symptomatic ureteric stones, primary treatment of the stone should be the goal and should be undertaken within 48 hours of the decision to intervene"

The Elective Care Framework – Restart, Recovery and Redesign (June 2021) proposes a £700m investment over five years. It sets out firm, time bound proposals for how we will systematically tackle the backlog of patients waiting longer than Ministerial standards, and how we will invest in and transform services to allow us to meet the population's demands in future. It describes the investment and reform that are both required - targeted investment to get many more people treated as quickly as possible; and reform to ensure the long-term problems of capacity and productivity are properly addressed.

Based on the success of the elective care centre prototypes in cataracts and varicose veins, and the development of the first Regional Day Procedure Unit, there are opportunities for further planning to involve other specialties and procedures to be expanded via Day Elective Care Centres.

The Southern Trust has been participating in the Urology Project Improvement Group for a number of years, alongside other Trust Urology Clinicians with a view to collectively working to develop regional pathways and service improvements to tackle the long waiting lists for urological procedures. Development of the Lagan Valley Site to manage Ureteroscopies is well underway with a collective regional approach across the Trusts to ensure improved access for patients requiring this day case intervention. Subsequently this proposal supports a full pathway development for stone treatment by increasing throughput in CAH for those patients suitable for ESWL. Collectively the pathway being developed in LVH and approval to proceed with additional sessions in CAH for ESWL will significantly improve the waiting list position for this patient cohort.

Current Service Provision

At the present time, there is only one fixed Lithotripsy machine in Northern Ireland, located in CAH, with a mobile unit available variably in Belfast arriving by boat from the main land provided by an external company. The current machine in CAH is funded to provide 3 sessions of activity – a fourth session is funded at risk.

The fixed Lithotripter machine at CAH provides stone treatment to the resident population of the Southern Trust and receives referrals from the SE Trust.

Current Capacity

The Stone Treatment Centre (STC) in CAH facilitates a total of four weekly ESWL sessions. The first treatment commences at 9.00 am with the session ending at 1.00 pm then afternoon session 1.30pm – 5pm. A total of **8** patients undergo ESWL treatments every week, equating to 2 patients being seen per session.

Patients' referrals for ESWL are received via a number of channels including:-

1. Emergency Departments at Craigavon Area and Daisy Hill Hospitals
2. General Practitioners within the Southern Trust region
3. Wards in Craigavon Area Hospital and Daisy Hill Hospital
4. Consultant Urologists from Southern and South-Eastern Health & Social Care Trusts
5. Altnagelvin Hospital

At present, emergency ESWL treatments can be made available ad-hoc if there is a cancellation but as the unit develops, we would plan to offer regular emergency slots to relieve pressure on the emergency inpatient lists.

The current staffing establishment to provide 3 sessions is:-

- 0.30 WTE Consultant
- 0.30 WTE Radiographer
- 0.30 WTE Band 5 Nurse

- 0.30 Band 3 Healthcare Assistant
- 1 PA/ week Speciality Doctor

Key Issues/Assessment of Need

The growing demands being placed upon the Trust's ESWL & Generalised Stone Service understandably proves challenging when taking into consideration the number of issues in terms of:-

1. Demand & Capacity

Since the introduction of the Extra Corporal Shockwave Lithotripsy (ESWL) service on 11 September 1998, there has been a steady increase in the number of patients being offered this treatment regime.

As at November 2021 there are 163 on the waiting list for stone treatment, 157 weeks is the longest waiter.

- 69 urgent waits – longest wait 90 weeks
- 94 routine waits - longest wait 157 weeks
- On average 4 patients are added to the waiting list per week

A summary of waiting list position as per other Trusts in the region is provided below for comparison:

WHSCT – 17 urgent cases and 31 routine cases and BHSCT – 1 urgent – 23 routine however this is not representative of true numbers of patients who should be offered ESWL as described by a Western HSC Trust consultant:

' Most (patients) I think would get follow up imaging primarily given lack of access to both ESWL and ureteroscopy.'

There are increasing numbers of patients being referred into the Service internally and externally with rising waiting times. This burden is translated into other areas like radiology waiting lists as scans need repeated prior to ESWL. Also, with delay to stone treatment there is a risk of patient morbidity and presentation as an emergency adding pressure to the Emergency Department and inpatient services. Furthermore, delays in treatment means that stones that could have been offered a lower risk and lower cost procedure move to requiring more invasive and more costly surgery as their stone burden progresses over time.

2. Emergency ESWL Provision for Upper & Distal Ureteric Stones

In addition to the number of adult patients awaiting outpatient (elective) ESWL treatment, on average approximately 8 patients will have a Ureteroscopy performed each week at Craigavon Area Hospital.

Understandably, this practice is counter-productive as it hinders the Trust's ability to adhere with the respective guidelines associated with the assessment and treatment of ureteric stones[1] which states that "primary treatment of the stone should be the goal and should be undertaken within 48 hours of the decision to intervene". More non-invasive procedures and extended availability across the week would support the Trust to comply with guidelines.

3. Service Model

The proposed regional service to meet the demand for ESWL stone treatments for the population of Northern Ireland would have the STC providing treatments 5 days a week for elective and emergency cases. Each session be would be staffed by 2 nurses and 2 radiographers with 2PAs/ week for a doctor to help with documentation and preparation for the elective patients. A dedicated administrator would support the unit. The currently funded stone meeting would continue to provide multidisciplinary input to patient treatment planning and follow-up. We would expect to be able to provide 3 treatments per session totalling 30patients a week. This would cover current demand from across the province but extra lists may be needed to clear waiting list backlog. There is a dedicated stone treatment centre in CAH capable of providing such a service and with minor architectural changes and staffing increase, capacity may be further increased. In time, increasing the size of the unit, incorporating a more defined management structure and staff developing expertise in delivering ESWL would further improve throughput and improve the patient's experience.

Regarding the current service model, a lithotripter machine has been in operational use since the late 1990s (circa 20 years). At that time, the working practices put in place adequately met the needs of the service. Inevitably increased demand and changes in medical practice have evolved in recent

years with only a few modifications or adaptions to the working practices within the STC.

However over the last 4 years the STC team have been actively reviewing, auditing and improving various aspects of the STC to maximize efficiency and throughput including:

- Securing funding for a dedicated STC secretary to aid with administration from the unit
- Increase of ESWL treatment frequency to 1.4Hz, maintaining treatment quality but reducing treatment time
- Organisation of pre ESWL medications being posted to the patient to reduce patient time in the unit and nursing supervision requirements
- Stone meeting setup to standardise vetting of patients, treatment plan and follow-up with multidisciplinary input. The treatment plan and self-care advice is then communicated in a timely and effective manner to the patient. The Stone meeting was short listed for the HSJ value awards in Sept 2021.

4. Resource limitations

The STC has optimized its performance within the resources available, however to further improve the efficiency and productivity of the service the following challenges remain:

- Staffing
  Currently an ESWL session has one radiographer, a nurse and a health care assistant. In order to have the lithotripter actively treating throughout a session and reaching patients numbers of 3 per session, **2 radiographers and 2 nurses are required for each session** to support efficient patient flow and prevent lithotripter down time. The provision of 2 radiographers and 2 staff nurses at any one time means that patients can be prepped and consented while another patient is receiving their treatment. This model also avoids any downtime for breaks and ensures appropriate governance measures are in place for administration of medications. The provision of a clinical sister role for the unit also supports the governance arrangements in a stand-alone unit whilst providing necessary patient support and administration functions for the team. The unit will be lead by radiography with a strong nursing support. The staff grade cover will enable pre-checking of patients booked for treatment, ordering of appropriate diagnostics and follow up if required. Outside the availability of the Speciality Doctor, on call arrangements will be in place with the core urology team if required. Consultant input will only be required at the MDT to support patient selection and to provide service oversight.
  The Team have approached the Scottish lithotripter Centre in Western General Hospital, Edinburgh to seek advice and guidance on the model that they have implemented. Their staffing model of 4 fulltime radiographers, 2 fulltime Nursing staff and fulltime admin support the service model undertaking diagnostic imaging for all stone patients, delivery of lithotripsy treatment 5 days er week and all necessary patient follow-up it is therefore felt that the bid for expansion of CAH service is in keeping with nationally recognised models for stone treatment.
- Environment
  Particularly in the COVID era, a reconfiguration of the STC floor plan would improve patient flow, reduce risk of cross infection and facilitate a recovery area to increase throughput of the unit. The preparation for this work has already been done with architects, but funding is required to action the recommended changes.
  The lithotripter was replaced in 2015 and with a lifespan of 15 years is not expected to require replacement until 2030.

A financial analysis on the costs of current practice has been provided below:

	17/18	19/20	Difference
Craigavon Urology Theatre for elective ureteroscopy			
• As an elective day case £1,071 (based on 131 daycases)	1608	1071	-537
• As an elective case with average inpatient stay £2,495 (based on 59 elective inpatients)	2747	2495	-252
Craigavon Urology Theatre for emergency ureteroscopy			
• Long stay inpatient No long stay patients in 19/20	2862	No 19/20 costs	
• Short stay inpatient £2,706 (based on 8 non-elective short stay patients)	2376	2706	330
Craigavon Stone Treatment Centre for elective ESWL (Extra Corporal Shockwave Lithotripsy)			
• Cost per elective outpatient patient Not costed at outpatient level.	363	No 19/20 costs	
• Cost per inpatient ESWL No ESWL inpatients identified for 19/20	627	No 19/20 costs	
Cost per Daycase ESWL £451 (based on 309 daycases	0	451	

SECTION 2 (a): OBJECTIVES

Project Objectives	Measurable Targets
1. Improve access to ESWL Service by 31 March 2022	• Increase access across the week ➢ Baseline – 3 sessions per week ➢ Target – 10 sessions per week by March 2022 • Provide daily slots for emergency ESWL provision for upper and distal ureteric stones
➢ Reduction of waiting time for ESWL Treatment in CAH	• Facilitation of appropriate ESWL provision which increases available sessions for elective treatment:- ➢ Baseline – 163 patients as at November 2021 ➢ Clinical Target – 2 weeks for Urgent and Routine ESWL Treatment
2. Improve the efficiency of the current ESWL Service by 31 March 2022	• Increase number of patients treated per session:- ➢ Baseline – a total of 2 patients per session (as of November 2021) ➢ Target – a total of 3 patients per session (on appointment of additional staffing resources) on appointment of recurrent additional staffing resources

SECTION 2 (b): CONSTRAINTS

Constraints	Measures to address constraints
1. Availability to appoint additional staffing resources	The Trust will ensure that robust recruitment processes are in place, maintaining close links with BSO and Human Resources to ensure that any issues which may arise are promptly addressed
2. Recurrent revenue funding not secured	The Trust will maintain close links with the HSCB in order to proactively seek financial support for the service
3. Environment development	Architectural changes to improve patient flow and throughput through the unit

SECTION 3: IDENTIFY AND DESCRIBE OPTIONS

Option No	Brief Description of Option
1	**Do Nothing/Status Quo - continue with existing arrangements** This option will entail the continuation of the existing service model of 4 ESWL sessions per week permitting a total of 8 patients to be treated per week. Although this option will not meet the project objectives, it has been shortlisted as a base case comparator.
2	**Increase ESWL Sessions from 4 to 10 Sessions per week within Stone Treatment Centre at Craigavon Area Hospital** This option seeks to maximize the existing lithotripter by providing a full 10 session service resulting in 30 treatments per week. The following additional staffing is required to cover a full 10 session service • 2.36 WTE Band 7 Radiographer • 2.36 WTE Band 5 Nurse • 1.32 WTE Band 6 Clinical Sister • 1.02 WTE Band 3 Healthcare Assistant • 1 PA's Specialty Doctor • 0.50 WTE Band 3 audio typist • 0.10 WTE Band 2 Health Records / booking Clerk • 0.13 WTE Band 2 Domestic • 1.00 WTE Band 4 Administrator for the Stone Treatment Centre **Total 8.89**
3	**Increase ESWL sessions on a phased basis by increasing from 4 to 6 sessions within Stone Treatment Centre at CAH** This option seeks to improve capacity in a phased manner by increasing sessions to 6 per week (additional 2 per week) which would result in 18 treatments per week, The following additional staffing is required to cover a full 6 session service • 1.30 WTE Band 7 Radiographer • 1.30 WTE Band 5 Nurse • 0.80 WTE Band 6 Clinical Sister • 0.50 WTE Band 3 Healthcare Assistant • 0.50 WTE Band 3 Audio typist • 0.10 WTE Band 2 Health Records / booking Clerk • 0.13 WTE Band 2 Domestic • 0.70 WTE Band 4 Administrator for the Stone Treatment Centre **Total 5.33** NB: Radiographer, Nursing and HCA staff WTE is inclusive of 25% uplift to cover annual leave, sick leave and training requirements.

SECTION 4: MONETARY COSTS AND BENEFITS OF OPTIONS

Option 1: Status Quo	**Year 0 22/23 £ 000**	**Year 1 23/24 £ 000**	**Year 2 24/25 £ 000**	**Year 3 25/26 £ 000**	**Year 4 26/27 £ 000**	**Year 5 27/28 £ 000**	**Totals £ 000**
Capital Costs							
(a) Total Capital Cost	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Revenue Costs							
Baseline Costs	2,152.5	2,152.5	2,152.5	2,152.5	2,152.5	2,152.5	12,915.0
(b) Total Revenue Cost	**2,152.5**	**2,152.5**	**2,152.5**	**2,152.5**	**2,152.5**	**2,152.5**	**12,915.0**
(c) Total Cost = (a) + (b)	**2,152.5**	**2,152.5**	**2,152.5**	**2,152.5**	**2,152.5**	**2,152.5**	**12,915.0**
(d) Disc Factor @ 3.5%pa	*1.0000*	*0.9662*	*0.9335*	*0.9019*	*0.8714*	*0.8420*	
(e) NPC = (c) x (d)	**2,152.5**	**2,079.7**	**2,009.4**	**1,941.3**	**1,875.7**	**1,812.4**	**11,871.0**

COST ASSUMPTIONS:

Finance Assumptions

1. Year 0 is 2022/23 Financial Year.
2. The baseline for this Service is the 2021/22 recurring revenue budget for the Head of Service Urology (CA7830) in the Acute Directorate of the SHSCT.
3. No other revenue or capital costs are associated with this option
4. A discount factor @3.5% pa has been applied to calculate the NPC.
5. Please note all figures above have been rounded to thousands and shown to one decimal place.
6. Total Net Present Cost (NPC) equates to £11,871.0k for this option

Option 2:: Increase ESWL Sessions from 4 to 10 Sessions per week within Stone Treatment Centre at CAH with the staff requirements identified in Section 3	**Year 0 22/23 £ 000**	**Year 1 23/24 £ 000**	**Year 2 24/25 £ 000**	**Year 3 25/26 £ 000**	**Year 4 26/27 £ 000**	**Year 5 27/28 £ 000**	**Totals £ 000**
Capital Costs							
(a) Total Capital Cost	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Revenue Costs							
Baseline Costs	2,152.5	2,152.5	2,152.5	2,152.5	2,152.5	2,152.5	12,915.0
Payroll	391.8	391.8	391.8	391.8	391.8	391.8	2,350.8
Payroll related G&S	29.0	29.0	29.0	29.0	29.0	29.0	174.0
Other G&S	102.2	102.2	102.2	102.2	102.2	102.2	613.2
(b) Total Revenue Cost	**2,675.5**	**2,675.5**	**2,675.5**	**2,675.5**	**2,675.5**	**2,675.5**	**16,053.0**
(c) Total Cost = (a) + (b)	**2,675.5**	**2,675.5**	**2,675.5**	**2,675.5**	**2,675.5**	**2,675.5**	**16,053.0**
(d) Disc Factor @ 3.5%pa	*1.0000*	*0.9662*	*0.9335*	*0.9019*	*0.8714*	*0.8420*	
(e) NPC = (c) x (d)	**2,675.5**	**2,585.1**	**2,497.6**	**2,413.0**	**2,331.4**	**2,252.8**	**14,755.4**

COST ASSUMPTIONS:

Finance Assumptions

1. Year 0 is 2022/23 Financial Year.
2. The baseline for this Service is the 2021/22 recurring revenue budget for the Head of Service Urology (CA7830) in the Acute Directorate of the SHSCT.
3. The staff identified in section 3 are costed per HSCB Costings 2021/22, Version 1. Radiographer, Nursing and HCA staff WTE is inclusive of 25% uplift to cover annual leave, sick leave and training requirements
4. The AFC staff costs include Employee related G&S but exclude any provision for Unsocial Hours or Excess Travel.
5. As the staff are expected to be in place from 01 April, 2022 a 12 month effect for 2022/23 (Year 0) is assumed.
6. The costs of the Medical Staff include a provision for employee related G&S but no provision for On-Call, Cover or Excess Travel.
7. No Capital costs have been identified in this IPT.
8. Additional G&S costs have been identified in this IPT - these are taken as 15% of the Day Case Cost for the Extra Corporal Shockwave Lithotripsy (ESWL) service in CAH for 2018/19 adjusted for inflation to 2021/22 rates = £71 per patient per session. The calculation is 30 Treatments per week * 48 weeks @ £71 each.
9. A discount factor @3.5% pa has been applied to calculate the NPC.
10. Please note all figures above have been rounded to thousands and shown to one decimal place.
11. Total Net Present Cost (NPC) equates to £14,755.4k for this option
12. The additional Current Year cost will be £522,988 or £535,610 after a 3% allowance for a 2021/22 Pay Award

Option 3: Increase ESWL sessions on a phased basis from 4 to 6 sessions within Stone Treatment Centre at CAH with the staff requirements identified in Section 3	**Year 0 22/23 £ 000**	**Year 1 23/24 £ 000**	**Year 2 24/25 £ 000**	**Year 3 25/26 £ 000**	**Year 4 26/27 £ 000**	**Year 5 27/28 £ 000**	**Totals £ 000**
Capital Costs							
(a) Total Capital Cost	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Revenue Costs							
Baseline Costs	2,152.5	2,152.5	2,152.5	2,152.5	2,152.5	2,152.5	12,915.0
Payroll	226.7	226.7	226.7	226.7	226.7	226.7	1,360.2
Payroll related G&S	17.0	17.0	17.0	17.0	17.0	17.0	102.0
Other G&S	61.3	61.3	61.3	61.3	61.3	61.3	367.8
(b) Total Revenue Cost	**2,457.5**	**2,457.5**	**2,457.5**	**2,457.5**	**2,457.5**	**2,457.5**	**14,745.0**
(c) Total Cost = (a) + (b)	**2,457.5**	**2,457.5**	**2,457.5**	**2,457.5**	**2,457.5**	**2,457.5**	**14,745.0**
(d) Disc Factor @ 3.5%pa	*1.0000*	*0.9662*	*0.9335*	*0.9019*	*0.8714*	*0.8420*	
(e) NPC = (c) x (d)	**2,457.5**	**2,374.4**	**2,294.1**	**2,216.4**	**2,141.5**	**2,069.2**	**13,553.1**

COST ASSUMPTIONS:

Finance Assumptions

1. Year 0 is 2022/23 Financial Year.
2. The baseline for this Service is the 2021/22 recurring revenue budget for the Head of Service Urology (CA7830) in the Acute Directorate of the SHSCT.
3. The staff identified in section 3 are costed per HSCB Costings 2021/22, Version 1. Radiographer, Nursing and HCA staff WTE is inclusive of 25% uplift to cover annual leave, sick leave and training requirements
4. The AFC staff costs include Employee related G&S but exclude any provision for Unsocial Hours or Excess Travel.
5. As the staff are expected to be in place from 01 April, 2022 a 12 month effect for 2022/23 (Year 0) is assumed.
6. No Capital costs have been identified in this IPT.
7. Additional G&S costs have been identified in this IPT - these are taken as 15% of the Day Case Cost for the Extra Corporal Shockwave Lithotripsy (ESWL) service in CAH for 2018/19 adjusted for inflation to 2021/22 rates = £71 per patient per session. The calculation is 18 Treatments per week * 48 weeks @ £71 each.
8. A discount factor @3.5% pa has been applied to calculate the NPC.
9. Please note all figures above have been rounded to thousands and shown to one decimal place.
10. Total Net Present Cost (NPC) equates to £13,553.1 for this option
11. The additional Current Year cost will be £305,081 or £312,393 after a 3% allowance for a 2021/22 Pay Award

SECTION 5: NON-MONETARY BENEFITS

The non-monetary benefits associated with the project are detailed below:-

Non-Monetary Benefit	Option 1 Status Quo/Do Nothing	Option 2	Option 3
Provision of additional sessions per week	• With no improved access to the service, enhanced utilisation of Hospital facilities will be untenable	• This option will support an increase in the sessions to provide 5 day service, 10 sessions (additional 6 sessions) per week	• This option will support moderate increase in th sessions to provide 3 day service, 6 sessions (additional 2 sessions) per week.
Greater accessibility to Stone Treatments	• As the number of patients being referred into the Service will continue to grow, it will result in a rise in waiting times. Therefore, patients will continue to experience lengthy waiting times for their treatment	• It is anticipated additional investment to increase sessions will support greater accessibility to stone treatment for both emergency and elective patients	• It is anticipated additional investment to increase sessions will support greater accessibility to stone treatment for both emergency and elective patients
Improved efficiency	• With the volume of administrative tasks associated with both MDT meetings and the ESWL processes, the degree of administrative support from the Specialty Doctor will still be prevalent (understandably, a situation which does not make best use of skills). • With no improved service provision, the use of Main Theatres at CAH for some patients' procedures will continue.	• The provision of 10 sessions of ESWL per week will enable the unit to be maximised and throughput increased by implementing a staffing model that can provide cover during the day for breaks etc. and enable no downtime for the machine. • In addition the increased availability of ESWL sessions and ability to provide more emergency slots will mean patients don't have to wait for elective slots or be admitted as an inpatient thus freeing up beds and theatres slots	• The provision of 10 sessions of ESWL per week will enable the uni to be maximised and throughput increased by implementing a staffing model that can provide cover during the day for breaks etc. and enable no downtime for the machine. • In addition the increase availability of ESWL sessions and ability to provide more emergenc slots will mean patients don't have to wait for elective slots or be admitted as an inpatient thus freeing up beds an theatre sots

SECTION 6: PROJECT RISKS & UNCERTAINITIES

The project risks associated with this scheme are detailed in the table below:-

Risk Description	Likely impact of Risk H/M/L			State how the options compare and identify relevant risk management/mitigation measures
	Opt 1	Opt 2	Opt 3	
1. Inability to Appoint Staff	**N/A**	**L**	**L**	**Option 1** – N/A **Options 2&3** - there is the potential that no applicants may apply for the new posts, however this is deemed to be a 'low' risk. • **Mitigation Measure** - the Trust will ensure that robust recruitment processes are in place and any issues raised by BSO are promptly addressed
2. Recurrent revenue funding not secured	**N/A**	**M**	**M**	**Option 1** – N/A **Options 2&3** – this is a possibility that recurrent funding may not be secured and therefore this is considered a 'medium' risk • **Mitigation Measure** – the Trust will maintain close links with the HSCB/continue to seek financial support from the HSCB
Overall Risk (H/M/L):	**N/A**	**L/M**	**L/M**	

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

The preferred option is Option 2: Expand the existing service to provide 5 day service cover and improved access to emergency ESWL slots. This option will see the existing infrastructure in CAH maximized and patient throughput improved through a fully embedded stone centre resource.

SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS

AFFORDABILITY STATEMENT	Year 0 2022/23 £ 000	Year 1 2023/24 £ 000	Year 2 2024/25 £ 000	Year 3 2025/26 £ 000	Total £000's
Required:					
Capital required	0.0	0.0	0.0	0.0	0.0
Revenue required	2,688.1	2,741.9	2,796.7	2,852.7	11,079.4
Existing budget :					
Capital	0.0	0.0	0.0	0.0	0.0
Revenue	2,152.5	2,195.6	2,239.5	2,284.3	8,871.9
Additional Allocation Required:					
Capital	0.0	0.0	0.0	0.0	0.0
Revenue	535.6	546.3	557.2	568.4	2,207.5

AFFORDABILITY ASSUMPTIONS:

Finance Assumptions

1. Year 0 is 2022/23 Financial Year.
2. The baseline for this Service is the 2021/22 recurring revenue budget for the Head of Service Urology (CA7830) in the Acute Directorate of the SHSCT.
3. The staff identified in section 3 are costed per HSCB Costings 2021/22, Version 1 with an allowance for a 3% pay increase in 2021/22.
4. The AFC staff costs include Employee related G&S but exclude any provision for Unsocial Hours, Excess Travel or Annual Leave and Sickness Cover.
5. As the staff are expected to be in place from 01 April, 2022 a 12 month effect for Year 0 (2022/23) is assumed.
6. The costs of the Medical Staff include a provision for employee related G&S but no provision for On-Call or Excess Travel.
7. No Capital costs have been identified in this IPT.
8. Additional G&S costs have been identified in this IPT - these are taken as 15% of the Day Case Cost for the Extra Corporal Shockwave Lithotripsy (ESWL) service in CAH for 2018/19, adjusted for inflation to 2021/22 rates = £71 per patient per session
9. Revenue costs have been uplifted by 2% for inflation from 2023/24.
10. Please note all figures above have been rounded to thousands and shown to one decimal place.

SECTION 9: MANAGEMENT ARRANGEMENTS

The following project management roles have been agreed:-

- **Project Owner** – Mrs Melanie McClements (Director of Acute Services)
- **Project Director –** Mr Ronan Carroll, Assistant Director of ATICS
- **Project Manager –** Ms Wendy Clayton, Head of ENT, Urology, Ophthalmology & Outpatients

The project timescales associated with this proposal are detailed in the table below:-

Project Timescales	
Business Case Approval	**February 2022**
Submission of Business Case to HSCB	**February 2022**
Confirmation of Funding	**February / March 2022**
Recruitment Process Commenced	**March 2022**
Staff in Post	**May / June 2022**

SECTION 10: MONITORING AND EVALUATION

Who will manage the implementation? **(please provide the name of the responsible individual where possible)**	Ms Wendy Clayton, Head of Service
Who will monitor and evaluate the outcomes? **(please provide the name of the responsible individual where possible)**	Ms Wendy Clayton, Head of Service
What other factors will be monitored and evaluated?	
When will this take place? **(preferably 4 to 12 months after project closure)**	12 months post service implementation

SECTION 11: ACTIVITY OUTCOMES (TRUSTS ONLY)

	Specify activity, e.g. IP, DC OPN, OPR, Contacts etc					
	IP	**DC**	**OPN**	**OPR**		
Baseline						
Additional activity						
New Baseline Activity						

There is no separate SBA for ESWL, if funding is allocated non-recurrently the Trust would not propose a SBA. If funding is recurrently allocated the Trust is happy to agree a SBA with Commissioners.

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

Appendix A:- Schedule of Costs

Summary Costing schedule for Investment Decision Making Templates					**Ref Number**								
Provider				SOUTHERN									
Hospital Site or Community development				CRAIGAVON									
Scheme Title				2022/23 - Development of the Northern Ireland Stone Treatment Centre for provision of ESWL for the province.					**Commissioner Use only**				
Pay and Price Levels				2021/22					**Sign and Date for TRAFFACS update**				
		Base Case - option 1				**Option 2**				**Option 3**			
Band	**Description**	**months claimed**	**wte**	**fye**	**cye**	**months claimed**	**wte**	**fye**	**cye**	**months claimed**	**wte**	**fye**	**cye**
	Baseline			2,152,506	2,152,506			2,152,506	2,152,506			2,152,506	2,152,506
Band 7	Radiographer					12.00	2.36	140,798	140,798	12.00	1.30	77,558	77,558
Band 6	Band 6 Clinical Sister					12.00	1.32	66,809	66,809	12.00	0.80	40,490	40,490
Band 5	Band 5 Nurse					12.00	2.36	95,960	95,960	12.00	1.30	52,859	52,859
Band 4	Administrator for the Stone Treatment Centre					12.00	1.00	31,826	31,826	12.00	0.70	22,278	22,278
Band 3	Healthcare Assistant					12.00	1.02	28,256	28,256	12.00	0.50	13,851	13,851
Band 3	audio typist					12.00	0.50	13,851	13,851	12.00	0.50	13,851	13,851
Band 2	Health Records / booking Clerk					12.00	0.10	2,523	2,523	12.00	0.10	2,523	2,523
Band 2	Domestic					12.00	0.13	3,280	3,280	12.00	0.13	3,280	3,280
									0				0
Medical	Specialty Doctor					12.00	0.10	8,450	8,450			0	0
Payroll Related G&S Costs													
Band 7	Radiographer					12.00		10,502	10,502	12.00		5,785	5,785
Band 6	Band 6 Clinical Sister					12.00		5,001	5,001	12.00		3,031	3,031
Band 5	Band 5 Nurse					12.00		7,226	7,226	12.00		3,981	3,981
Band 4	Administrator for the Stone Treatment Centre					12.00		2,416	2,416	12.00		1,691	1,691
Band 3	Healthcare Assistant					12.00		2,156	2,156	12.00		1,057	1,057
Band 3	audio typist					12.00		1,057	1,057	12.00		1,057	1,057
Band 2	Health Records / booking Clerk					12.00		193	193	12.00		193	193
Band 2	Domestic					12.00		251	251	12.00		251	251
Medical	Specialty Doctor					12.00		193	193			0	0
AY COSTS			**0.00**	**2,152,506**	**2,152,506**		**8.89**	**2,573,254**	**2,573,254**		**5.33**	**2,396,243**	**2,396,243**
Non-Pay Costs													0
	30 Treatments per week * 48 weeks = 1,440 additional treatments @ £71 per patient per session.					12.00		102,240	102,240				0
	18 treatments per week * 48 weeks = 864 additional patients @ £71 per patient per session.									12.00		61,344	61,344
TOTAL NON-PAY COSTS				**0**	**0**			**102,240**	**102,240**			**61,344**	**61,344**
GRAND TOTAL				**2,152,506**	**2,152,506**		**8.89**	**2,675,494**	**2,675,494**		**5.33**	**2,457,587**	**2,457,587**
Additional Cost per 2021/22 HSCB, Version 1								**522,988**	**522,988**			**305,081**	**305,081**
Estimated 3% pay award 2021/22								12,622	12,622			7,312	7,312
Additional Cost after Inflation Adjustment								**535,610**	**535,610**			**312,393**	**312,393**
GRAND TOTAL - after 3% Pay Award							**8.89**	**2,688,116**	**2,688,116**		**5.33**	**2,464,899**	**2,464,899**
Phasing/Timescale		*(Can development be phased, if so provide details in this box)*				*(Can development be phased, if so provide details in this box)*				*(Can development be phased, if so provide details in this box)*			
PROGRAMME OF CARE		acute				acute				acute			
SUB-SPECIALTY INFORMATION eg inpatients, outpatients, daycases if known													
LCG		Southern				Southern				Southern			

Southern Health and Social Care Trust
Directorate of
Finance, Procurement and Estates

SOUTHERN HEALTH & SOCIAL CARE TRUST
FINANCIAL MANAGEMENT CAPITAL SERVICES

CAPITAL BUDGET ALLOCATION REPORT

GENERAL CAPITAL ALLOCATION:
JOB CODE:
SCHEDULE:

PERIOD: **1ST APRIL 2020 TO 31ST MARCH 2021**

DATE REQ SENT TO PALS	REQUISITION NUMBER	E-PROC ORDER NUMBER	LOCATION/FACILITY	JOB CODE
N/K	R2084726	CA255531	STH THEATRES	C20ME005
N/K	R2179664	CC01922	STH MAIN THEATRE	C20ME018
N/K	R2179664	CC01922	STH MAIN THEATRE	C20ME017

DATE REQ SENT TO PALS	REQUISITION NUMBER	E-PROC ORDER NUMBER	LOCATION/FACILITY	JOB CODE
N/K	R2218758	CC01971	CAH MAIN THEATRES	C20ME068
N/K	R2217967	CC01975	CAH	C20ME065
N/K	R2221093	CC01974	CAH - ENT	C20ME033
N/K	R2218462	CC01985	CAH - ENT	C20ME033
N/K	R2218565	CC01960	CAH - THEATRES	C20ME069
N/K	R2218565	CC01992	CAH - THEATRES	C20ME069
N/K	R2218765	CC01962	CAH - DAY PROCEDURE	C20ME035
N/K	R2218754	CC02005	CAH - THEATRES	C20ME066
N/K	R2218754	CC02000	CAH - THEATRES	C20ME067
N/K	R2218767	CC01959	CAH - THEATRES	C20ME040
N/K	R2229698	CC02034	CAH - THEATRES	C20ME069
N/K	R2248386	CC02048	CAH - THEATRES	C20ME079

DATE REQ SENT TO PALS	REQUISITION NUMBER	E-PROC ORDER NUMBER	LOCATION/FACILITY	JOB CODE
N/K	R2218700	CC01961	DHH - MAIN THEATRES	C20ME070
N/K	R2218700	CC01970	DHH - MAIN THEATRES	C20ME070
N/K	R2218720	CC01999	DHH - THEATRES	C20ME067

MEDICAL EQUIP

EQUIPMENT

DESCRIPTION OF ITEM	CAPITAL ADDITION £
KARL STORZ CYSTO-URETHO-FIBERSCOPE	8,925.07
COLONOSCOPE	40,200.00
OGD SCOPE	35,867.00
TOTAL	**84,992.07**

DESCRIPTION OF ITEM	CAPITAL ADDITION £
TH 1-4 INSUFFLATOR - AIRSEAL	19,582.47
ENDOFLEX SYSTEM FESS	37,749.76
TELE PACK & ENDOSCOPIC UNIT, TROLLEY, CAMERA HEAD	24,520.20
ENT SCOPES	37,213.70
TH 1-4 CAMERA SYSTEMS - PRINTER, INSUFFLATOR ETC	80,647.83
TH 1-4 CAMERA SYSTEMS - PRINTER, INSUFFLATOR ETC	367.00
OLYMPUS EVIS LUCERA ELITE VIDEO GA STROSCOPE	35,867.00
SWISS LITHOCLAST TRILOGY	48,477.00
CYBER HOLMIUM LASER	62,500.00
TH 1-4 URETERSCOPE - GYNAE, UROLOGY RENOSCOPE	7,614.00
ROLL STAND FOR LCD VARIABLE HEIGHT OLYMPUS (CAMERA SYSTE	600.00
SENTIMAG SYSSTEM SMS02	20,000.00
TOTAL	**375,138.96**

DESCRIPTION OF ITEM	CAPITAL ADDITION £
DHH TH STACK SYSTEM & SCOPES - LEADS, PROCESSORS ETC	252,770.05
DHH TH STACK SYSTEM & SCOPES - LEADS, PROCESSORS ETC	176.00
CYBER HO 60W HOLMIUM LASER	62,500.00
TOTAL	**315,446.05**

20190612
Q17 · 144

From: Carroll, Ronan [redacted]
Sent: 12 June 2019 14:10
To: Haynes, Mark; OKane, Maria; McClements, Melanie
Cc: Reid, Trudy; Carroll, Anita; Stinson, Emma M; Scullion, Damian
Subject: RE: GP concerns regading red flag referral
Attachments: Updated with ATICS Medical Equipment priorities 2019 20.xlsx

Importance: High

Afternoon,
I have attached an updated capital equipment list for atics/sec (99%) atics.
We have added in two additional columns (J,K,L) J is the age of the equipment and L is the impact on failing not replacing
I have raised this within our acute smt but the cost of replacing our 'old' equipment is now so large it does require a higher decision making power.
Almost daily I am asked by surgeons and anaesthetists to upgrade or replace old equipment
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery/Elective Care
Mob [redacted]

From: Haynes, Mark
Sent: 12 June 2019 06:57
To: OKane, Maria
Cc: Carroll, Ronan; Reid, Trudy; Connolly, Carly
Subject: RE: GP concerns regading red flag referral

Ooops forgot the attachment.

From: Haynes, Mark
Sent: 12 June 2019 06:57
To: OKane, Maria
Cc: Carroll, Ronan; Reid, Trudy; Connolly, Carly
Subject: RE: GP concerns regading red flag referral

How long have you got?!

In short, no we are not working at elective capacity or at maximum efficiency. Simply because we do not have the resource to do so.

Regarding efficiency in what we deliver, one aspect that is eternally frustrated is equipment investment. Within Acute services and from my perspective SEC/ATICS we have multiple items requiring investment sitting on a long list (attached). In total there are 54 items of equipment, totalling approximately £2.6 million. Each round of CAG allocations funds a tiny proportion of these items, while the list continues to grow. The net impact is that without equipment in OP and theatres our delivery of patient care is inefficient and delayed. For example, without available endoscopes for ENT outpatients, patients need to be brought back for second visits to have the endoscopy, without the equipment for delivery of transperineal biopsies for prostate cancer diagnosis we utilise a trans rectal route resulting in a 3-5% acute admission rate and using inpatient theatres to deliver what should be an outpatient procedure for the 5% of patients that require a transperineal biopsy procedure (this frustrates me more than

anything as I have driven the move in NI away from TRUS as NICAN CRG chair, and the only trust that hasn't invested in delivering this is the trust I work in. It is just embarrassing).

I don't believe there is any transparency or objectivity in the allocation of monies to purchase medical equipment, certainly I have never seen any evidence of an objective system being used to decide which items of equipment from different directorates gets funded, nor have I seen any minutes or commentary on any meeting where decisions are made as to what equipment to purchase outlining how the decisions were made. I contrast this to my experience in England where medical equipment requirements were outlined in a business case, scored on paper against multiple factors (eg impact on ongoing delivery, impact on delivery against standards of care, impact on staff, impact on patient outcomes, cost and income), and higher ticket items subjected to additional scrutiny and board level presentation and decision making.

Every item that is on the list as a replacement (because the existing equipment is past it's usuable life span), or new (in order to deliver current standards of care) requires investment immediately.

As you know, bed capacity is a major issue. In order for secondary care to deliver elective care at maximum capacity and maximum efficiency we need to fix the unscheduled care issues. Fundamentally this means an increase in bed capacity. No trust can manage elective care while bed occupancy runs in the high 80's to 90+%. Ideally we need an expansion in beds to get to a point where on the acute sites bed occupancy is 85% (or ideally 80%). There is no quick fix to this but a first step is acknowledging that this is a major issue that requires primary focus is essential. All LOS reduction strategies are contingent on this being in place. Continued focus on strategies which are needed, but deliver small impacts on unscheduled care requirements misses this essential problem. There has never been a proposal floated that fixes the problem of 40+ medical outliers on surgical wards in the trust. Without fixing this by increasing the bed capacity, all other attempts to deliver care become stifled, our wards become unspecialised, extra patients are bedded in environments which are not suited to patient care, and staff leave, deepening our problems. A first step in moving towards this is a corporate recognition that the primary issue affecting the trust is a lack of capacity for unscheduled care. Once this is accepted and recognised I believe we can start to make progress towards identifying how this can be addressed, but as with equipment, solutions will require investment.

Regarding increasing demand for trust services, I believe the underlying issue comes down to how services are commissioned and delivered within primary / secondary care. The NI model does not place any onus or requirement on primary care to manage demand. This is in stark contrast to England where demand management is a key component of primary care CCG's functions. Secondary care commissioning is to meet a projected service baseline. This baseline is based on previous years activity and not meeting demand meaning that the demand:capacity mismatches within our services grow.

What we have (when manpower etc get factored in) is a stretched primary care service, with no capacity to, or requirement to pre-investigate or pre-treat patients, and no penalty for referring patients who don't need seeing referring ever increasing numbers of patients, managing progressively longer routine waiting lists by 'upgrading' referrals (Urology referrals have increased each year but if you look at each clinical category, routine has reduced and both urgent and red flag have increased significantly). Meanwhile in secondary care, capacity is based upon delivery of the service based activity figures. This does not match demand, is based upon 'bean counting' (that was what Dean Sullivan always called it, not me!) and can be 'cheated' by 'imaginative' coding (from urology DECC work it appears that one trust has a waiting list for insertion of a urethral catheter with near 1000 elective admissions for this a year, but none in the other 3 trusts! Nb almost no one is put on an elective waiting list for urethral catheterisation). Performance meetings focus on delivery against said service based delivery figures, but not on meeting referral demand, and waiting times for services spiral upwards. There is also a perverse negative incentive whereby, if secondary care start delivering over and above their SBA, the SBA expectation is changed to meet this, without any increase in service funding. Decisions to create new permanent posts are made centrally and do not always match where demand for services is highest but can be influenced by other factors.

Again to contrast with England, if secondary care demand goes up, additional money comes into secondary care from CCG's as money follows the patient, this enables secondary care to react to and pre-empt increasing demand by planning development and expansion of services, with money coming into the system to fund this. Decisions for new permanent staff appointments are made by the trust, not reliant on central 'commissioning' of new posts, and

infrastructure and equipment investment by the trust drives increased income into trusts as it increases services delivered.

To be delivered demand management needs to be led by primary care. There is some hope that through the federations this may start to happen, but I fear that in order to deliver what GPs consider to be enhanced primary care services, they will want in increase in investment in their services. I am constantly told there is no additional money (in my interactions through the PIG and through the DECC work), so I am concerned that this will become a barrier to successful demand management. Secondary care needs to be commissioned to deliver demand.

(Climbs down from soapbox).

Happy to discuss further.

Mark

From: OKane, Maria
Sent: 11 June 2019 21:05
To: Haynes, Mark
Cc: Carroll, Ronan; Reid, Trudy; Connolly, Carly
Subject: RE: GP concerns regading red flag referral

Thanks for this. Outside of what you suggest Mark – are there any other changes we can make to increase capacity that you feel are being frustrated or do we think we are working at capacity and as effectively as possible? Regards, Maria

Dr Maria O'Kane
Medical Director
Tel: Personal Information redacted by the USI

From: Haynes, Mark
Sent: 11 June 2019 20:37
To: OKane, Maria
Cc: Carroll, Ronan; Reid, Trudy; Connolly, Carly
Subject: RE: GP concerns regading red flag referral

'm happy to follow up on this myself 1st thing tomorrow morning as it is an issue that cuts across all surgical specialities, and is something that as a NICAN CRG chair I can feed into NICAN if required. As you are aware there has been considerable lag in the region adopting NICE guidance from 2015 regarding suspected cancer referrals, with concern regarding direct access to MRI scanning being the main reason behind this regional delay (from my understanding). This means that the RF criteria applied to NI patients are not those that are applied to patients in England, Wales and Scotland. Additional targets timelines and real world timelines for patient being seen in NI lags far behind the situation in England (English Referral to treatment target timeline is 18 weeks for all referral categories, in NI we only meet this for RF referrals, we have no 2 week rule for any speciality other than breast, I can continue on my soapbox of why the situation here is as it is!).

The difficulty here is that there are clear RF criteria that apply to NI (NICAN referral guidance 2014). If a patient doesn't meet them then they can and should be downgraded. This is one of the purposes of triage. However, not meeting RF criteria does not mean no possibility of a malignant diagnosis, just a lower likelihood. The real problem here is that a clinically urgent patient (non RF) is not seen within an acceptable period of time due the waiting time pressures (and in some specialities routine referrals are almost not seen). The fact that these criteria are not current NICE criteria is not down to clinicians.

If we cannot downgrade referral that do not meet the RF referral criteria currently applied to NI patients, we will never be able to provide RF OP appointments within a reasonable time as patients are referred in without RF symptoms because in some specialities this is the only way they are likely to be seen. If we do, appropriately

downgrade referrals, when one receives a malignant diagnosis, we are criticised for applying nationally agreed criteria. We know , for instance, that in urology up to 20% of GP referrals are either upgraded or downgraded (in both Southern and western trusts). If all were left at the original referral category, some would be seen without meeting RF criteria, with an approximately 3% risk of cancer diagnosis, while many others would wait longer, who do meet RF criteria, and have a 9% risk of a malignant diagnosis.

As an aside and as an example of how arbitrary RF criteria are, the risk of a malignant diagnosis in patients with severe storage urinary symptoms in the absence of infection is around 2-3% but this is not a red flag criteria, and a urine dipstick screening study (done in Leeds) demonstrated an equal risk of bladder cancer in patients with dipstick haematuria and patients without dipstick haematuria, yet dipstick haematuria has constituted a RF criteria for referral for many years for urology, with a risk of a malignant diagnosis of 2-3%.

The only real solution to this problem is to match demand with capacity, but that requires investment in manpower (nursing, medical and administrative, primary and secondary care) and infrastructure (both physical (eg Wards, OP facilities, theatres), technological (eg scanners, endoscopy equipment) and supporting diagnostic services (labs, cytology, histopathology)).

Carly – if you get anything on email from Personal Information redacted by the USI could you forward to me please?

Mark

From: OKane, Maria
Sent: 11 June 2019 18:50
To: Carroll, Ronan; Haynes, Mark
Subject: FW: GP concerns regading red flag referral

Mark could you ask on of the CDs to ring the GP please as vi to understand clinically what has happened and to let me know. Thanks Maria

Dr Maria O'Kane
Medical Director
Tel: Personal Information redacted by the USI

From: Reid, Trudy
Sent: 11 June 2019 17:18
To: Connolly, Carly; Carroll, Ronan
Cc: OKane, Maria
Subject: Re: GP concerns regading red flag referral

Carly than you, these will need screening
Ronan please see below for investigation, action and contact with the GP
Regards,
Trudy

On Jun 11, 2019 3:49 PM, "Connolly, Carly" Personal Information redacted by the USI wrote:
Dear Trudy

I received a phone call today from Dr Personal Information redacted by the USI Personal Information redacted by the USI y. I advised Dr Personal Information redacted by the USI Patricia was off at present and not due back for a couple of weeks. Dr Personal Information redacted by the USI expressed his concerns about the red flag referral system. Dr Personal Information redacted by the USI reports he referred one of his patients via red flag surgical referral in Dec 2017, however this was downgraded and his patient was not seen until February 2019. This patient has subsequently being diagnosed with a tumour. Dr Personal Information redacted by the USI also said another situation happened again recently, he referred a patient via red flag ENT , but the patient was not seen for a number of weeks later. This is 2 incidents within months. Dr Personal Information redacted by the USI expressed his concerns about the red flag referral process and reports GPs need confidence

that patients will be followed up as per red flag procedure. Dr [redacted] has asked to speak to you specifically regarding his concerns. Telephone [redacted] I have advised Dr [redacted] to email me his concerns . Can you return his call please.

Many Thanks

Regards

Carly

Mrs Carly Connolly
Clinical Governance Manager
Governance Office
Administration Floor
CAH
[redacted]

MELANIE McCLEMENTS INTERIM DIRECTOR ACUTE SERVICES	Ronan Carroll ASSISTANT DIRECTOR – ACUTE SERVICES Surgery & Elective Care and ATICS 1-1 Discussion

DATE: MONDAY 17TH JUNE 2019

Range of helpful summary documents shared by Ronan.

No	Issue for discussion	Discussed / Actions agreed
1	Capacity/Vacancies	Number of vacant posts and Consultant impact/locums 3 South = 80% agency/non-core 4 beds closed as a result
2	Banding Issue	Some 5 to 6 rebandings lodged And 7 to 8A Nurse Endoscopists Cystoscopy nurses - challenge
3	Surgical Clinics	Every morning – (easement for ED) Issue = urgent bookable lists → happens ad-hoc

4	Equipment Concern	Major issue with End of Life equipment On Risk Register 2.8m requirement Action – Melanie to discuss with Aldrina
5	"10 Things" that would help	• Right Person → Decision – Senior • More junior doctors (letters/scripts) • Radiology – hot reporting →E/D • AHP 7 day • Less agency staff • Medical locums/risk averse/no decisions made • Discharge barriers – POC/Placement/Repatriation
6	Surgical waiting times	Action – Melanie to raise due to pension impact

7	DATE OF NEXT MEETING	8th July 2019

Priority for Budget Holder (top priorities by Division)	Directorate	Lead AD	Item description	New or replacement item (new/Replacement)	Cost £	CAG Recommendation	Notes	Age of the equipment (Years old approx.)	Age equipment should be replaced (Years old)	Implications if equipment is not replacement
	ACUTE ATICS	Ronan Carroll	Theatres 1-4 4K Camera Systems	Upgrade	£70000 - £80000		Upgrade current systems x2 Systems over 10yrs – end of life - quantify x 2 This has an impact on patient outcomes Th3 and Th4 poor laproscopic services	10+	5-7	Systems over 10yrs – end of life - quantify x 2 This has an impact on patient outcomes Th3 and Th4 poor laproscopic services
	ACUTE ATICS	Ronan Carroll	POA CAH & DHH Metabolic stress system - MGC Ultima CPX	Replacement x1 & 1xNew	£110,000		quantity x 2	10+	5-7	Unable to provide a efficient pre-op service for patients requiring a stress test
	ACUTE ATICS	Ronan Carroll	STH Patient Transport Trolley QA3 x 10	Replacement x 5 New x5	£30,170.00		quantity x 10	15+	5-7	Patient safety
	ACUTE ATICS	Ronan Carroll	STH Portable Ventilator with stand Oxylog 3000	Replacement	£11,316.33		quantity x 1	28	5-7	Unable to safely transfer a patient to a base ward
	ACUTE ATICS	Ronan Carroll	Anaesthetic machine MONEY AGREED AND PROCESS IN PROGRESS	Replacement	£360,000.00		replacement programme each financial year until all machines replaced	10 - 12	7	unavailable and new generation anaesthetic machines use less gases and
	ACUTE ATICS	Ronan Carroll	DHH Theatres Karl Storz Choledochoscope-Videoscope set Video Endoscope adapter 90cm Video Choledochoscope 6.5fr 37cm plastic container for sterilizing with gas	Replacement	£23,824.98		quantity x 1	10	5-7	Maintaining service / increase use with 2nd scope unfunded room in DHH
	ACUTE ATICS	Ronan Carroll	DHH Theatres Choledocho-Fibrescope Set	Replacement	£59,328.79		quantity x 1 £6,775.00 – Service Contract per year	10	5-7	Maintaining service / increase use with 2nd scope unfunded room in DHH
	ACUTE ATICS	Ronan Carroll	DHH Theatres Olympus stack system	Replacement	£270,877.33		quantity x 3 Each £73,854.18 Total for 3 systems-£270,877.33	10	5-7	Maintaining service / increase use with 2nd scope unfunded room in DHH
	ACUTE ATICS	Ronan Carroll	Pentax Video Bronchoscope Standard (Sterrad Compatible with 3 years TRUST aintenance contract.Insertion tube 5.2 Instrument Channel 2.0)	Replacement	£21,986.25		quantity x 1	10-12	5-7	Maintaining service / increase use
	ACUTE ATICS	Ronan Carroll	ICU CAH Cardiac Output Monitor	Replacement	£35,200 with yearly contract of £3,100		The current model is coming to the end of its life as it will no longer be supported by the company who service it. The ability to accurately measure cardiac output is a core requirement for ICU by clinicians and also visiting organ retrieval teams request placement at times.	10+	5-7	The current model is coming to the end of its life as it will no longer be supported by the company who service it. The ability to accurately measure cardiac output is a core requirement for ICU by clinicians and also visiting organ retrieval teams request placement at times.
	ACUTE ATICS	Ronan Carroll	ICU, CAH Prismax machine (Dialysis)	Replacement	£56,000.00		quantity x 4	10+	5-7	If no replacement unable to provide dialysis for patients
	ACUTE ATICS	Ronan Carroll	ICU, CAH Temperature Management System	Replacement	£15,000.00		quantity x1	10+	5-7	If no replacement unable to provide temperature management to patients to heat or to cool
	ACUTE ATICS	Ronan Carroll	ICU, CAH US –S5-1 PROBE	Replacement	£5,730.99		quantity x1	8+	5-7	Current probe continuously breaks. Unable to safely place all lines
	ACUTE ATICS	Ronan Carroll	STH AERs	Replacement	£124,844.28		£127.844.28 EWD £3,000 attachments	15+	5-7	Ongoing issues with AER's due to breakdowns, therefore not providing an efficient service
	ACUTE ATICS	Ronan Carroll	STH FBE001281 Cystoscopes Flex- Ref 11272c1 x 3	Replacement	£26,141.07		quantity x 3	10+	5-7	Continuously out for service due to breakdowns therefore not providing an efficient service
	ACUTE ATICS	Ronan Carroll	STH Stacking system/Scope	Replacement	£84,500.00		quantity x 1	10	5-7	New generation scope which are not compatiable with current stacking system therefore needs replaced
	ACUTE ATICS	Ronan Carroll	Theatres 1-4 Lithoclast machine - olympus	Replacement	£24,500.00		Quantity x 1 Regular repair issues & Datix Urgent ** only 1 in department. Current system critical end of life 12years old (overheating)	12	5-7	Regular repair issues & Datix Urgent ** only 1 in department. Current system critical end of life 12years old (overheating)
	ACUTE ATICS	Ronan Carroll	Theatres 1-4 Karl Storz Choledochoscope – videoscope set video endoscope adapter 90cm Video Choledochoscope 6.5fr 37cm plastic container for sterilizing with gas	Replacement	£47,649.96		£23824.98 each x 2 Insufficent numbers in department. Surgoens request video screen to optimize surgery Higher demand of exploration of CBD	10+	5-7	Insufficent numbers in department. Surgoens request video screen to optimize surgery Higher demand of exploration of CBD
	ACUTE ATICS	Ronan Carroll	Theatres 5-8 Orthodrive Handpieces and attachments.	Replacement	£255,255.20		quantity x 12	12	5-7	Elective ortho surgery will cease
	ACUTE ATICS	Ronan Carroll	Theatres 5-8 Orthodrive sagittal saw headpiece and attachments.	Replacement	£90,336.00		quantity x 8	12	5-7	Elective ortho surgery will cease
	ACUTE ATICS	Ronan Carroll	Theatres 5-8 Stacking System	Replacement	£46,575.73		quantity x 1	12	5-7	for expansion of service for Shoulder surgery
	ACUTE ATICS	Ronan Carroll	X-ray, CAH Olympus Camera Stack	Replacement	£82,335.84		quantity x 1	10+	5-7	Not supported by service contract
	Acute SEC	Ronan Carroll	Bladder scanner for Trauma x2	New	£17,000		quantity x 2		5-7	Enhances discharges and unable to measure urinary output effectively
	ACUTE ATICS	Ronan Carroll	DHH Endoscopy Stacking system/Scope	New	£82,355.84		quantity x 1		7	Maintaining service / increase use with 2nd scope unfunded room in DHH
	ACUTE ATICS	Ronan Carroll	DHH Endoscopy Standard colonoscope	New	£40,200.00		quantity x 1		5 - 7	Maintaining service / increase use with 2nd scope unfunded room in DHH
	ACUTE ATICS	Ronan Carroll	DHH Endoscopy Standard gastroscope	New	£35,867.00		quantity x 1		5 - 7	Maintaining service / increase use with 2nd scope unfunded room in DHH
	ACUTE ATICS	Ronan Carroll	DHH Endoscopy Ultra slim colonoscope	New	£40,200.00		quantity x 1		5 - 7	Maintaining service / increase use with 2nd scope unfunded room in DHH
	ACUTE ATICS	Ronan Carroll	DHH Endoscopy Video Bronchoscope Standard.	New	£28,430.00		quantity x 1		5 - 7	New respiratory consutlant - increase use
	ACUTE ATICS	Ronan Carroll	DHH Theatres Fess tray- Functional endoscopes	New	£14835.10 each		quantity x 2			provide FESS surgery on the DHH site
	ACUTE ATICS	Ronan Carroll	DSU, CAH GIF-XP260NS LUCERA GASTROSCOPE Paed	New	£34,645.00		quantity x 1		5-7	Maintaining service / increase use
	ACUTE ATICS	Ronan Carroll	DSU, CAH PCF-PG260L Olympus Slimline Colonoscope	New	£40,200.00		quantity x 1 Additional to enable smooth running of lists		5-7	Maintaining service / increase use
	ACUTE ATICS	Ronan Carroll	ICU, CAH Fresenius LINK 6 Plus, Agilia Rack System	New	£14,670.00		quantity x 9		5-7	Maintaining bed space
	ACUTE ATICS	Ronan Carroll	STH Bed for pain clinic model CFPMB301 (bariatric model)	New	£14,830.00		quantity x 1 at request of Dr Sobocinski for past 3yrs		5-7	Patient safety

	ACUTE ATICS	Ronan Carroll	STH ULTRASOUND Sono Site sii ultrasound system	New	£30,447.00		quantity x 1		5-7	Unable to provide full Foot & Ankle service
	ACUTE ATICS	Ronan Carroll	Theatre 1-4 Alaris PK Anesthetic syringe pump ref 8005PK201	New	£19,800.00		£2475 each x 8 Insufficient numbers in department. Risk assessment completed (4 pumps for Th5-8)		5-7	Maintaining anaesthetic service / increase use and safety for patient
	ACUTE ATICS	Ronan Carroll	Theatares 1-4 Insufflator – Bowel Surgery. Conmed	New	£30,000.00		£36000 x 2 (10% discount) Mr McKay requirement for lower rectal surgery - service improvement and patient safety/impact on patient outcomes		5-7	New generation equipment, decreases bed stay and safer surgery for patients
	ACUTE ATICS	Ronan Carroll	Theatres 1-4 Sonosite Ede II and SII Ultrasound System –LA Block - Anaesthetics	New	£60,000.00		Additional requirement/new guidance - quantity x 2 Insufficient amount in the department which impacts upon delays of surgery		5-7	Increased use of current sonosites, delays in surgery as sharing of equipment
	ACUTE ATICS	Ronan Carroll	Theatres 1-4 Gamma finder III compelte probe – Breast Surgery ref GFIII-L01	New	£18,000.00	?? Removal - TBC	quantity x 1 Only 1 in department - no back up. 12/12/19 - need advice from Ms Mathers		5-7	Only 1 in department - no back up.
	ACUTE ATICS	Ronan Carroll	Theatres 1-4 Erbe VIO 300 D Systems with Smoke Evac. Cart and pedals	New	£23,344.60	?? Price of Quote	Quantity x 1 2 in department require a 3rd		5-7	Safety requirement for staff
	ACUTE ATICS	Ronan Carroll	Theatres 1-4 LED 9000 1W Wireless Headlight System	New	£2,500.00	?? Removal - TBC	quantity x 2 Ms Salmon Breast service		5-7	Enhancement of breast surgery
	ACUTE ATICS	Ronan Carroll	Theatres 5-8 Cannula & Trocar (pencil point)	New	£26,792.40		quantity x 5		5-7	for expansion of service for Shoulder surgery
	ACUTE ATICS	Ronan Carroll	Theatres 5-8 30 degree Scope & Shaver Set	New	£51,533.20		quantity x 5		5-7	for expansion of service for Shoulder surgery
	ACUTE ATICS	Ronan Carroll	Theatres 5-8 Basic Hand Held Arthroscopy x6 (Baskets not included)	New	£74,209.56		quantity x 6		5-7	for expansion of service for Shoulder surgery
	ACUTE ATICS	Ronan Carroll	Theatres 5-8 ENT Telescopes	New	£20,416.80		Quantity x 4 (to include VAT)		5-7	new generation, current scopes broken and visibility poor. Replacement old with new generation
	ACUTE ATICS	Ronan Carroll	Theatres 5-8 Havas Operating Laryngoscope	New	£5,128.60		quantity x 1 (to include VAT)		5-7	Difficult airway cases, requested by anaesthetic lead
	ACUTE ATICS	Ronan Carroll	Theatres 5-8 Microdebrider Handpiece	New	£15,876.00		quantity x 3 (to include VAT)		5-7	Currently loaned for 4 years, need to purchase
	ACUTE ATICS	Ronan Carroll	Theatres 5-8 Mitek Shoulder Instruments Sets	New	£77,665.70		quantity x 5		5-7	for expansion of service for Shoulder surgery
	ACUTE ATICS	Ronan Carroll	Theatres 5-8 Sonosite	New	£30,447.00		quantity x 1		5-7	To stop surgery delays awaiting machine from other areas for anaesthetic blocks
	ACUTE ATICS	Ronan Carroll	Theatres 5-8 Timex Nail Extraction Set	New	£8,461.20		quantity x 1		5-7	Current set brought in on loan for specific cases, safety for patients if on the shelf
	ACUTE ATICS	Ronan Carroll	Theatres 5-8 Visao High Speed drills	New	£15,028.30		quantity x 3 for drills		5-7	Current systems are on loan without cannot run the service
	ACUTE ATICS	Ronan Carroll	Data management system for Acute Pain Services	New	£16,000		quantity x 1	5 years subscription		IT programme for Acute Pain to enhance service and data collection
	ACUTE ATICS	Ronan Carroll	DSU, CAH Stacking system/Scope	1 - Upgrade & 1 new	£164,671.60		quantity x 2 2nd at request of Mr McKay to enable 2 endo lists to run at the same time £82335.84 (stack system without scopeguide)	10-12	5-7	Maintaining service / increase use
	Acute SEC	Ronan Carroll	Prime plus bladder scanner and probe (2 year warranty)		£8,144.00		quantity x 1			
	Acute SEC	Ronan Carroll	Vitacon vitascan PD bladder scanner + cart for Vitascan		£5,500.00		quantity x 1			
		Ronan Carroll	Transperineal prostate biopsy	New						
		Ronan Carroll	X3 paeds nasopharyngoscopes (1 for each OPD)	New						

MELANIE McCLEMENTS INTERIM DIRECTOR OF ACUTE SERVICES	Ronan Carroll ASSISTANT DIRECTOR – ACUTE SERVICES Surgery & Elective Care and ATICS 1-1 Discussion

DATE: MONDAY 8TH JULY 2019

No	Issue for discussion	Discussed / Actions agreed
1	Capacity/Vacancies	• 3 South - remains unchanged re risk • Surgical beds – Mark Haynes not keen to decrease surgical beds. ENT and Urology need 24-25 ?+Gynae = 1 ward
2	Banding Issue	B5 in ICU x15 appealed Banding – currently 34% B6. May be a 5 year backpay
3	Theatres	• Chronic Pain Service – recruiting CNS Chronic Pain for retirement • Anaesthetic Hub – Meeting tomorrow • DEC – STH – Furniture purchased has been used by GPs –

		Following up with Mark and Helen. • Seamus Murphy wishing to ringfence USC Endoscopy in DHH and Bowel Cancer waiting list in STH. Would have fall out for medical side of his role. Ronan scoping. • General Surgeons – 2 off and some off on-call rota for range of reasons. 1 locum from last week. • Issue with Colorectal Surgeons – 2 relocated to CAH. No theatre space. Need clarity – suggest meeting with Melanie, Mark and Ronan
4	Pre-Op Assessment	• Small service but demand increasing. • Internal Audit – May 19 report – Review Pre-Op recommendation • In-patient theatre 82% usage (good) • Emergency Theatre – demand driven. CAH 35% DHH 25% • Nurses redeploy to other theatres and wards – nowhere else in province does this. Working groups/steering group on IA actions
5	Equipment Concern	Action – Melanie to follow up with Aldrina re £2.8m equipment requirement

		Risk assessments – Equipment spreadsheet details age, consequence of failure etc
6	Surgical waiting times	Pension impact will impact Some surgeons suggesting 7 PAs and Locum sessions (4/4.5) Action – Melanie to discuss with Maria clarity re who approves decrease in PAs
7	Paed OP	Plan for ENT/Audiology and other services. Estates involved. Ronan to send final confirmation of spec to Estates to progress and to include on minor works priorities.
8	DATE OF NEXT MEETING	5th August 2019

Risk to Surgical Waiting Times

In house additionality (IHA) has been the means by which waiting times including patients with red flag and urgent referrals have been managed. However with the current 'pension issue' consultants have essentially stopped IHA additionality from June 19 and for the foreseeable future. The following tables is an attempt to illustrate and advise SMT what the impact on waiting times could be for patients with red flag, urgent and routine referrals. To note these tables do not take into account a further increase in waiting times should consultants wish to reduce their PA's. The first priority for sec & acute services is the preservation of our emergency/unscheduled services on both hospital sites

Table 1: below shows waiting times for **red flag** 1st outpatient appointment at the end of April 19, June 19 and March 20 predicted if outpatient templates remain the same. Ultimately for the Trust this will impact on the performance against the 62 days cancer target, with more patients breaching.

Table 1	April 19	June 19	March 20
G Surg	32 days	40 days	80 days
Urology	42 days	47 days	55 days
Haematuria	53 days	31 days	53 days
ENT	12 days	26 days	30 days
Endoscopy	14 days	21 days	55 days

Table 2: below shows waiting times for 1st outpatient appointment for urgent and routine by the end of May 19 and predicted by the March 20 (add on 43 weeks to end of March 20)

Table 2	End of May 19	End of March 20	End of May 19	End of March 20
Outpatients	**Urgent**	**Urgent**	**Routine**	**Routine**
G Surg	132wks	175wks	143wks	186wks
Urology	178wks	218wks	182wks	225wks
ENT	95wks	138wks	50wks	93wk
IPDC				
Endoscopy	28wks	49wks	129wks	172wks
G Surg	119wks	162wks	132wks	175wks
Urology	277wks	320wks	264wks	307wks
ENT	86wks	129wks	131wks	174wks

Table 3: shows waiting times for **elective IPDC planned** urgent and routine backlog patients at June 19. The last column is the total patients currently on the planned waiting list with a 'see by' date for March 20, please note there could be more patients added and some patients may be scheduled.

Speciality	HOS	Total planned at May 19	Longest wait	Number of pts on the elective planned waiting list up to Mar 20
GSURG	Amie	43	Oct 16	82
Breast	Amie	30	Sept 17	34
Endo	Amie	1686	Jan 18	2927
Pain	Helena	35	Nov 18	159
Urology	Martina	191	Aug 16	600
ENT	Martina	2	March 19	4
Ortho	Brigeen	140	Nov 16	241

Table 4: shows waiting times for **outpatient review backlog** urgent and routine backlog patients at May 19.

Speciality	HOS	Total review backlog log at May 19	Longest wait	Estimated number of pts on RBL by Mar 20
GSURG	Amie	2502	April 16	3398
BFH	Amie	1160	April 16	1304
Breast	Amie	13	Oct 16	20
Pain	Helena	566	Feb 15	640
Urology	Martina	2691	May 15	3091
ENT	Martina	2642	April 17	3340
Ortho	Brigeen	962	Nov 16	1100

Solutions/Options:

- Prioritise red flags over urgent and routine
- Change outpatient clinic templates e.g reduce routine and urgent slots and increase red flag
- Stop general surgery daycase / minor op sessions and replace with outpatient red flag clinics
- Switch from another clinical activity to virtual outpatient clinics (this might increase direct to test e.g endoscopy)
- Look at distribution of upper and lower GI red flag referrals against outpatients templates with expectation of equally sharing red flags between Gastro and G Surg
- Further exploration of evaluation of the straight CT Colonography pilot and exploration of expansion
- Consider independent sector, however, patient will require to remain out in the IS for their full pathway e.g scope, review, diagnostic test and any follow up scopes.
- Review specialist nurse / staff grade led services e.g bright red colorectal clinic

MELANIE McCLEMENTS INTERIM DIRECTOR ACUTE SERVICES	**Ronan Carroll** **ASSISTANT DIRECTOR – ACUTE SERVICES** **Surgery & Elective Care and ATICS** **1-1 Discussion**

DATE: WEDNESDAY 7th AUGUST 2019

No	Issue for discussion	Discussed / Actions agreed
1	Equipment	• Working through list for £500k. To be available for tomorrow. • To review risk assessment scoring/rationale and measures
2	Pensions News	Reversal should help Consultants uptake of additionality – Improved picture.
3	OPD Priority	Has been prioritised. Ronan to follow up with Mark Bloomer. – Priority (1)
4	Anaesthetic Hub	• Sorted – area agreed. • Helena to follow up with Tim & Estates with minimal cost.

Progressing

5	Bowel Cancer Screening	• Moving from Fob to FIT by April 2020 • Will need to increase 3 lists in afternoons • Tracey Owens was to support additional nursing and equipment. Ronan to follow up. → D e-mailed Tracey
6	Paediatric Endoscopy in DHH	• Long waiting times regionally. Keen to use DHH to address (none currently in DHH) • Would impact on dental and ENT and needing to ? move. • HSCB requesting support from Capital pot in Trust – unlikely.
7	Workforce Issues	• Remains very problematic • Contact from May Day. Meeting happened with Iain Gough • Ronan to follow up with Iain and May Day. Meeting in diary.
8	Consultant Anaesthetist Posts DHH x3	• Recruitment underway • 2 Consultants out of 8 at risk

9	HDU – IPT and Beds	• Requested to join DHH Consultant meeting • To discuss with Anne, Mary Haughey etc re HDU beds and discuss with clinicians HDU IPT & read across to Medical Specialty Drs
10	ICU Upgrades	All nurses informed re B6 – Considering all Sisters? To discuss with HR
11	Endoscopy Nurses 8A	Re-banded and re-advertised
12	Consultant Risk	2 have applied for other posts and 1 other leaving. Ronan to discuss with both surgeons
13	Urology	7th Consultant approved/2 CNS
14	3 South	Still concerns. 3 x B6 left. Only 2 x B6 left. Recruitment underway. To respond to H Trouton email. Need discussion with B7 re way forward with HR

15	SPEED	To consider timely ED response, surgical access etc
16	ENT Trache	Working group to be set up. Will increase with repatriation (Martina, Ted, Kay, Lead Nurses) Meeting to agree best model. (inc OHA)
17	Cataracts	DECs – cataracts and veins (Omagh). Going at risk at present (nursing). If ENT DEC goes to STH – someone would have to move
18	Meeting with family re Ombudsman Case	Ronan to follow up re family meeting ✓ Meeting arranged.
19	SHO	3m. RTB and lower cost options to be considered/progressed
20	Breast	0.5 surgeon Business case = Sandra Wardell no funds
21	Feedback from Damian	Discussed with Ronan

22	DATE OF NEXT MEETING	Monday 2nd September 2019

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Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: Assistant Director ATICs/SEC 8c **Staff Number:** Personal Information redacted by the USI

Is Professional Registration up to date? yes Revalidation April 2020

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? **Post Outlines can be accessed via Trust Intranet (KSF link)** **YES** ☐ **NO** ☒ x **Have Post Outline levels been achieved:** **YES** ☐ **NO** ☒ x **If no, record below what action to be taken:**	Personal Information redacted by the USI **Line Manager's Feedback on staff members performance over past year:** Personal Information redacted by the USI

Objectives for Next Year:
My objectives are detailed through the Divisional work plan.

Work plan 2019-2020.docx

Reviewee Staff Name (Print) Ronan Carroll____ Signature _[redacted] Date 3/9/19_____

Reviewer Manager/Supervisor (Print) _____ Signature _____ Date _____

Part B ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link **Staff Number:** _____

Training type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction		
	Departmental Induction/Orientation		
	Fire Safety		
	Information Governance Awareness	31/8/19	
	Equality & Human Rights		
	Moving and Handling	13/7/17 due 13/7/20	
	Infection Prevention Control	13/7/17 due 13/7/20	
	Equality, Good Relations and Human Rights – Making A Difference	31/8/19	
	Safeguarding People, Children & Vulnerable Adults		
	Waste Management		

Corporate Mandatory Training ROLE SPECIFIC	**Right Patient, Right Blood (Theory/Competency)**		
	Control of Substances Hazardous to Health (COSHH)		
	Food Safety		
	Basic ICT		
	MAPA (level 3 or 4)		
	Professional Registration		
Essential for Post			
Best practice/ Development (Coaching/Mentoring) (Relevant to current job role)			

Reviewee Staff Name (Print) ___Ronan Carroll___ Signature __[redacted] Date __3/9/19____

Reviewer Manager/Supervisor (Print) _____ Signature _____ Date _____

PLEASE SEND COMPLETED PART B TO: KSF DEPARTMENT, HILL BUILDING, ST LUKES HOSPITAL, LOUGHGALL ROAD, ARMAGH BT61 7NQ OR EMAIL TO: - VOCATIONAL.ASSESSMENTCENTRE[redacted].

20190916
Q17 151

From: Carroll, Ronan [redacted]
Sent: 16 September 2019 12:39
To: Donaghy, Gary
Cc: Cassells, Carol; Ward, Sarah; McClements, Melanie
Subject: FW: Position Number
Attachments: Create position request (3.97 KB); Z_OM_FORM_CREATE_POS_NEW.PDF; FW: Practice Educator SEC (7.84 KB)

Importance: High

Gary,
Yes you are correct this is a new post, there is no funding, it is at risk. This post was approved by the Cx.
Attached is the email I sent to my team following conformation from Melanie. Happy for you to contact his office for confirmation.
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery/Elective Care
Mob [redacted]

From: Donaghy, Gary
Sent: 16 September 2019 12:34
To: Carroll, Ronan; Cassells, Carol; Ward, Sarah
Subject: RE: Position Number

Ronan/Sarah
Please find attached correspondence – I don't have any record of a response confirming the funding source for this new position (copy also attached as original email archived), can you please advise?
Regards
Gary

From: Carroll, Ronan
Sent: 16 September 2019 09:53
To: Donaghy, Gary; Cassells, Carol; Ward, Sarah
Subject: FW: Position Number
Importance: High

Carol/Gary
Would this post be with you?
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
[redacted]
Ext [redacted]

From: Ward, Sarah
Sent: 16 September 2019 09:51
To: Carroll, Ronan
Subject: Position Number

Ronan

Can I just check did you get notification to approve a request for the position number for the Clinical Education Practitioner? Just trying to chase it up and get it moving along but HRPTS dashboard doesn't seem to show what stage it is at

Sarah Ward

Lead Nurse
SEC
Ext Personal Information redacted by the USI
Mobile Personal Information redacted by the USI

Health and Social Care in Northern Ireland

Create Position

Unique Ref No Personal Information redacted by the USI

Requestor Details

Employee Name	Mrs Sarah Ashleigh Ward
Personnel Number	Personal Information redacted by the USI
Full Contact Number (no spaces)	Personal Information redacted by the USI
Work E-Mail	Personal Information redacted by the USI

Form Help

The purpose of this form is to request the creation of a new position with appropriate approvals within your area of responsibility.
This form will flow to your manager for approval. Once approved it will flow to Finance. On approval the form will flow to the HR OM Team for processing.
Please complete the boxes below and include any further information/clarification in the comments box.
If unsure how to complete, please contact your OM Team.

Details

Org Unit Number and Name	Personal Information redacted by the USI Surgery & Elective Lead Nurse C
Effective Date	Apr 1, 2019
Position Title	Practice Education Facilitator
Job (Grade)	5B27 TEACHER/TRAINER (7) X007
Cost Centre	C0333N-CAH C.N.S - SURGICAL
Weekly Funded Hours	37.50
Employee Group	C Southern - HSCT
Employee Subgroup	01 - HSC Monthly
Personnel Area	Nursing & Midwifery
Personnel Subarea	Acute - PG
Department	General Surgery
Location	Craigavon Area Hosp-Main Building

Does this Position Manage Staff? ◉ No ○ Yes

If 'Yes' to the above question, does the position require Manager Self Service (MSS) or Sub Manager Self Service (Sub MSS) Role?			
Will this Position approve Travel & Expenses?	◉ No	○ Yes	ⓘ
Will this Position approve Overtime?	◉ No	○ Yes	ⓘ
Are there any other roles to be assigned to this position?	◉ No	○ Yes	ⓘ

Comments

Previous Comments

Sarah Ashleigh Ward 11.04.2019 15:39:02
For Finance: If Cost Centre is incorrect please advise of correct Cost Centre in Comments. (BT)

New Comments

Audit Log

PROCESSED by Sarah Ashleigh Ward on 11-04-2019 at 15:38:59
APPROVED by Ronan Carroll on 15-04-2019 at 15:52:57

20190916
Q17 · 151 #2

From: Carroll, Ronan [redacted]
Sent: 16 September 2019 12:38
To: Carroll, Ronan
Subject: FW: Practice Educator SEC

Importance: High

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery/Elective Care
Mob [redacted]

From: Carroll, Ronan [redacted]
Sent: 14 August 2019 12:51
To: Kelly, Brigeen; Nelson, Amie; Corrigan, Martina; Matthews, Josephine; Sharpe, Dorothy; Ward, Sarah
Cc: Walker, Helen
Subject: Practice Educator SEC
Importance: High

Afternoon all
Melanie has confirmed that we have approval for the above post for SEC.
This post is for all SEC but in the first instance spending a lot of time in 3S
I have ask Sarah to create a position and to progress with external recruitment
Good news ☺
Ronan

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery/Elective Care
Mob [redacted]

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Part A

KSF PERSONAL DEVELOPMENT REVIEW FORM

Post Title, Pay Band: Assistant Director ATICs/SEC 8c **Staff Number:** Personal Information redacted by the USI

Is Professional Registration up to date? yes Revalidation April 2023

KEY ISSUES & OUTCOMES	COMMENTS
Have you read and understood your Post Outline? **Post Outlines can be accessed via Trust Intranet (KSF link)** **YES** [X] **NO** [ ] **Have Post Outline levels been achieved:** **YES** [X] **NO** [ ] **If no, record below what action to be taken:**	**Staff members comments on his/her performance over past year:** Personal Information redacted by the USI **Line Manager's Feedback on staff members performance over past year:** Personal Information redacted by the USI

Personal Information redacted by the USI

Objectives for Next Year:
My objectives are detailed through the Divisional work plan. Whilst this work plan was for 19/20, the pandemic prevented any progression, so remains valid

Reviewee Staff Name (Print) **Ronan Carroll**____ Signature Personal Information redacted by the USI Date 13/6/21_____

Reviewer Manager/Supervisor (Print) **MELANIE MCCLEMENTS** Signature _____ Personal Information redacted by the USI Date 14/6/21

Southern Health and Social Care Trust
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Part B

ANNUAL PERSONAL DEVELOPMENT PLAN

For training requirements specific to your staff group refer to Trust Intranet Training Link

Staff Number: ____ : [Personal Information redacted by the USI] _____

Training type	Identified learning need	Date Training Completed	Agreed Action
Corporate Mandatory Training ALL STAFF	Corporate Induction		In post August 2007
	Departmental Induction/Orientation		In post August 2007
	Fire Safety	? nov 19	
	Information Governance Awareness	31/8/19	30/08/2022
	Equality & Human Rights		
	Moving and Handling	? 13/7/20	
	Infection Prevention Control	? 13/7/20	
	Equality, Good Relations and Human Rights – Making A Difference	13/7/20	30/08/2022
Corporate Mandatory Training ROLE SPECIFIC	Safeguarding People, Children & Vulnerable Adults		
	Waste Management		
	Right Patient, Right Blood (Theory/Competency)		
	Control of Substances Hazardous to Health (COSHH)		
	Food Safety		
	Basic ICT		
	MAPA (level 3 or 4)		
	Professional Registration		1/4/2023
Essential for Post	Recruitment & selection	yes	09/07/2022
Best practice/ Development (Coaching/Mentoring) (Relevant to current job)			

Reviewee Staff Name (Print) _____ Signature ___[Personal Information redacted by the USI]_ Date __14/6/21_____

Reviewer Manager/Supervisor (Print) _____ Signature _[Personal Information redacted by the USI] _____Date _____14/6/21

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20190911
Q17.155

From: Walker, Helen [redacted]
Sent: 11 September 2019 17:47
To: McClements, Melanie
Subject: Update on 3S
Attachments: Discussion with [redacted] 30.8.19.docx; Managerial Action Plan 3 South.docx

Mel you asked to have sight of the action plan for [redacted] when it was finalised. See attached. Not sure if you are aware but [redacted] and Alicia in involved with Sarah in following this up. 2 band 6s on the ward have been asked if they are interested in acting up in [redacted]'s absence. They are both thinking about it but likely to say no. Plan be will probably be an EOI. Ronan has discussed none of this with me.
H

Helen Walker

Assistant HR Director (Acute Services)
Craigavon Area Hospital
68 Lurgan Road
Portadown
BT63 5QQ

Telephone – [redacted]
Mobile - [redacted]

From: Ellis-Gowland, Alicia
Sent: 11 September 2019 15:12
To: Walker, Helen
Subject: FW: Discussion with [redacted] 30.8.19

Alicia Ellis-Gowland
Senior HR Advisor

From: Ward, Sarah
Sent: 11 September 2019 08:20
To: Ellis-Gowland, Alicia
Subject: Discussion with [redacted] 30.8.19

Sarah Ward
Lead Nurse
SEC
Ext [redacted]
Mobile [redacted]

Discussion with Personal Information redacted by the USI on 30th August 2019.

Issue #1

I began by giving Personal Information r some feedback from my first impressions of being in charge of the ward the previous week. I spent some time discussing how the team seems "sad" and felt that they came on duty with a severe lack of motivation, enthusiasm and there was no sense of awareness of time and handover was not starting on time, it seems disorganised and I had to go find the staff to handover at 07:40am. The handover itself was tedious, every word on the handover page was read out and there was information missing which I felt should be included. The handovers conducted in the office were not conducive to a quick/ concise team handover and it took approx. 45 mins to receive one side. NIC wasn't getting the full handover for ward prior to bed meeting. Safety brief didn't include entire ward, structure wasn't easy to follow and the staff completing on night duty had ticked the uniform/ badge/ jewellery check before the NIC had even checked staff. Attendance at bed meeting was poor. Ward must have representation at all meetings, and can be from Band 7,6 or band 5. Bed meetings have to be recognised as important. Side Room risk assessment forms/ Delirium audits not being completed at present (all info has been sent) we need to get a system in place to have these completed to bring to the meeting.

Suggestions/ Actions

- Between band 6 and Band 7, I would suggest taking it turn about to have a 7am start (finish 30 mins earlier) as is done in other areas. This allows them to get handover on one side of the ward and have full handover completed by 8am. You need to start this pattern from Monday. You are in agreement to try this adjusted pattern.
- Handover needs to be end of bed/ end of bay. You need to get this commenced from Monday. Night duty staff who will be handing over need to have reports printed, ready to commence sharp at 07:30am. CD Checks can be completed by an allocated nurse, as long as NIC/ Sr/ Clinical Sister is completing one check per day either am or pm. Staff should be allocated daily, and CDS must be checked prior to handover. CD cupboard was busy, I understand this logging system works for you but cupboard stock must be managed and a clear out with pharmacist needs to be arranged asap (sarah happy to arrange if needed)
- Staff need to be instructed on how to hand over, ie if its on the handover page, it doesn't need read out, keep it simple, concise and focused. Staff giving handover need to lift each patients end of bed chart as they go, review NEWS, Fluid balance and scan kardex to ensure all is completed. This will take a little time to get staff into the way of it but we must keep being consistent and support staff to embed this into practice.
- Safety brief- can we review layout. You need to ensure there is a night and day safety brief completed at each shift handover time. Whole staff cohort for the day need to stand together on ward and safety brief be lead by the NIC of night duty/ day duty. I would also suggest that you use this forum to highlight important info eg update risk assessment for the day.
- Forms for Delayed discharges/ side room risk assessment and recording patients with delirium need to be printed and kept together in an easily accessible place and completed at time of handover ready for bed meeting.

Issue #2

Flexibility with staff requests/ requirements. Discussed that we need to have an open minded view on what staff are requesting to work/ adjustments to work. Discussed that discussion with Personal Information redacted by the USI last week raised issues that she felt her WLB agreed by Sarah was not going to stand and she would be expected to work outside of what was agreed. Personal Information redacted by the USI has been granted a 3 month WLB to allow working on a Tuesday and Thursday. It is understood that although this was initially declined at a previous HR meeting Personal Information redacted by the USI and on discussion with HOS/ AD it felt it was reasonable to allow Personal Information redacted by the USI request for a 3 month period to facilitate a return to work. This was very clearly communicated both verbally and in written and signed confirmation to Personal Information redacted by the USI. It is clear that this WLB cannot be facilitated in the long run. The new band 6 coming from Cathlab has raise issues with working long days. It has been discussed that there has to be an element of compromise and we need to request that she works one long day per week, and we can work with her with regards to the day.

Suggestions/ Actions

- All WLB must be discussed with an open mindset. It cannot be a straight 'no' without full consideration. Staff need to feel that it is a 2 way process and you need to be seen to accommodate and try to maintain staff in post. If it is a request that is completely beyond possibility, then it must be discussed in a way that staff understand why. At this stage, staffing cannot be any worse. So you need to have the attitude that we should accommodate staff as much as possible in the aim to retain them. You must put end dates on the requests, I would suggest 3 months and advise the staff that this is the case and what is required within that timeframe. Whilst we are aware that we don't want to create a culture that all staff start asking for specifics, we are not in a position to decline and not compromise for short period of time.
- The new band 6 coming, is aware of their responsibilities in their new role. As this is an EOI, this could be for a very short time, so you must be accommodating and ensure we entice them to stay in the role. I would expect any adjustments we are facilitating for the new Band 6 to be the same for the current band 6. So for example if they can only work one long day shift on their allocated weekend and the other is a 4.45pm finish, then this is the same for the other band 6s in post.

Issue #3

Core band 5 staff not taking charge/ lack of exposure to in charge role. After the crisis last week with staffing, we need to look at the core staffs abilities and build on these to be in charge. Whilst we have few staff, those that are qualified and have been working for over a year on the ward need to be developed and supported to be in charge. Lead Nurse does not want to be put in the position again to have to justify why core staff trained 2 years are not fit to be in charge. Reasons for not being in charge need to be very clear and appropriate. Having an overly confident or nervous nurse is not a reason. You must support them and allow them opportunity to develop and gain insight into the role. You need to ensure the structure is there, even though it is a very small structure, to have band 5s able to step up when things happen.

Suggestions/ Actions

- Starting with immediate effect as of Monday staff need to be identified daily and opportunity given to be exposed to the in charge role. Aim for 1 nurse per shift. This needs to happen during the Monday-Friday working week, when band 7/band 6 is present and can act as the support/ guide and encourage the band 5 nurse.
- You need to work your core hours over Monday-Friday. The long day on a Monday pattern needs to stop and we need to create the opportunities for the band 5 nurses to be in charge. Allowing them the opportunities during the day, builds their confidence to do it when you leave at 5pm. Having band 6s finish at 5pm on weekend days also allows the band 5 staff exposure to managing the ward, and they will be gaining confidence getting opportunities during the week therefore weekends will not be as daunting for them.
- You need to swap roles with the band 5 on duty on a regular basis. Allow them to complete ward round on their side, attend bed meeting on your behalf, give changes, allocate breaks, do daily allocations, complete spot checks and conduct huddles with staff etc.
- Band 5 nurses will be boosted by this ultimately. Allowing them to take charge shows them that you trust them, you value their abilities and you want to build their skills, develop their confidence and gives them a sense that you value them. By swapping roles and you taking on band 5 role whilst they develop in charge skills, allows the nurses to feel that you are invested in your team and can allow them the opportunity to grow.
- If band 5s are not fit to be in charge, you must ensure this decision is based on actions following letting them be in charge. It must be well justified and not based on personality etc. Performance and attitude are the markers we focus on.

Issue #4

I explained that I has asked for some feedback on how I was as Nurse in Charge on the ward last week. I explained that staff had said “we have never been asked if we are ok or if you can do anything to help us”, this was from more than 1 staff member. Yon indicated that Band 6s assist, however it is vital that the Band 7 is proactive in doing this. I noted that my first impressions of a “sad” team first thing in the morning had begun to change, and staff were coming to me to talk through things/ advice etc etc. And that I felt very well supported by the staff, given that I was out of my comfort zone knowing nothing regarding ENT/ Urology. My impression was that staff didn’t feel supported, especially in the morning and that there was no checking in or assisting the staff to get the mornings work cleared up. The band 7 presence on the ward is vital. As explained you create the tone, attitude, standards, atmosphere and work ethic on the ward . Staff need to feel you are heavily involved, and that you are fully available to assist at any stage. If staff see you getting involved with their work, ensuring they are okay, assisting with tasks for eg ivabs/ CD drugs dispensing/ washing patients/ doing observations etc and encouraging a team effort approach to the morning especially, staff respond to this and feel this team approach. But this must be lead by you. The band 6s ultimately feed into this, but you must lead by example.

Suggestions/ Actions

- You must be fully clinical in the mornings. Office work should not be priority. I appreciate that if staff phone in sick for example we need to act, however utilise your lead nurse etc and ensure this does not take away from the ultimate priority of being present for the staff at the busiest time of the day.
- Band 6 and Band 7 to swap roles routinely. You need to have days per week where you are fully clinical on the ward, and allow the band 6 to do office duties.
- You, in collaboration with the band 6 need to take a side each following ward rounds, and assist staff to get duties cleared up before breaks commence. Hands on approach is what staff value from you as their band 7
- You need to check in with all staff regularly throughout the day, I would suggest staff feel more benefit from you asking them 1:1 what you can do to assist.
- You need to have a constant positive attitude especially first thing in the morning to show staff that things will be okay and you are a team and will work together.
- If a patient takes unwell, you need to be there. Staff need to feel you are there to assist, support and part of the team. There should be no other priority in these situations, staff really appreciate seeing the band 7 being hands on and sharing the workload when a patient takes unwell.
- Staff need to feel smothered by you as the sister. They need you to make them feel they are so valuable to you, and that them being here is brilliant!

Issue #5

I explained that I had noted staff were not confident in some skills, for example G+H. When asked you explained that staff do not do G+H and I feel it is important that if they have had RPRB training that they need to use their skills, and not rely on other staff. G+H in my opinion is a relevant skill to have on a ward where patients are being cared for that have the potential to bleed.

Suggestions/ Actions

- Staff who have went to training for skills need to use them. In particular G+H, venepuncture and cannulation and ECG. If staff feel confident in using these skills it provides more satisfaction for them and feel that they are a real asset to the team. You as the band 7 also need to lead by example on these and for eg if a patient is sick, assisting by obtaining the bloods/ inserting cannula etc and demonstrate the importance of being skilled and utilising these skills.
- If competencies are required please inform lead nurse, we will get these made priority and sarah is happy to assist.

Issue #6

The amount of staff leaving post is very concerning. On discussion you feel that the promise of bed closure is a major factor in why staff are leaving and that they have been given false promises. As discussed and as you understand the pressures of the hospital have ultimately made this impossible, and reflecting on the situation perhaps we should not of made that assumption that this was going to happen. With the 4 beds being closed, staff are responsible for 4 patients. This is not reflected in any other ward, and we need to look at why the staff are still focusing on the lack of bed closure as the issue, rather than why they cannot cope with managing 4 patients. The bed closure issue needs put to the side, and we all have to reflect on what has happened, what role we have in the situation, what we have learnt, what we will do differently and that it is time to move on and forget about the past issues that are no longer there. I have explained that we need to look at the environment; this is what sells us, and how we entice staff in, and keep our own staff. I have explained that the environment is not right. The culture is wrong, the atmosphere is wrong, the attitudes are wrong and the approach to the situation is wrong. The ward needs to have an overly welcoming, motivated and supportive atmosphere and that responsibility lies with you as the ward sister.

Suggestions/ Actions

- Move the focus away from the lack of bed closure. Remind staff of the positives, we are working 1 nurse to 4 patients, no one else in this hospital gets this. We are in a privileged position and need to appreciate what has been done so far.
- Your positivity. You need as said to come in with an overly positive attitude and make staff feel that regardless of the challenges ahead, yous are a team, you are just as involved with patient care as they are, and ultimately they need to feel that any office duties are not your priority when things get tough, or at key times of the day.
- You need to fully embrace the new band 6s coming, their induction needs to be thorough and they need to experience all that being a band 6 involves. Release control over certain elements, eg roster. They only learn from trying and their mistakes.
- Staff who are considering leaving, encourage them to be open and honest of the reasons, and utilise the lead nurse.
- Communicate openly with staff. Daily priority to ensure everyone knows everything going on. Staff focus on communication and I would suggest you need to overly communicate to ensure they feel comfortable in asking for help/assistance and can approach you for any reason.

As discussed with you on 30th August, I have been asked to compile a Managerial Focused Action plan by multiple members of SMT to ensure all that has been discussed is being done. As explained the responsibility lies with the Band 7, the band 6 currently and the new band 6s will feed into this as part of their induction to ensure we are all approaching this with the same attitude. As discussed this is ‘ make or break’ and we need to get these elements right to ensure we have the ward environment right moving forward.

Signed ……/……..

Band 7 Ward Sister Managerial Action Plan 3 South (September 2019)

Issue	Action	Owner	Time Scale	Update	Complete
Practice Development • Handover Structure • Safety Brief Structure • Attendance at Bed Meeting • Completion of Side Room Risk Assessments ETC for Bed Meeting	1. Either band 6 or band 7 to take in turns to start at 7am. One side of ward handover to be obtained between 7-7.30. This does not need to include weekend days if ward round structure is different. 2. Ward Nurse on both day and night duty to be allocated in advance CD check. This must be prioritised before handover starts. 3. End of Bed/ Bay handovers to start with immediate effect. All staff to be educated on how to complete, minimal reading out of what is on page, review of end of bed	Personal Information redacted / Ward Sister	With Immediate Effect. Commencing week beginning 2nd Sept. It is expected that this will be fully embedded/ actioned within 2 weeks (Week ending 15th Sept)		

	charts and ensuring handovers are quick/ concise and ready to start on time. 4. Safety brief to be with entire ward staff. Together before start of handover. Structure of page to be reviewed and focus on uniform/ badge checks etc 5. Night time safety brief to be completed also. Structure needs to reflect the issues overnight that would be different from the day shift. 6. Band 5 can represent at bed meeting. Must be made priority to attend. All required forms for bed meeting need to be				

	easily accessible, all staff aware where they are and completed before coming				
Staff Management • Flexibility	1. All WLB to be fully considered. Cannot be declined without this. If completely unachievable, conversation to be had. 2. Timescale placed on all WLB of 3 months and expectations documented 3. Fairness across all staff including band 6s	Personal Information r / Ward Sister	With Immediate Effect. Week Beginning 2nd Sept and further WLB/ Adjustments are to be considered in this format.		
Develop Leadership Skills • Develop current band 5 core staff to take on in charge role • Building of core staff confidence, skills and creating autonomy	• Band 7 to identify band 5 nurse per core working day to focus on exposure to in charge role. • Band 7 to swap roles with band 5 and encourage and support band 5 to	Personal Information r / Ward Sister	With Immediate Effect. Week Beginning 2nd Sept. This must be achieved and embedded in daily practice within 2 weeks. (week ending 15th Sept)		

	be in charge whilst they are on duty. • Allow band 5 to complete tasks such as ward rounds, bed meeting, break allocation, spot checks etc daily to maximise opportunities to develop. • Allow band 5s to feel trusted, supported and valued in their role and that you have confidence in their abilities. • Reasons for not progressing band 5 to be in charge must be based purely on performance and attitude towards the role. Not personality. • Facilitate a learning environment				
Role modelling/ Visibility /Accessibility/Approachability • Presence on floor • Organisation of Day • Support to Staff	• Ward sister needs to be fully clinical in the mornings. Office work should not be priority at this time of the	Personal Information, Ward Sister	With Immediate Effect. Week Beginning 2nd Sept. This must be achieved and embedded in daily practice within 2 weeks. (week ending 15th Sept)		

• Hands on Approach • Culture/ Environment/ Attitude/ Standards/ Work Ethic.	day. • Ward sister must work hands on with band 5 staff. Band 6 for eg can take one side and band 7 the other. • Regular 1:1 chats with staff throughout the day, checking in and assisting with any tasks required. • Positive attitude consistently • Present when patients take unwell. Support and assist staff. • Make staff feel valued at all times				
Develop Clinical Practice • Staff to be encouraged to utilise skills. In particular G+H/ Venepuncture etc. • Competencies to be priority and Ward Sister to assist and utilise their own skills.	• Ward Sister to remain up to date in these skills and use them on the ward. • Support and encourage staff to build their skills and be 'self sufficient'	Personal Information / Ward Sister	With Immediate Effect. Week Beginning 2nd Sept. This must be achieved and embedded in daily practice, appreciate that competencies take some time to obtain and staff may require updated training.		

	and ensure they maximise the opportunities. • Competencies to be reviewed and staff to complete asap				
Staff Retention/ Acceptance of Issues • There has been a large volume of staff leaving, including 4 band 6s. • Focus from management to staff on the lack of progress regarding closure of beds. • Review of Nurse to Patient Ratio • Communication with staff • Positivity and instilling a confidence in staff	• Move focus to the positives (one nurse to 4 patients) • Positive attitude at all times. • Staff to be communicated with openly, they must feel they can approach ward sister at any time with any issue. • Allowing staff to be open and honest with reasons for leaving. Need to remain neutral and not take things personal • Embrace and support to the highest level new staff coming on board. Full in depth inductions to be completed.	Personal Information / Ward Sister	With Immediate Effect. Week Beginning 2nd Sept. This must be achieved and embedded in daily practice within 2 weeks. (week ending 15th Sept)		

Signed ……../…….

20191118
Q17 · 157

From: Carroll, Ronan [redacted]
Sent: 18 November 2019 11:58
To: McKeown, Ronan; Haynes, Mark; Murnaghan, Mark; Watson, Bruce; Magill, Paul; Mclean, Gavin; Bunn, Jonathon; Patton, Sean; Scullion, Damian; Rutherford-Jones, Neville; McMurray, David; Wilson, Lynn; Roberts, Veronica; Doyle, Timothy; OHagan, Julie; Murray, Helena; Ward, Sarah; Clayton, Wendy; Currie, Louise; Farley, Maureen; Trauma Coordinators; Kearney, Emmajane; Wells, CharlotteAnne; Robinson, Jeanette; Donnelly, Rachel; Robinson, Katherine; Scott, Jane M
Cc: Conway, Barry; McClements, Melanie; Magwood, Aldrina; Trouton, Heather; OKane, Maria
Subject: FW: Theatre nursing shortage
Attachments: Briefing paper CAH Theatre Nursing Challenges from Nov 2019 onwards.docx

Importance: High

Dear all,
No doubt you are aware that within theatres and in particular inpatient theatres in CAH we have been experiencing significant nurse staffing shortages. These nursing staff shortages are made up of vacant posts (12.23) and nurses on maternity leaves (3.42) for which we have been unable to recruit to.
At the time of writing this email theatres 5-8 have a nursing theatre shortage of 12.58wte (funded for 32.25wte- 39% absence).
Actions taken to mitigate this shortfall includes:

- Specific theatre nursing advertisements
- Increasing the hours of full & part time staff
- Recruitment of agency theatre nursing / ODPs. (3.6 backfill when combined with OT & additional hrs)
- Reducing hours allocated to mandatory training / non-essential training cancelled
- Deferred annual leave over xmas period
- Daily conversations with nurse bank to try and secure more skilled agency nurse/OPD's
- Communicated with MPH & Altnagelvin

Unfortunately, all of the above actions has not been able to bridge the nursing shortages within Theatres 5-8. Following a meeting this morning with Melanie McClements, Director of Acute Services, Ronan McKeown, Damian Scullion, Helena Murray, Wendy Clayton and myself where several options were discussed (see attached paper pages 3-4) the decision has been taken for the **month of Dec 19 that no elective orthopaedic surgery will take place (option 3).**

We fully appreciate the gravity of this decision for all concerned, medical staff, nursing staff, doctors in training and most importantly patients who will have to wait longer for their orthopaedic surgery. However, we find ourselves in a position where there is insignificant nursing staff (number & skill set) to provide the commissioned level of Trauma & Orthopaedic operating. We will continue to work with the nurse bank and HR colleagues to maximise every opportunity to recruit nursing staff for theatres.

Please contact me if there is any option we have forgotten to consider or suggestion/s you want us to consider

Regards

Wendy Clayton
Acting Head of Service for Trauma & Orthopaedics
Ext: [redacted]
Mob: [redacted]

CAH Theatre Nursing Challenges from Dec 2019 onwards

Background/Current position

The purpose of this paper is to highlight further serious and significant nursing deficits that theatres are experiencing. I am raising my concerns in reference Theatres (T) 1-8 in Craigavon Hospital (CAH)

Theatres 1-8 is managed by 2 Theatre Sisters; 1 for T1-4 and 1 for T5-8

Table 1

Theatre	Speciality
T1	Emergency
T2-4	General Surgery, Urology Gynae, Breast, ENT
T5	Emergency Trauma
T6	ENT, Gynae, Urology
T7-8	Orthopaedics / Trauma

There have been ongoing theatre reductions in T2, 3, 4 & 6 due to staffing deficits, the reduction continued after the 18/19 winter pressure with a loss of 10.5 theatre sessions per week

- Theatre sessions funded = 45 sessions per week
- Theatre sessions currently available due to reductions = 34.5 sessions per week

There have been no reductions in theatre sessions in emergency T1, trauma T5 and ortho T7-8. However, trauma patients are scheduled into the Ortho T7-8 due to the trauma demand, decreasing current ortho elective provision by 25-30%.

Unfortunately, theatre nursing continues to be a challenge with more resignations, maternity leaves, retirements and the loss of some agency staff e.g. in T5-8 there were 6 agency nurses however from beginning of November there are only two agency nurses left.

As illustrated above, to date there has been no reduction in T7-8, however from December 2019 due to staffing deficits the Theatre Sister is unable to staff the T&O theatres safely.

Tables 2 below demonstrates increased theatre nursing gap in all CAH theatres:

Funded RN WTE 82

Reasons for nursing Gap	Sept 19	Dec 19	Jan 20
Vacant Posts	18.2	19.94	20.85
Maternity Leave	4.42	6.42	10.42
LTS	5.1	4.33	4.33
Secondment	0.23	0	0
Other (reduced hours, career break)	2.75	2.54	2.34
Total Gap	30.7	33.23	37.94 (46.2%)

We have managed to decrease the overall gap by engaging bank, agency and extra hours and also reducing funded sessions by 23%

Backfill	-11.65	-7.6	-6.6
Reduced sessions requirement	-6.3	-6.3	-6.3
Overall total Gap	**12.75**	**19.33**	**25.04 (30.5%)**

Over the last 6 months (May – Nov 19) the following WTE staff have resigned:

- Theatres 1-4 x 5.67wte
- Theatres 5-8 x 6wte

REASONS

Theatres 1-4 (5.67wte)	Theatres 5-8 (6wte)
• Work life balance e.g. closer to home, no nights • Retirement • Promotion to Band 6 • Community posts • Travelling (Australia)	• Work life balance e.g. closer to home • Promotion to Band 6 • Moved to ROI

Actions to date to mitigate the loss:

- Band 7 Sisters have both worked exceptionally hard in securing additional hours from staff either through bank or additionality.
- Over Christmas period the Sisters have agreed with the current agency staff that they will not take time off over the periods of increased leave for core staff and have agreed that they will delay their planned leave until January.
- We also have a member of staff who has agreed to do additional hours within theatres whilst on annual leave rather than do agency hours within a different Trust.
- There are staff with theatre skills from other areas (South Tyrone Theatres, Fracture Clinic, pre-op) continuing to cover shifts when they are able.
- Some staff have postponed their planned annual leave
- Daily conversations with Nurse bank to try and secure more skilled agency staff.
- Staffing is discussed and monitored daily at communication hub with Sisters and Lead Nurse
- All non-essential training cancelled as necessary for the month of Nov 2019

Please note that the December and January figures projected from the information we currently hold does not include any unforeseen sickness and does not take into account any potential agency staff that may commence or leave.

Proposed theatre sessions from December 2019

In order to staff theatres safely and following discussions with the theatre sisters and lead nurse the following sessions cannot be staffed:

Week commencing	T2,3,4	T7-8
2/12/18	2 sessions in the week (1 all day list)	2 sessions (1 all day) each day Mon – Friday Total 10 sessions
9/12/19	2 sessions in the week (1 all day list)	2 sessions each day Mon – Friday Total 10 sessions
16/12/19	2 sessions in the week (2 half days) *No PCNL / nephrectomy patients due to skill mix (discussed with HOS)*	2 sessions each day Mon – Friday Total 10 sessions
23/12/19	Xmas week due to bank holidays and reduced sessions due to leave, anticipate	

	being able to nurse. There is no planned annual leave given for nursing staff w/c 23/12/19 and also w/c 30/12/19

Please note if any further sickness occurs there may be cancellations on the day

Suggestions

- Continue to explore agency and bank block bookings
- Retirements have agreed to come back on reduced hours temporarily
- Scoping exercise completed for the uplift to Band 6 in theatres to cover 24/7
- Job description and scoping for a Practice Educator for theatres; would require 2wte (1 WTE for T1-4 and 1 WTE for T5-8)
- Explore collapsing of CAH and STH day surgery sessions and moving staff to be trained in theatres (this will require a lead in time for training in some anaesthetists skills, scrub for all specialities and circulating duties) – the length of time for this will depend on the current skills of these staff and how quick they can be upskilled
- Explore staff who have left to other areas within the hospital and transfer back to theatres on a temporary basis – movement has been due to band promotion and work life balance
- Continue to hold recruitment fairs, social media adverts and specific theatre drives
- All additional orthopaedic theatre sessions to cease (WLI funded by HSCB)

Consequences / Options for Theatre 7-8

Part 1 – Coping with Trauma
OPTIONS and consequences

Option 1: Run one all day trauma and one all day ortho theatre per day

- This would lead to a downturn in elective capacity
- There is already too much trauma demand – and would mean that trauma would spiral out of control
- We could possibly take some lists off other specialties in STH and do some daycase # lists but would not be enough to meet trauma demand e.g fixation of ankles, wrists can be done in day surgery

Option 2: Run one trauma and 1/3 ortho 2/3 fracture list (i.e. moving the trauma case normally done in the 3rd theatre to the second theatre.

- This would only have one elective case per day.
- This list would be shared amongst the 2 elective surgeons that would normally operate that day – effectively one elective case every two weeks for each consultant
- It would be hard to staff ring fenced ortho ward for 1 patient per day

Option 3: Run 2 all day trauma theatres

- Would have to change ortho ward to trauma ward
- Likely to mostly meet trauma demand.
- **Zero elective activity**

Regardless of which of these three options we choose we will not be able to meet trauma demands on occasions as currently we occasionally have to convert all three theatres to trauma in times of need.

In these circumstances we will either have to

1. Send excess trauma to Belfast
2. Send some daycase trauma to STH and cancelling another specialties cases in STH that day
3. Using theatre 1-4 on occasions – either with its own staff / diluted T 7/8 staff / bringing staff from STH

Part 2: Elective Practice – OPTIONS

Foot, ankle and hands should be mostly unaffected as on the STH day surgery site

Other body areas (non foot & ankle) have significantly reduced theatre sessions or no sessions at all to operate on their patients

In the first instance these other areas should not be seeing new outpatients and adding to an in-patient workload that we cannot address.

In order to get our elective patients treated options for discussion include:

1. Take some slots from STH and do some daycase type surgery that is normally on site e.g. Mr McClean could perhaps do ACL / uni knee. Mr Gibson, middle grade could do a Mon am on selected shoulder cases. This requires cancellation of those slots for other specialities e.g. in STH on a Monday morning

2. Musgrave Park Hospital – becomes a regional waiting list and becomes part of the MPH workload.

3. Musgrave Park Hospital – Southern Trust T&O Surgeons go to MPH to keep up their skills

4. Independent Sector (IS) - Send out to the IS

5. Independent Sector - Board / trust purchase sessions with IS providers e.g all day Monday theatres each week to enable our consultants do some elective work – this would need to be worked through with each Consultant and the IS provides

Concerns

1. Concern regarding T&O consultant team not doing any elective practice for 4-6 months.
2. This would also have training implications for our juniors and a high risk of having our registrars removed by NIMDTA.

Urology Team Departmental Meeting
Thursday 24th March 2022 at 12:45

Notes of meeting

Urology Team include Melanie McClements and Jane McKimm

Apologies	Kate O'Neill
Covid update	ICU is full with 2 covid positive Wards CAH = 49 pts DHH = 14 pts
Public Inquiry update	Better guidance on what is required and how we can support Support to do, knowledge, criteria, standardised approach Melanie will come back with after clarity from SMT A number of questions Questions from cousel and the burden it has on the team Jane is having a conversation with counsel and DLS – we did not have clarity originally Understand the pressure There is now a number of section 21 coming individually to staff, however, when do can take staff out for a number of weeks to respond to Melanie is taking to SMT concerns and that patient care is our priority Double ask of patient care and public inquiry, require a healthy balance and keep up pragmatic view of what can deliver AJG – stress this is causing in the team and burden being shared by the clinicians All operational teams are in breaking points Need to consider health and well being MTY – coming from an outside position into Trust, backlog of waiting lists, amount of patients not been seen is causing a lot of stress MTY has confirmed that is stressed due to volume without having the additional burden of AOB inquiry

	Additional support - Melanie has asked what additional support is required
NIECR sign off for speciality doctors	Stone team are happy that Laura order radiology requests under Laura's name and the report comes back directly to Laura Laura is exploring with the radiology team ordering her name, obviously if consultants wish they can remain under the consultant name if required Aim is to streamline work as best as possible MY – work well for the team, talk well and gel within the team. Need more secretarial / admin support AJG – taking into account governance structures, there needs to be a policy drafted agreed and signed off. Needs to happen before any of this happens prior to sign off NIECR sign off for PSA – Jenny would do as part of LUTS (PSA and U&E). AJG has no issue with Jenny signing off Need a policy in place first – include in the LUTS policy
Elective/Outpatient activity update	**Performance update** - Matthew gave an over of the Urology performance for March 2022 **3fivetwo contract** **Matthew** had a discussion with NIECR regarding uploading of the outpatient 3fivetwo audit 100 letters Letters backs – Immediate discharges – should not be sent back Matthew to complete a SOP of the IS admin process **Hermitage** 23 TURPs complete in 21/22 12 in April 22 MY has given an April 22 date PCNL's – MTY asked regionally if anyone will help with PCNL,
Referrals	**AJG** received a print out with a blood result with a name on it
Staffing	No applicants Matt to redraft advert for recruitment

	Kate – Personal Information redacted by the USI
Urology CNS Update	Nothing this week
Governance	Wendy to provide a monthly governance report of: Complaints/compliments Datix SAIs
AOB	Laser is a demo and needs to remove in near future. Need a decision on replacement or 100watt laser Upload cost as low as £30k Priority for 22/23 capital funding **Validation letter** – completed 150 that they have been actioned as per spreadsheet. Amended validation letters – need to check they are being used No action column

MELANIE McCLEMENTS DIRECTOR ACUTE SERVICES	Ronan Carroll ASSISTANT DIRECTOR - ACUTE SERVICES SEC & ATICS 1-1 Discussion

DATE: 14 10 2021

No	Issue for discussion	Discussed / Actions agreed
1	Theatres + Workforce plan	Ccanni de-escalation plan in place @ 10 beds and new surge levels agreed. Theatre lists increasing on back of return of some staff to approx. 50% of normal – 12-14 ubl in cah and 5 in dhh. New theatre nurse recruitment 18 band 5's applied and 32 B6 applicants. Could enable 3 theatres @ 90 pts /w. if interview outcomes positive.
2	Elective Surgery plans	Weekly meetings staring next Wednesday following RPOG Orthopaedics included .... Discussions regionally re ortho 2 trusts and dhh surgical hub Ronan to follow up PHA re hub potential in DHH
3	WLI underspend	Ronan following up on SMT query re underspend non recurrent in ATICS - do Consultants do virtual outpatients at higher level in times of reduced surgical commitments and reason for underspend (infographic shared)

4	Gen surgery planning – impact on CAH - Regional gen surgery group and local planning re Gen surgery	Need 6 wards to do surgical services... 4 for emergency admissions, inc 18 urology/ENT and trauma/Orthopaedics + 2 elective Need to reduce medical footprints to enable new models of working Regional meeting – no real decisions, generating data Site visit positive meeting ceo and Alastair Campbell/Ronan positive also Smt paper today re progressing to public consultation on options Interface meetings underway with ED, NIAS, Paeds, O&G, Acute Medicine, anaes, Nursing/AHP etc.
5	Governance gap	Urology inquiry has highlighted the need for additional capacity to attend to robust governance structures Need embedded posts in each division – mel to d/w CEO/SMT
6	urology	Capacity concerns with backlogs and lookback exercise commenting with reduced capacity 40% of P2's sit in urology Has been raised @ both HSCB and DOH but process underway for additional Commissioner support (letter being currently drafted)
7	HDU	Glasgow now able to host visit Ronan to dw team who is best placed to visit and assess working model Recent appointment of Intensivist/anaesthesia and one on waiting list – ronan to dw team and any underspend in funding/unmet need
	DATE OF NEXT MEETING	17th November 2021

RAG Status	R/A/G

Annex A

Health and Social Care

Request for Approval of Single Tender Action (STA)

This form to be completed by the requesting officer, authorised by the appropriate Assistant Director / Co-Director and sent to BSO Procurement and Logistics Service (PaLS) along with a properly completed requisition.

	Ronan Carroll
Job Title	Assistant Director – Acute Services (Anaesthetics & Surgery)
Department	Acute Service Directorate
HSC Organisation	Southern Health and Social Care Trust
Address	68 Lurgan Road, Portadown, Craigavon BT63 5QQ
E-mail address	Personal Information redacted by the USI
Office Telephone Number	
Mobile Telephone Number	Personal Information redacted by the USI

Section 2. STA Details

Title of STA	Outpatient Urology Oncology Reviews
Estimated value of STA	£60,038 (£50,032 Confirmed Funding) £50,032 for the delivery of 236 urology oncology outpatient reviews to be completed by 31 December 2020. The estimated value of the STA also includes the provision to procure up to 20% additional service volumes should additional funding (£60,038) become available.
Proposed length of contract of STA	From the contract award date (ASAP) to 31 December 2020 with the option to extend for further periods up to 31 March 2021.

Section 3. STA justification: Sole Source

Are these goods or services only available from one source? ~~Y~~/N

If Yes complete section 3.1; if No proceed to section 4

This section to be completed where goods or services can be procured from only one source and no competition is available.

3.1 Technical Reasons or Exclusive Rights

Is this STA being justified for technical or artistic reasons or because the supplier has exclusive rights?

If Yes, specify the reasons and explain in detail

Now proceed to section 5.

Section 4. STA justification: Preferred Supplier

This section to be completed where goods or services can be procured from multiple sources, but where for specific reasons only one supplier is to be used.

4.1 Justification for Procuring without Competition

State the reasons for procuring the goods or service without competition (including vfm justification):

This contract falls under the category of commissioned services – Healthcare / Social Care Section 7 Public Contracts Regulations 2015 and in line with Circular Reference: HSC(F) 58-2016 Revision of Procurement Guidance Note (PGN) 03/11 Direct Award Contracts (DACs) (Amended)

Background

- The Trust is considering options to create additional capacity for the delivery of new outpatient urology oncology reviews.
- Options to maximise in-house additional capacity have been exhausted; further no other Trust in Northern Ireland is placed to provide additional capacity.
- The Trust is therefore looking to the independent sector to carry out initially 236 reviews by 31 December 2020 (With the option to extend a contract for further periods up to 31 March 2021 to complete any outstanding activity or provide additional service volumes should additional funding become available)
- Previously services in the independent sector were sought from Providers on the Regional Eligible Providers List for Acute Elective Health Services, however, as this List is currently not available to the Trust, the Trust is seeking to approach a Provider previously on the Regional Eligible Providers List (Orthoderm Private Clinic) to establish capacity and make a Direct Award.
- While a new procurement activity is underway, via the Social Care Procurement Unit, to establish a Dynamic Purchasing System for the future purchase of these services, it has not yet been finalised, or advertised and therefore the timeline for completion is unclear and will not be in place to allow planning for the effective provision of this service by 31 December 2020.
- Mr Patrick Keane who is a retired Urologist has agreed to do this work. His remit is to see each of these patients face to face and either discharge from the Urology Team or agree an appropriate plan for ongoing management that will be shared with the Urology Oncology Multi-disciplinary Team who will take this forward.

Proposed Volume of Service

236 Outpatient Urology Oncology Reviews to be completed by 31 December 2020

236 @ £212 each = £50,032

Total Value = £60,038

The total DAC value = £50,032 x 20% = £60,038 ***(This includes the option to increase volumes of activity by 20% should additional funding become available)***

Now proceed to section 5.
Section 5. Single Tender Action - Contract Extension or Extension of Scope of Contract ***This section to be completed where extension of the scope or duration of an existing contract is being requested. If no contract currently exists, ensure that you have completed either section 3 or section 4 and then proceed to section 6.***

5.1 Details of Contract				
Name of the Contract				
Name of the supplier(s) on the contract				
Start and end dates of the contract including extensions	**Start Date**		**End Date**	
If the contract has been extended beyond the original options to extend, please provide details:				
Was this contract awarded under STA?	**YES**		**NO**	
If No, was there an advertisement placed in the local papers and/or the OJEU and, if so, provide dates	**Local papers**		**OJEU**	
Value of the initial contract at the time of award				
Actual spend to date from the commencement of this contract				

5.2 Proposed Extension of Contract Term				
Name of the supplier(s)				
Start and end dates of the proposed extension	**Start Date**		**End Date**	
Estimated value of the extension				
Reason for new extension of contract term (including vfm justification):				
5.3 Extension of Contract Scope - new requirement				
Justification for the STA to this supplier (including vfm justification):				

SHSCT Only - Single Tender Action Declaration

Calculation of Whole Life Costs ***(this section MUST be completed by the requestor)***		
o ***Please complete the costing table below to ensure that the STA application takes into account the whole life costs – please note that not all of the considerations outlined below will be applicable:***		
STA Consideration	**One Off Cost £**	**Annual Cost £**
Initial cost of purchasing goods or services.		£50,032 for the completion of 236 Outpatient Urology Oncology Reviews (to be completed by 31 December 2020). *(Should additional funding become available the Trust reserves the right to procure up to 20% additional service volumes and extend the contract for further periods up to 31 December 2021)*
Cost of consumables for quantity of goods or services identified.		
Service / Maintenance costs for quantity of goods or services identified.		
Training cost in line with implementation plan.		
Decontamination cost.		
Any other identified cost.		
Sub Total:	**£**	**£**
Overall Total:	Total Contract Value = £60,038 (See notes above) (Contract to commence asap until 31 December 2020 with the option to extend for further periods up to 31 March 2021)	
STA Renewal – Additional Consideration		

Previous STA Number	N/A	
Period of STA	**From:**	**To:**
Approved Value of Previous STA	**£**	
Actual Expenditure of Previous STA	**£**	
o ***Where the previous STA covered equipment Service / Maintenance please provide breakdown of the following costs:***		
Planned Annual Servicing Costs	**£**	
Emergency Call-Out Charges	**£**	
Repair Costs	**£**	
Additional Comments:		

	Print	**Signature**
Name of Requesting Officer:	Ronan Carroll	
Director Acute Service:	Melanie McClements	
Date:		

Section 6: Requesting Officer Approvals		
Requester I hereby seek approval for a single tender action as detailed above. In doing so, I declare that **I do not** have an external personal or monetary interest in the company to which this STA will be awarded.		
Print Name Ronan Carroll	**Signature**	**Date**
Recommended by Director I hereby confirm that the details provided in respect of this single tender action are correct, and I declare that **I do not** have an external personal or monetary interest in the company to which this STA will be awarded.		
Print Name Melanie McClements	**Signature**	**Date**

BSO PaLS ADVICE – For PaLS Use Only	
Risk RAG Status of this Request:	**R/A/G**
Signed:	
Print Name:	
Grade (Senior Procurement Manager and above only):	
Date:	

ACCOUNTING OFFICER DECISION		
I authorise the following action: **a) progress this STA on behalf of the Contracting Authority as detailed above** **b) do NOT progress this STA – take no further action** **c) do NOT progress this STA – procure these goods or services in accordance with normal HSC procurement procedures.** **(*delete as applicable*)**		
I hereby declare that <u>I do not</u> have an external personal or monetary interest in the company to which this STA will be awarded (applicable only in respect of option (a) above). I have read CPD Policy Guidance Note 03/11, related DHSSPS Guidance HSC(F) 05/12 and the comments above provided by HSC Centre of Procurement Expertise.		
Name: **Helen O'Neill**	**Title:**	**Date:**
Signature:		
Departmental Accounting Officer Approval (where required)		
Name:	**Title:**	**Date:**
Signature:		
Publication of award notice (if applicable)		

Southern Health and Social Care Trust

Quality Care - for you, with you

Ref: SHSCT 24/01: 2020/21

14 October 2020

Ms Andrea Pollock
Manager
Orthoderm Private Clinic
2 Ballynahinch Road
Hillsborough
Co Down
BT26 6AR

SENT VIA E-MAIL to: office@orthoderm.co.uk

Dear Ms Pollock

Provision of Outpatient Urology Oncology Reviews

Further to recent discussions in relation to the provision of Outpatient Urology Oncology Reviews to the Southern Health and Social Care Trust, I am pleased to confirm that the Trust wishes to proceed with a contract award. **Please find attached the contract for 236 Outpatient Urology Oncology Reviews which are required to be completed by 31 December 2020.**

The contract period will run from the contract award date until 31 December 2020, with the option to extend for further periods up to 31 March 2021 if required.

The Trust also reserves the right to increase service volumes by 20% should additional funding become available to spend in this way and against this contract. This is **NOT** a guarantee of additional volumes of activity for completion.

Please note that the full number of procedures must be completed within the timescale detailed above and that DNAs and / or cancellations will not count as completed activity.

The attached contract must be signed and returned prior to commencement of the service provision.

The contract documentation includes the following:

- Terms and Conditions of Contract (Including the Service Specification and Integrated Elective Access Protocol)
- Clinical CV Approval Sheet

To expedite the contracting process I have attached the contract in an electronic format and it should be returned by e-mail in the first instance. Therefore, I would be grateful if you would review the contract and confirm that you are willing to accept the terms by printing, signing, scanning and returning **the signatory page only (Page 84) via email** to

admin.communitycontracts[Personal Information redacted by the USI] **before 12:00 noon on Monday 19 October 2020.** This will enable prompt initiation of the contract.

Two signed hard copies should subsequently be forwarded in the post to Claire McAdam at the address on the bottom of this letter (Each with an original signature). An original signed copy of the entire contract will be sent back to you for your records.

In addition, I would like to take this opportunity to draw your attention to the following points.

Please be advised that the award of this contract is conditional upon:

- **Trust Approval of CVs**
  The CVs for the Nominated Consultants for this contract being approved by the Trust.

  I would be grateful if you would list on the attached sheet the consultants that you propose to engage for treatment of SHSCT patients under this contract and forward CVs to admin.communitycontracts[Personal Information redacted by the USI] before the date noted above. I can advise that the CVs will be reviewed by the Trust and you will be advised of the outcome prior to commencement of the contract;

- **Data Protection**
  Acknowledging and agreeing that the Trust will be amending the attached contract terms in respect of matters relating to the GDPR and DPA to include liability and indemnity provisions.

  As you may be aware, the Data Protection Act 1998 which is referred to in the attached contract terms has now been repealed and replaced.

  New data protection legislation is now in force, being the General Data Protection Regulation (Regulation (EU) 2016/679) ("the GDPR") and the Data Protection Act 2018 ("DPA"), which will be applicable to this contract.

  The Trust recognises the large volume and highly sensitive nature of the personal data and special categories of personal data which will be processed under the contract and the importance that all parties processing personal data under the contract comply with their obligations and responsibilities under data protection legislation.

  At this stage, the Trust anticipates that the Trust and IS Provider will each act as controllers in their own right in respect of the majority of data processing activities under the contract and in respect of some other data processing activities under the contract the relationship may be that of controller to processor, however this assessment has not yet been finalised and may be subject to change.

  The Trust will be amending the attached contract terms in respect of matters relating to the GDPR and DPA to include liability and indemnity provisions.

  By signing this Contract, you are acknowledging this and agreeing that in respect of any contract that is entered into, the attached contract terms will be amended in respect of these matters; and

- **Location of Service Delivery**
  A valid leasing agreement must be in place if using premises not registered to 3FiveTwo Healthcare Ltd and a copy of this agreement must be provided to the Trust.

I would therefore be grateful if you would confirm the location(s) for service delivery and provide the agreement noted above.

I will be the operational contact for the contract and can be contacted at Personal Information redacted by the USI or Personal Information redacted by the USI The ability to provide safe and effective treatment for these patients is critical to the Trust's achievement of its elective performance standards and therefore can I emphasise the importance of robust communication processes with prompt escalations of any issues to me in order that this contract can be initiated swiftly and without delay for our patients.

I will be in touch shortly to discuss referrals, administrative responsibilities and other operational issues.

If you have any queries in the meantime please do not hesitate to contact me directly.

Many thanks for your interest in providing this service and we look forward to working with you.

Yours sincerely

_____

MARTINA CORRIGAN
HEAD OF ENT, UROLOGY, OPHTHALMOLOGY & OUTPATIENTS

Enc:

- Terms and Conditions of Contract (Including the Service Specification and Integrated Elective Access Protocol)
- Clinical CV Approval Sheet

ANNEX B

Ref: SHSCT 24/01 - 2020/21

SUMMARY SHEET - APPROVAL OF CVs

SHSCT use only REVIEWED BY: DATE:

PROVIDER:

Note: Full CVs must be attached to completed Tender Submission

Number	Consultant's Name	GMC registration or IMC equivalent (please state number)	No of years experience as Consultant	Is Consultant on Specialist Register Yes/No	State which part of Specialist register Consultant is on and date registered	Name of Indenmity Company	Indication of volumes and specific procdures performed in the last year (relevant to contract)	Referral to the independent safe guarding authority (ISA or DHSSPS or equivalent) as a result of misconduct involving children or vunerable adults Yes/No	Currently the subject of a referral to, or an investigation by, regulatory body e.g. GMC or equivalent? Yes/No	Ever convicted, charged, prosecuted, cautioned or bound over for any offence, no matter how minor? Yes / No	Currently the subject of police investigation or any prosecutions pending? Yes / No	Any pending investigations/ disciplinary Yes/No	State nature of investigation/ disciplinary if applicable	Annual Appraisal (date)	SCHCT use only Approval
	Dr Ronan McNally	Personal Information redacted by the USI													
	Dr Noel Napier														
	Dr John McNamee														
	Dr Keith Lowry														
	Dr Barry James														
	Dr David Taylor														
	Dr Imran Yousuf														
	Dr Alastair Campbell														
	Dr Mark Worthington														
	Dr Patrick Wilson														
	Dr Satyen Shukla														
	Dr Peter Ball														
	Dr Melvyn Ang														
	Dr Myles Nelson														
	Dr Louise Bamford														
	Dr John Canning														
	Dr Eugene McKenna														
	Dr Chris Hutchinson														
	Dr Raghuram Sathyanara														
	Dr Graham Smyth														
	Debarata Bhattacharya														
	Radiographer														
	Kelly Thompson														
	Miriam Butler														
	Meabh Connolly														
	Kevin McCullagh														
	Craig Clarke														
	Anthony McKenna														
	Ivar van Zijl														
	Leighton Robinson														
	Ross Mannus														

Southern Health and Social Care Trust

Independent Sector Terms and Conditions of Contract

CONTRACT FOR THE PROVISION OF: OUTPATIENT UROLOGY ONCOLOGY REVIEWS

CONTRACT ID CODE: SHSCT 24/01: 2020/21

***FOR THE PERIOD:* Contract award date until 30 December 2020, with the option to extend for further periods up to 31 March 2021**

PARTIES TO THE AGREEMENT AND AUTHORISED SIGNATORIES

Ms Andrea Pollock
Manager
Orthoderm Private Clinic
2 Ballynahinch Road
Hillsborough
Co Down
BT26 6AR

AND

Mr Shane Devlin
Chief Executive
Southern Health and Social Care Trust
Trust Headquarters
68 Lurgan Road
Portadown
BT63 5QQ

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CONTRACT SCHEDULES

CONTRACT APPENDICES

1 Definitions

1.1 In these General Terms and Conditions and in the Service Specification unless the context otherwise requires, the following terms have the following meanings:

"Activity"	any clinical activity in respect of a HSC Patient under the Services pursuant to this Contract;
"Adverse Incident"	any event or circumstance in the delivery of the Services that could have or did lead to harm, loss or damage to people, property, environment or reputation;
"**AHP"**	an allied healthcare professional being a healthcare professional who provides treatment and helps rehabilitate adults and children who are ill, have disabilities or special needs, to live life as fully as possible including but not limited to physiotherapists, occupational therapists, speech and language therapists and dieticians.
"**Authorised Officer**"	the Officer appointed by Orthoderm Private Clinic pursuant to the provisions of clause 9 who is responsible for the daily management of the Services pursuant to the provisions of the Contract;
"Award Letter"	the letter of award issued by the Trust to Orthoderm Private Clinic informing Orthoderm Private Clinic that its tender submission has been accepted by the Trust and the Contract entered into;
"**Commencement Date**"	The date of commencement of the Contract which will be the date of the Award Letter
"**Confidential Information**"	means any information or data in whatever form disclosed (whether in

	writing, verbally or by any other means and whether directly or indirectly) by one party ("the Disclosing Party") to the other ("the Receiving Party") or by a third party on behalf of either of the parties (whether before or after the date of the Contract) including without limitation any information relating to the Disclosing Party's business affairs, operations, products, finances, plans, market opportunities, designs, processes, research, development, know how, personnel, distributors, suppliers and other trade secrets (including all confidential information of any third party) as well as the results of any discussions between the parties and the results of any evaluations or studies relating to any of the foregoing, and which is by its nature confidential, or which the Disclosing Party states in writing to the Receiving Party is to be regarded as confidential, or which is marked "Confidential";
“Consent Policy”	means the policy operated by Orthoderm Private Clinic in accordance with the provisions of clause 10.1;
“Contract”	the agreement entered into between the successful Orthoderm Private Clinic and the Trust made up of Service Specification, the General Terms and Conditions, and all schedules, appendices and other documents incorporated therein and the Award Letter
"**Contract Manager**"	the Officer appointed by the Trust pursuant to the provisions of clause 9.2
"**Contract Monitoring and Management Information Protocol**"	the contract monitoring and management information protocol as set out in Appendix 2 - the Service Specification

	and Schedule 9 and 10 of the Contract
““DHSSPSNI”	the Department for Health, Social Services and Public Safety of Northern Ireland;
"DPA"	the Data Protection Act 1998;
“Emergency Treatment”	healthcare or treatment for which a HSC Patient has an urgent clinical need (assessed in accordance with Good Practice and which is in the best interests of the HSC Patient);
“External Audit”	An audit undertaken by an independent third party who has been facilitated in the audit process by Orthoderm Private Clinic;
"Fees"	the fees payable for the full and proper performance of the Services under the Contract as set out in Schedule 1 and which for the avoidance of doubt shall not exceed the Northern Ireland Tariff for Independent Sector Treatment as set by HSCB;
"FOIA"	the Freedom of Information Act 2000;
“General Terms and Conditions”	these Independent Sector Providers General Contract Terms and Conditions;
“Goods”	anything including equipment and consumables but with the exception of the Provider’s Premises that Orthoderm Private Clinic may use in the delivery of the Services
“Good Practice”	using standards, practice, methods and procedures conforming to the Law and reflecting up to date published evidence and using that degree of skill and care, diligence, prudence and foresight which

	would reasonably and ordinarily be expected from a skilled, efficient and experience provider of services the same as or similar to the Services at the time the Services are provided;
"**GP**"	medical practitioners providing general medical services and whose name is included on the General Practitioner Register under the General & Specialist Medical Practice (education, Training and Qualifications) Order 2003;
"**Guidance"**	any applicable health or social care guidance, guidelines, direction or determination, framework, standard or requirement including DHSSPSNI circulars to which HSCB, the Trust and/or Orthoderm Private Clinic have a duty to have regard (whether specifically mentioned in the Contract or not) to the extent that the same are published and publicly available or the existence or contents of them have been notified to Orthoderm Private Clinic by the HSCB, the Trust and or any relevant Regulatory Body;
"**HSC"**	Health & Social Care;
"**HSC Patient Health Record**"	any Patient Health Record (other than Orthoderm Private Clinic Patient Health Record) made in respect of any HSC Patient and supplied to Orthoderm Private Clinic by or on behalf of the Southern Health and Social Care Trust in connection with the provision of the Services;
"**HSC Patient**"	an HSC patient who is referred by the Trust in accordance with the provisions of the Contract for treatment or care as part

	of the provision of the Services delivered by Orthoderm Private Clinic ;
“HSCB”	The Health and Social Care Board of Northern Ireland;
“IEAP”	Integrated Elective Access Protocol contained at Schedule 6 of these General Terms and Conditions;
"Independent Hospital"	has the meaning set out in The Independent Healthcare Regulations (Northern Ireland) 2005;
“**Indicative Activity Plan**”	the plan identifying the anticipated indicative volume of Activity for the Contract Period as provided for in the Service Specification;
“Indirect Losses”	loss of profits (other than profits directly and solely attributable to provision of the Services), loss of use, loss of production, increased operating costs, loss of business, loss of business opportunity, loss of reputation or goodwill or any other consequential or indirect loss of any nature, whether arising in tort or on any other basis;
"Individual Care Package"	the treatment plan and appropriate care to be provided by Orthoderm Private Clinic as part of the provision of the Services in respect of an HSC Patient;
“IS Provider”	the entity, whether a limited company, a partnership, a sole trader or consortium lead contractor, or all members of a consortium or otherwise, who by the Contract undertakes to supply the Service to the Trust;
“**Law**”	(i) Any applicable statute or proclamation or any delegated or

subordinate legislation or regulation;

(ii) Any enforceable EU right within the meaning of section 2(1) European Communities Act 1972;

(iii) Any applicable judgment of a relevant court of law which is a binding precedent in Northern Ireland;

(iv) Guidance;

(v) Statement of National Minimum Standards; and

(vi) Any applicable code

in each case in force in Northern Ireland.

"Losses" any loss, damages, costs, expenses, liabilities, claims, actions and/or proceedings (including the cost of legal and/or professional services) whether arising under statute, contract or at common law, but excluding Indirect Losses;

"Medical Advisory Committee" the medical advisory committee of Orthoderm Private Clinic which recommends the granting of Practising Privileges to clinicians, including Nominated Consultants, employed by or engaged by Orthoderm Private Clinic in respect of the provision of the Services under the Contract;

"Nominated Consultant" a person named in the Service Specification as a Nominated Consultant (or if no such person is named, a person

	selected in accordance with the Service Specification), on the General Medical Council's Specialist Register in an appropriate specialty and who is employed or engaged by Orthoderm Private Clinic in respect of the provision of the Services under the Contract;
"Ombudsman"	The Northern Ireland Commissioner for Complaints www.ni-ombudsman.org.uk
"Patient Data Protection Notice"	a data protection notice in the prescribed form or as otherwise agreed between the parties, in writing from time to time;
"Patient Health Record"	any record which consists of information relating to the physical or mental health or condition of any HSC Patient which has been made by or on behalf of a health professional at any time in connection with the care of that HSC Patient;
"**Performance Targets**"	the performance targets which Orthoderm Private Clinic is required to achieve as specified in Appendix 2 - the Service Specification;
"Practising Privileges"	such privileges as are granted by Orthoderm Private Clinic to a Nominated Consultant having taken advice from its Medical Advisory Committee and without which a person would be unable to carry out activities as a medical practitioner employed by or engaged by Orthoderm Private Clinic in the provision of Services under the Contract;
"Process	means in relation to personal data as defined in the DPA, obtaining recording

Processed Processing"	or holding the personal data or carrying out any operation or set of operations on the personal data, including organisation, adaptation or alteration of the personal data, retrieval, consultation or use of the personal data, disclosure or sharing of the personal data by transmission, dissemination or otherwise making available, or alignment, combination, blocking, erasure or destruction of the personal data;
"**Provider Patient Health Record**"	a Patient Health Record which is not an HSC Patient Health Record and is prepared by Orthoderm Private Clinic in connection with the care of an HSC Patient as part of the provision of the Services;
"**Provider's Premises**"	any premises not owned by or in the control of the Trust and used by Orthoderm Private Clinic for any purposes connected with the provision of the Services as set out in the Service Specification;
"**Quality Standards**"	the quality standards as detailed in Clause 15;
"**Request For Information**"	a request made under Section 1 of the FOIA;
"**Regulatory Body**"	Any statutory or other bodies responsible for assessment and regulation of health and social care service provider organisations and having authority to issue guidance, standards or recommendations with which Orthoderm Private Clinic must comply or to which it must or should have regard, for example (without limitation): RQIA - Regulation & Improvement Authority

	CCQ - Care Quality Commission (formerly the 'Healthcare Commission') SCRC - Scottish Commission for the Regulation of Care HIW - Healthcare Inspectorate of Wales
"Replacement Provider"	any third Party appointed by the Trust to provide the Service following the expiry, termination or partial termination of the Contract;
"Retained Employee"	any employee of the Provider not listed in the Schedule of Transferring Employees to be agreed between the Parties and who is to be retained by the Provider after the Transfer Date
"Serious Adverse Incident"	an Adverse Incident falling within the criteria for "serious adverse incident" as set out in HSCB's Procedure for the Reporting & Follow up of SAIs: October 2013 and which criteria are contained at Schedule 2 of these General Terms and Conditions;
"**Service Specification**"	the service specification issued by the Trust as part of its tender documentation;
"**Services**"	the specified acute hospital services set out in the Service Specification and to be provided by Orthoderm Private Clinic pursuant to and in accordance with the Contract;
"**Services Environment**"	the rooms, theatres, wards, treatment bays, clinics or other physical location, space, area or accommodation in which the Services are provided;
"SPC"	the Service Provision Change (Protection of Employment) Regulations (Northern Ireland) 2006;

"Staff"	the clinical and non-clinical staff members employed or engaged by Orthoderm Private Clinic and provided as part of or involved in the provision of the Services;
"Statement of National Minimum Standards"	the DHSSPS Minimum Care Standards for Independent Healthcare Establishments July 2014 as may be amended from time to time;
"Subject Access Requests"	requests made by HSC Patients under Section 7 of the DPA;
"Sub-contractor"	any party other than an employee of the Orthoderm Private Clinic whom the Orthoderm Private Clinic has engaged to provide Services under the Contract
"Transferring Employee"	those persons listed in a schedule to be agreed by the Parties prior to the end of the Contract Period who it is agreed were employed by the Provider (and/or any subcontractor) wholly and/or mainly in the undertaking of the Service before the end of the Contract Period;
"Transfer Date"	the date on which the Service transfers from the Provider to the Replacement Provider;
"Trust"	the HSC Trust which enters into the Contract with Orthoderm Private Clinic for the provision of the Services;
"TUPE"	the Transfer of Undertakings (Protection of Employment) Regulations 2006 as amended;

"Working Day"	a day other than a Saturday, Sunday or public holiday in Northern Ireland when banks in Belfast are open for business.

1.2 A reference to the singular shall include the plural and vice versa and a reference to a gender shall include any gender.

1.3 The headings in this Contract shall not affect its interpretation.

1.4 References to any statute or statutory provision include a reference to that statute or statutory provision as from time to time amended, extended or re-enacted.

1.5 References to a statutory provision shall include any subordinate legislation made from time to time under that provision.

1.6 In the event and to the extent only of any inconsistency between two or more documents which form part of the Contract those documents shall be interpreted in the following order of priority:- the Service Specification, these General Terms and Conditions, the remaining Schedules and any documents incorporated by reference.

2. Period of Contract and commencement

2.1 The Contract takes effect from the Commencement Date and shall expire on the conclusion of the provision of the Service to all HSC Patients referred to Orthoderm Private Clinic by the Trust during the period detailed in the Service Specification subject to earlier termination in accordance with clause 37 ("the Contract Period").

2.2 Prior to the Commencement Date, the parties will use the suggested checklist contained at Schedule 8 of this Contract to agree each party's operational roles and responsibilities for the duration of the Contract Period.

3. Services

3.1 In accordance with the Contract, Orthoderm Private Clinic will provide the Services to HSC Patients identified by agreement with the Southern Health and Social Care Trust.

3.2 Services must only relate to a HSC Patient's original referral or presentation. Where assessment by Orthoderm Private Clinic identifies further treatment needs beyond the scope of the original referral, Orthoderm Private Clinic must obtain the prior agreement of the Southern Health and Social Care Trust before engaging in further treatment.

3.3 Orthoderm Private Clinic shall ensure that the Services are provided in accordance with:

3.3.1 the Specification

3.3.2 the Performance Targets;

3.3.3 the agreed level of activity detailed in the Indicative Activity Plan;

3.3.4 the terms and conditions of the Contract;

3.3.4 the Law, Guidance and Good Practice.

4 Information for HSC Patients

4.1 Orthoderm Private Clinic shall on request by the Southern Health and Social Care Trust or by HSC Patient give to HSC Patients a copy of Orthoderm Private Clinic 's current patient guide.

4.2 Orthoderm Private Clinic shall promptly notify the Contract Manager of any material changes to such guides, policies, procedures and protocols as have been made available to Southern Health and Social Care Trust.

4.3 The parties shall comply with the requirements of the Service Specification, or as otherwise agreed, in relation to the provision of information, including Patient Data Protection Notices to HSC Patients regarding the Services.

5 HSC Patients

5.1 Subject to the terms of the Contract Orthoderm Private Clinic shall ensure that the Services that it provides to HSC Patients are of at least an equal standard to those it provides to its other patients. Orthoderm Private Clinic shall not discriminate and shall secure that its Staff, agents (including Sub-Contractors) do not discriminate against HSC Patients in any way or do anything or abstain from doing anything which draws the attention of its other patients and their visitors, to HSC Patients' status as patients being treated by Orthoderm Private Clinic on behalf of the Southern Health and Social Care Trust. For the avoidance of doubt, nothing in this clause 5 shall require Orthoderm Private Clinic to provide as part of the Services any additional non-clinical services or services of a standard for which its other patients would normally be charged premiums, unless otherwise agreed between the parties. Orthoderm Private Clinic shall ensure that non-clinical services of a standard for which its other patients would normally be charged premiums are equally available for purchase by HSC Patients as by its other patients.

5.2 Nothing in the Contract shall require Orthoderm Private Clinic to provide or continue to provide the Services to HSC Patients:

5.2.1 who, in the reasonable professional opinion of the Nominated Consultant, are not suited to receive the treatment identified in the Individual Care Package under the Services on clinical grounds;

5.2.2 who, in the reasonable professional opinion of the Nominated Consultant, are temporarily not suited to receive the treatment identified in the Individual Care Package under the Services on clinical grounds for as long as such unsuitability remains;

5.2.3 who have not validly consented, in accordance with the Consent Policy, to the treatment identified in the Individual Care Package provided under the Services;

5.2.4 whose behaviour, having taken their mental well-being into account, is unreasonable and unacceptable to Orthoderm Private Clinic, or its staff who are clinically

responsible for the management of the care of such HSC Patient; or

5.2.5 in such other circumstances where Orthoderm Private Clinic has reasonable and justifiable grounds on which to refuse treatment such grounds having been notified to the Southern Health and Social Care Trust pursuant to the provisions of clause 5.4;

provided always that nothing in this clause shall be deemed to enable or permit Orthoderm Private Clinic to exclude HSC Patients from treatment under the Services on grounds of the cost to Orthoderm Private Clinic of providing such treatment.

5.3 For the avoidance of doubt, Orthoderm Private Clinic shall in all cases when refusing to provide the Services to an HSC Patient pursuant to the provisions of clause 5.2.4 take into account only the behaviour of that HSC Patient and disregard the behaviour of any visitor of that HSC Patient or the behaviour of any other person, and the behaviour of such visitor or other person shall not be grounds to refuse treatment pursuant to the provisions of clause 5.2.5.

5.4 Where pursuant to the provisions of clause 5.2.4 or 5.2.5 Orthoderm Private Clinic proposes to refuse to provide or continue to provide the Services to any HSC Patient:

5.4.1 Orthoderm Private Clinic shall where practicable discuss the continuing conduct of the relevant HSC Patient's case with the Southern Health and Social Care Trust and the Nominated Consultant clinically responsible for the HSC Patient.

5.4.2 Where such discussion is not practicable Orthoderm Private Clinic shall in any event immediately notify the Southern Health and Social Care Trust of the steps it has taken or proposes to take.

5.4.3 Orthoderm Private Clinic shall explain to the HSC Patient, or where appropriate his/her parent or legal guardian:

(a) the action that it is taking, when that action takes effect and the reasons for such action, following

up any verbal explanations in writing within 24 (twenty four) hours of such explanation being given;

(b) that such written explanation shall be copied to the Southern Health and Social Care Trust;

(c) that Orthoderm Private Clinic shall discuss the HSC Patient's case with the Southern Health and Social Care Trust as soon as practicable; and

(d) that the HSC Patient has the right to complain about Orthoderm Private Clinic 's decision through any relevant complaints procedure.

5.4.4 Orthoderm Private Clinic and the Southern Health and Social Care Trust shall use all reasonable endeavours, including discussions with the HSC Patient and/or where appropriate the HSC Patient's GP or parent or legal guardian, to resolve the issue of the treatment or continued treatment of the HSC Patient in a way which minimises any disruption to the HSC Patient's care. Where the parties cannot agree about Orthoderm Private Clinic 's treatment or continued treatment of the HSC Patient, Orthoderm Private Clinic shall (subject to any discharge requirements) notify the Southern Health and Social Care Trust that it will discontinue treatment of that HSC Patient under the Services and the Southern Health and Social Care Trust shall make such alternative treatment arrangements for that HSC Patient as it deems necessary.

5.5 Nothing in clause 5.1 shall be deemed to enable or permit Orthoderm Private Clinic to refuse or withhold any emergency treatment required by any HSC Patient and Orthoderm Private Clinic shall secure that its Staff take appropriate clinical advice in determining whether such emergency treatment is urgently required.

5.6 The Southern Health and Social Care Trust reserves the right at any time to withdraw any HSC Patient from the Services provided that in the case of an HSC Patient who has been admitted, it is clinically appropriate to withdraw the HSC Patient and Orthoderm Private Clinic shall upon receipt of such notice from the Southern Health and Social Care Trust

cease to treat the HSC Patient. Unless otherwise agreed between the parties, the Southern Health and Social Care Trust shall notify the HSC Patient of the change in their treatment or care arrangements.

5.7 Where the Southern Health and Social Care Trust withdraws treatment of an HSC Patient after referral, the Southern Health and Social Care Trust shall pay a Fee for the Services actually delivered to that HSC Patient in accordance with the Schedule of Fees.

5.8 Nothing in this Clause 5 shall prevent Orthoderm Private Clinic and the Southern Health and Social Care Trust from agreeing at any time that an HSC Patient should be withdrawn from treatment under the Services.

6 Service environment and goods

6.1 Where the Orthoderm Private Clinic will provide the Service from Provider's Premises, prior to the Commencement Date the Trust shall satisfy itself in so far as it is reasonably practicable to do so that the Provider's Premises and the Services Environment is:

6.1.1 suitable and fit for the purpose of the performance of the Services;

6.1.2 clean, sterile (where appropriate), safe, conforms to the highest standards of health and safety, functional and fully accessible for all potential users of the Provider's Premises;

6.1.3 is sufficient to enable the Services to be provided at all times and in all respects in accordance with the Contract; and

6.1.4 where applicable registered with the relevant Regulatory Bodies operating in Northern Ireland.

6.1A For the duration of the Contract, Orthoderm Private Clinic shall at all times ensure that the Provider's Premises and the Service Environment complies with the terms set out in clauses 6.1.1 – 6.1.4

6.2 Subject to clause 6.9, all Goods to be used in providing the Services shall be supplied by Orthoderm Private Clinic and shall be included in the Fees unless otherwise agreed by the parties.

6.3 Subject to clause 6.9, Orthoderm Private Clinic will ensure that all Goods used are:-

6.3.1 suitable for the provision of the Services and comply with all relevant Law, Guidance and Good Practice relating to Health & Safety;

6.3.2 regularly maintained and stored in accordance with the manufacturer's instructions;

6.3.3 cleaned as specified by and in accordance with current Law and Guidance including but not limited to the Statement of National Minimum Standards.

6.4 Orthoderm Private Clinic shall ensure that all operating theatre in the Provider's Premises are equipped and maintained in accordance with applicable Law and Guidance including the use of appropriate theatre ventilation including any specific requirements as set out in the Service Specification. Theatres should comply with:-

6.4.1 "DOH *Heating and ventilation systems – Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises*"

6.4.2 DOH - Health Building note 26 *Facilities for Surgical Procedures*

and/or other supporting documents or their equivalents as applicable to Northern Ireland.

6.5 Orthoderm Private Clinic shall carry out a regular External Audit of compliance with all appropriate standards and regulations relating to the Service Environment and Goods as required under Law, Guidance or by a Regulatory Body and shall make available copies of any such audits to the Trust on request.

6.5 Orthoderm Private Clinic will at all times have full regard to extant
HSCB medicines management guidance available at: http://www.hscboard.hscni.net/medicinesmanagement/Prescribing%20Guidance/index.html#P-1_0 and the NI Formulary at: http://www.hscboard.hscni.net/medicinesmanagement/001%20Northern_Ireland_Formulary.html#TopOfPage or as may be amended from time to time.

6.7 Any Goods provided by Orthoderm Private Clinic must be of a high clinical standard and free from contamination, infection, disease or any other defect or disorder whatsoever and Orthoderm Private Clinic shall implement and maintain such adequate screening procedures as are agreed with the Southern Health and Social Care Trust from time to time to monitor and test such Goods for contamination, infection, disease or any other defect or disorder.

6.8 Orthoderm Private Clinic shall immediately report and confirm in writing to the HSCB and the Southern Health and Social Care Trust any actual or suspected case of contamination, infection, disease or other defect or disorder of (without limitation) the Services Environment, Orthoderm Private Clinic 's Premises, or any Goods which have been or were intended to be supplied by Orthoderm Private Clinic as part of the Services which affects or may affect the provision of the Services.

6.9 Where it is agreed between the parties that Orthoderm Private Clinic may provide all or any of the Services from premises owned by or in the control of the Trust ("Trust Premises"), the Trust shall be responsible for ensuring that the Trust Premises, the Services Environment and all Goods are in compliance with the requirements of clauses 6.1 – 6.8.For the avoidance of doubt, Orthoderm Private Clinic shall not be permitted to use any Trust Premises unless a licence agreement has been entered into in respect of the occupation and use of the Trust Premises.

6.9 All Goods provided by the Southern Health and Social Care Trust (if any) in connection with the Contract as set out in the

Service Specification, or otherwise agreed between the parties, shall:

6.9.1 remain the property of the Southern Health and Social Care Trust and shall be used in the performance of the Contract and for no other purpose whatsoever without the prior written approval of Southern Health and Social Care Trust;

6.9.2 be deemed to be in good condition when received by or on behalf of Orthoderm Private Clinic unless the contrary is notified to the Southern Health and Social Care Trust within 14 (fourteen) days; and

6.9.3 where appropriate be returned by Orthoderm Private Clinic on demand and Orthoderm Private Clinic shall be liable for all loss thereof and damage thereto howsoever caused prior to their re-delivery to the Southern Health and Social Care Trust except where such loss or damage is caused by any act or omission undertaken in strict accordance with the instructions of the Southern Health and Social Care Trust or by any act, omission or negligence on the part of the Southern Health and Social Care Trust its employees or agents.

6.10 On 1st February 2013 the NI Health and Social Care Board joined the UK **National Joint Registry** to help improve clinical standards and patient safety. Where the Service Specification relates to "**Orthopaedics**", the HSCB requires that all NI patients referred to NHS and Independent sector providers for treatment and who receive orthopaedic joints must have the NJR minimum dataset details registered on the NJR database. Providers of orthopaedic services will ensure that they comply with the arrangements described in the "Healthcare Providers" section of the National Joint Registry website: www.njrcentre.org.uk

7 Payment

7.1 The Fees for the Services shall be as shown in Schedule 1 and shall be payable monthly in arrears.

7.2 The Southern Health and Social Care Trust shall pay the Fees in accordance with the provisions of Schedule 1 and may pay such Fees by BACS (Bank Account Clearing System) if the Southern Health and Social Care Trust so chooses.

7.3 Orthoderm Private Clinic shall render a consolidated invoice in the agreed form to the Southern Health and Social Care Trust at monthly intervals within 2 (two) days of the month end for the Fees incurred for all Services provided within that month.

7.4 Orthoderm Private Clinic shall render all such invoices on Orthoderm Private Clinic's own invoice form which shall clearly show:-

7.4.1 the Southern Health and Social Care Trust order number;

7.4.2 the period over which the Services were provided;

7.4.3 the amount and type of the Services and the agreed identifying details of the HSC Patients who were subject to the Services for which payment is claimed;

7.4.4 the agreed charging rates; and

7.4.5 any other details the Southern Health and Social Care Trust may reasonably determine.

7.5 Payment of all invoices properly submitted pursuant to this clause will be made within 30 (thirty) days of the receipt of a valid invoice, (namely an invoice issued in compliance with clauses 7.3, 7.4 and 7.5A) and time for payment shall not start to run until a valid invoice has been received by the Trust.

7.5A Before payment is made pursuant to clause 7.5, the Trust shall check the invoice received against the information provided to the Trust pursuant to the Contract Monitoring and Management Information Protocol in order to verify that the Services detailed in the invoice have been provided.

7.5B The Trust reserves the right to refuse to pay the Provider for the Service or any part thereof which is in dispute or where the information required under clause 7.4 has not been

provided or is not capable of verification in accordance with clause 7.5A.

7.5C Where the invoice submitted by the Provider is not as prescribed in clause 7.4 or contains an error such that the invoice or part of the invoice cannot be processed by the Trust or is not capable of verification in accordance with clause 7.5A, the Trust will reject the invoice or part of the invoice and return it to the Provider for correction. In such a case, the time for payment of the rejected invoice or part thereof will not start to run until a corrected and valid invoice is received by the Trust.

7.6 The Fees are exclusive of any applicable VAT for which the Southern Health and Social Care Trust shall be additionally liable to pay Orthoderm Private Clinic upon receipt of a valid tax invoice at the prevailing rate in force from time to time.

7.7 Whenever under the Contract any sum of money shall be recoverable from or payable by Orthoderm Private Clinic the same may be deducted from any sum then due or which at any time thereafter may become due to Orthoderm Private Clinic under the Contract or under any other agreement with the Southern Health and Social Care Trust

7.8 The Southern Health and Social Care Trust shall not reimburse Orthoderm Private Clinic for any costs, disbursements or expenses of a personal nature incurred by HSC Patients whilst in receipt of the Services including without limitation telephone calls and any purchases made from any retail outlets situated within Orthoderm Private Clinic ’s Premises. Such costs, disbursements and expenses are incurred personally by HSC Patients and Orthoderm Private Clinic shall make its own arrangements for the collection of such costs, disbursements and expenses if not provided free of charge by Orthoderm Private Clinic to HSC Patients.

8 Other services

8.1 If Orthoderm Private Clinic identifies any non-urgent clinical or medical need of an HSC Patient which is not otherwise covered by the Individual Care Package which such HSC

Patient is receiving or is to receive as part of the Services Orthoderm Private Clinic may propose to the Southern Health and Social Care Trust that treatment for such clinical or medical need be provided to the HSC Patient by Orthoderm Private Clinic as part of the provision of the Services. Once the parties have agreed reasonable charges for that treatment the Southern Health and Social Care Trust may in its absolute discretion agree to such treatment being provided and Orthoderm Private Clinic shall provide such treatment in accordance with the Contract.

8.2 Orthoderm Private Clinic shall not at any appointment or during the admission of HSC Patients under the Services provide, any clinical or medical services to HSC Patients for which charges are payable by or on behalf of the HSC Patient otherwise than as agreed with the Southern Health and Social Care Trust.

9 Authorised Officer and Contract Manager

9.1 For the duration of the Contract Orthoderm Private Clinic shall appoint an Authorised Officer (and shall promptly notify any change in the identity of such Authorised Officer to the Southern Health and Social Care Trust in writing) who shall be the key point of contact at Orthoderm Private Clinic for the HSCB and Southern Health and Social Care Trust and to whom the HSCB or Southern Health and Social Care Trust may refer all queries and day to day communications regarding the operation of this Contract in the first instance.

9.2 For the duration of the Contract the Southern Health and Social Care Trust shall appoint the Contract Manager (and shall promptly notify any change in the identity of such Contract Manager to Orthoderm Private Clinic in writing) who shall be the key point of contact at the Southern Health and Social Care Trust for Orthoderm Private Clinic to whom Orthoderm Private Clinic may refer all queries and day to day communications regarding the operation of the Contract in the first instance.

10 Consent

10.1 Orthoderm Private Clinic shall:

10.1.1 operate a policy (the "Consent Policy") for obtaining the consent of HSC Patients which shall comply in all respects with the requirements of the Statement of National Minimum Standards, together with any Northern Ireland guidance notified to Orthoderm Private Clinic by the Southern Health and Social Care Trust and having regard to: Reference Guide to Consent for Examination, Treatment or Care (DHSSPS, 2003); HSS (MD) 7/2003 Circular: Good Practice in Consent; and Good Practice in Consent: Consent for Examination, Treatment or Care: A Handbook for the HSC (DHSSPS, 2003);or any amendment or re-issue of them from time to time in issue or any relevant code of practice or guidance notified to Orthoderm Private Clinic by Southern Health and Social Care Trust.

10.1.2 ensure that the consent of HSC patients is obtained wherever necessary in accordance with the Consent Policy.

10.3 Orthoderm Private Clinic shall implement model consent forms.

10.4

Orthoderm Private Clinic shall prepare and implement written statements of policies to be applied and procedures to be followed which ensure that:

10.4.1 the competence of each HSC Patient to consent to treatment is assessed;

10.4.2 in the case of a competent HSC Patient, informed consent (in accordance with the Consent Policy) to treatment is obtained;

10.4.3 in the case of a HSC Patient who is not competent, he is, so far as is practicable, consulted before any treatment proposed for him is administered;

10.4.4 information about a HSC Patient's health and treatment is disclosed only to those persons who need to be aware of that information in order to treat the HSC Patient effectively or minimise any risk of the HSC Patient harming himself or others, or for the purposes of the proper administration of Orthoderm Private Clinic ; and

10.4.5 where research is being carried out by Orthoderm Private Clinic or on Orthoderm Private Clinic's Premises, it is carried out with the consent of any HSC Patient or HSC Patients involved, is appropriate and is conducted in accordance with Good Practice.

10.5 Orthoderm Private Clinic shall provide all HSC Patients with all information relevant to their decision to give consent including inter alia:

10.5.1 details of the treatment itself;

10.5.2 significant risks associated with the treatment;

10.5.3 details of recovery period including likely duration;

10.5.4 alternative treatments and respective benefits; and

10.5.5 complication rates of Nominated Consultant.

10.6 Orthoderm Private Clinic shall ensure that informed consent is also obtained to a material change to the HSC Patient's Individual Care Package.

10.7 Except where appropriate on the instructions of a coroner or as otherwise agreed between the parties Orthoderm Private Clinic shall not:

10.7.1 collect, keep, retain, sell, donate or preserve any part or parts of the human body or by-products thereof which have been removed from HSC Patients and Orthoderm Private Clinic shall not permit any third party to collect, keep, retain, sell or donate any such part or parts; or

10.7.2 carry out a post-mortem on the body of a HSC Patient, without first obtaining the written consent of the relevant Patient (or, where appropriate, HSC Patient's representative) in accordance with the Consent Policy and DHSSPS guidance on Post-Mortems (2004) and from time to time in issue.

This clause 10 shall survive the termination or expiry of the Contract.

11 Nominated Consultants

11.1 Orthoderm Private Clinic shall ensure that there is a Nominated Consultant clinically responsible for each HSC Patient referred under the terms of the Contract.

11.2 Orthoderm Private Clinic shall ensure that clinical responsibility for an HPSSHSC Patient shall remain with their assigned Nominated Consultant and shall not transfer to another Nominated Consultant except in emergency cases or where the Service Specification permits such transfer or where the Southern Health and Social Care Trust has given its prior consent in respect of that particular HSC Patient.

11.3 Orthoderm Private Clinic shall use its best endeavours to secure that those medical treatments or procedures or other tasks which are designated to be performed by a particular Nominated Consultant or Nominated Consultants in the Service Specification are personally performed by that Nominated Consultant or one of those Nominated Consultants except in emergency cases or where permitted by the Service Specification or where the Southern Health and Social Care Trust has given its prior consent.

11.4 Orthoderm Private Clinic reserves the right at any time in its discretion to dismiss a Nominated Consultant or to review or withdraw Practising Privileges from a Nominated Consultant in the event of which:

11.4.1 Orthoderm Private Clinic shall immediately inform the HSCB and Southern Health and Social Care Trust of the reasons for such dismissal, review or withdrawal;

11.4.2 The HSCB and Southern Health and Social Care Trust may require Orthoderm Private Clinic to carry out or co-operate with a review of the treatment and outcome of care of all HSC Patients treated by the Nominated Consultant.

11.5 If Orthoderm Private Clinic exercises its right under 11.4 to dismiss a Nominated Consultant or to review or withdraw Practising Privileges from a Nominated Consultant, the parties shall, if either party considers it necessary or expedient to do so, use all reasonable endeavours to agree an alternative Nominated Consultant. In the event that, having used all such reasonable endeavours, they fail to agree, and one party is therefore materially unable to comply with its obligations under the Contract:

(a) the other party may, at its discretion, terminate the Contract forthwith subject to the provisions of clause 37, but

(b) the first party's failure to comply with its contractual obligations by reason of the parties' failure to agree an alternative Nominated Consultant shall not constitute breach of contract.

11.6 The Southern Health and Social Care Trust may require Orthoderm Private Clinic to disclose in advance the method of such medical treatment or procedure which a Nominated Consultant intends to use. In the event that the Southern Health and Social Care Trust notifies Orthoderm Private Clinic (in advance of the treatment) that it regards such method or procedure to be inappropriate and changes to the planned treatment are not agreed, Orthoderm Private Clinic shall cease to treat the HSC Patient if clinically appropriate to do so.

12 Staff

12.1 Orthoderm Private Clinic shall employ or engage sufficient clinical and non-clinical staff, to ensure that the Services are provided at all times and in all respects in accordance with the Contract. In particular, Orthoderm Private Clinic must ensure that a sufficient reserve of Staff is available to provide the

Services in accordance with the Contract during holidays or absences.

12.2 Orthoderm Private Clinic shall provide as Staff for the provision of the Services only such persons who:

12.2.1 are registered with the appropriate professional regulatory body (where relevant);

12.2.2 possess the appropriate qualifications, experience and skills to perform the duties required of them;

12.2.3 are careful, skilled and competent in practising those duties;

12.2.4 are covered by adequate indemnity insurance in compliance with clause 35.3 for the provision of the Services and are members of a medical defence society or equivalent where appropriate; and

12.2.5 have satisfied the applicable DHSSPSNI health clearance requirements;

and Orthoderm Private Clinic shall provide written evidence to the Southern Health and Social Care Trust of this on request.

12.3 Orthoderm Private Clinic shall at the Southern Health and Social Care Trust's request provide written evidence that it has complied with the Independent Healthcare Regulations (Northern Ireland) 2005 and the Statement of National Minimum Standards relating to pre- and post-employment procedures.

12.4 Orthoderm Private Clinic shall ensure that every Staff member involved with the provision of the Services:

12.4.1 receives proper and sufficient training and instruction in the execution of their duties; and

12.4.2 receives proper appraisal in terms of performance and on-going education and training in accordance with the standards of their relevant professional or regulatory body (where relevant); and

12.4.3 carries out the Services with regard to:

(a) the task that staff member has to perform;

(b) the provisions of the Contract;

(c) fire risks and fire precautions; and

(d) the highest standards of hygiene, courtesy and consideration.

12.5 Orthoderm Private Clinic shall ensure that all staff involved in the treatment and care of HSC Patients meet and have documentary evidence of their ability to meet DHSSPSNI health clearance requirements, including but not limited to Circular HSS (MD)14/2013 Guidance on health clearance for TB, Hep B, Hep C, HIV for new healthcare workers with direct clinical contact with patients and such additional health criteria (including proof that the staff member is up-to-date with all injections and treatments) as may be stated in the Service Specification or otherwise agreed between the parties, and Orthoderm Private Clinic shall provide copies of such documentary evidence to the Southern Health and Social Care Trust on request.

12.6 Where HSC Patients are treated at Orthoderm Private Clinic's premises as in-patients Orthoderm Private Clinic shall ensure that a resident medical officer with post-registration clinical experience relevant to the clinical work required in connection with the Services is available on immediate call at all times to deal with a clinical emergency in the absence of the Nominated Consultant under whom the HSC Patient is admitted and Orthoderm Private Clinic shall make available to the Southern Health and Social Care Trust on request at any time details of those doctors who will act as resident medical officers.

12.7 Neither Party shall discriminate unlawfully within the meaning and scope of any Law, relating to discrimination (whether relating to race, gender, disability, religion or otherwise) in employment or performance of the Services and each Party shall take all reasonable steps to ensure observance of this by its employees, Staff and agents and (in the case of Orthoderm Private Clinic) its Sub-contractors.

12.8 Orthoderm Private Clinic shall immediately notify the Trust in the event that any member of Staff:-

12.8.1 has been referred to the Independent Safeguarding Authority (ISA) or DHSSPS as a result of misconduct involving children and/or vulnerable adults; or

12.8.2 is currently the subject of a referral to, or an investigation, by a Regulatory Body; or

12.8.3 is currently the subject of police investigation or has any prosecutions pending; or

12.8.4 has ever been convicted, charged, prosecuted, cautioned or bound over for any offence, no matter how minor.

12.9 Orthoderm Private Clinic shall ensure that all Guidance on nurse to bed/dependency ratio and theatre equivalency is followed.

12A. TUPE/SPC

12A.1 The Parties hereby acknowledge that, where there is or is deemed to be a transfer pursuant to TUPE and/or SPC, there will be a relevant transfer on the date set as the Transfer Date and the contracts of employment of the Transferring Employees will take effect as if originally made between the Trust or the Replacement Provider and the Employees (save for those who object to transfer pursuant to Regulation 4(7) of TUPE/SPC).

12A.2 The Provider shall indemnify and keep indemnified and hold the Trust and/or any Replacement Provider harmless from and against all actions, suits, claims, demands, losses, charges, damages, costs and expenses and other liabilities which the Trust and/or any Replacement Provider may suffer or incur as a result of or in connection with:-

12A.2.1 any claim or demand by any Transferring Employee (whether in contract, tort, under statute, pursuant to European Law or otherwise) in each case arising

directly or indirectly from any act, fault or omission of the Provider in respect of any Transferring Employee on or before the Transfer Date;

12A.2.2 any failure by the Provider to comply with its obligations under Regulations 13 or 14 of TUPE/SPC or any award of compensation under Regulation 15 of TUPE/SPC save where such failure arises from the failure of the Trust and/or the Replacement Provider to comply with its duties under Regulation 13 of TUPE/SPC; or

12A.2.3 any claim (including any individual employee entitlement under or consequent on such a claim) by any trade union or other body or person representing any Transferring Employees arising from or connected with any failure by the Provider to comply with any legal obligation to such trade union, body or person.

12A.3 The Provider shall be responsible for all emoluments and outgoings in respect of the Transferring Employees (including, without limitation, all wages, bonuses, commission, premiums, subscriptions, PAYE and national insurance contributions and pension contributions) which are attributable in whole or in part to the period up to and including the Transfer Date (including bonuses or commission which are payable after the Transfer Date but attributable in whole or in part to the period on or before the Transfer Date), and will indemnify/keep indemnified and hold the Trust and/or any Replacement Provider harmless from and against all actions, suits, claims, demands, losses, charges, damages, costs and expenses and other liabilities which the Trust and/or any Replacement Provider may incur in respect of the same.

12A.4 The Trust and/or any Replacement Provider shall be responsible for all emoluments and outgoings in respect of the Transferring Employees (including, without limitation, all wages, bonuses, commission, premiums, subscriptions, PAYE and national insurance contributions and pension contributions) which are attributable in whole or in part to the period after the Transfer Date (including any bonuses, commission, premiums, subscriptions and any other prepayments which are payable

before the Transfer Date but which are attributable in whole or in part to the period after the Transfer Date) and will indemnify/keep indemnified and hold the Provider harmless from and against all actions, suits, claims, damages, costs and expenses and other liabilities which the Provider may incur in respect of same.

12A.5 At any time upon reasonable notice from the Authorised Officer (or in their absence the appointed Deputy) or (where the request is occasioned by the termination of the Contract) forthwith and in any event not later than three (3) Months prior to the end of the Contract Period or within four (4) weeks of early termination of the Contract, the Provider shall fully and accurately disclose to the Trust all information that the Trust may reasonably request in relation to the Provider's Staff employed or engaged directly in the Service (whether or not employed or engaged by the Provider) including but not limited to the following:-

12A.5.1 the total number of Transferring Employees wholly or mainly assigned to the undertaking or the Service other than on a temporary basis;

12A.5.2 the age, gender, salary or other remuneration, future pay settlements and redundancy and pensions entitlements of the Transferring Employees referred to in clause 12A.5.1;

12A.5.3 the terms and conditions of employment/engagement of the Transferring Employees referred to in clause 12A.5.1, their job titles and qualifications;

12A.5.4 details of any current disciplinary or grievance proceedings ongoing or circumstances likely to give rise to such proceedings and details of any claims current or threatened; and

12A.5.5 details of all collective agreements with a brief summary of the current state of negotiations with such bodies and with details of any current industrial disputes and claims for recognition by any trade union.

12A.6 At intervals to be stipulated by the Trust (which shall not be more frequent than every thirty days) and immediately prior to the end of the Contract Period the Provider shall deliver to the Trust a complete update of all such information which shall be disclosable pursuant to clause 12A.5.

12A.7 At the time of providing the information disclosed pursuant to clauses 12A.5 and 12A.6, the Provider shall warrant the completeness and accuracy of all such information and the Trust may assign the benefit of this warranty to any Replacement Provider.

12A.8 The Trust may use the information received from the Provider pursuant to clause 12A.5 and 12A.6 for the purposes of TUPE/SPC and/or any retendering process and in order to ensure an effective handover of all work in progress at the end of the Contract Period. The Provider shall provide the Replacement Provider with such assistance as it shall reasonably request.

12A.9 The Provider shall indemnify and keep indemnified and hold the Trust (both for itself and any Replacement Provider) harmless from and against all actions, suits, claims, demands, losses, charges, damages, costs and expenses and other liabilities which the Trust or any Replacement Provider may suffer or incur as a result of or in connection with:

12A.9.1 the provision of information pursuant to clauses 12A.5 and 12A.6;

12A.9.2 any claim or demand by any Retained Employee (whether in Contract, tort, under statute, pursuant to European Law or otherwise) in each case arising directly from any act, fault or omission of the Provider or any sub-contractor in respect of any Retained Employee on or before the end of the Contract Period;

12A.9.3 any claim or demand by any Retained Employee (whether in Contract, tort, under statute, pursuant to European Law or otherwise) in respect of the failure to include the Retained Employee in the list of Transferring Employees and/or the fact that the Retained Employee was not transferred to the Trust

or any Replacement Provider; and

12A.9.4 any claim by any person who is transferred by the Provider to the Trust and/or a Replacement Provider whose name is not included in the list of Transferring Employees.

12A.10 If the Provider becomes aware that the information it provided pursuant to clause 12A.5 has become untrue, inaccurate or misleading, it shall notify the Trust and provide the Trust with up to date information.

12A.11 The Provider undertakes to the Trust that, during the six(6) Months prior to the end of the Contract Period the Provider shall not (and shall procure that any sub-contractor shall not) without the prior consent of the Trust (such consent not to be unreasonably withheld or delayed):-

12A.11.1 amend or vary (or purport or promise to amend or vary) the terms and conditions of employment or engagement (including, for the avoidance of doubt, pay) of any employee (other than where such amendment or Variation has previously been agreed between the Provider and the employee in the normal course of business, and where any such amendment or Variation is not in any way related to the transfer of the Service);

12A.11.2 terminate or give notice to terminate the employment or engagement of any employee (other than in circumstances in which the termination is for reasons of misconduct or lack of capability); or

12A.11.3 transfer away, remove, reduce or vary the involvement of any of the employee from or in the provision of the Service (other than where such transfer or removal: (i) was planned as part of the individual's career development; (ii) takes place in the normal course of business; and (iii) will not have any adverse impact upon the delivery of the Service by the Provider, (PROVIDED THAT any such transfer, removal, reduction or variation is not in any way related to the transfer of the Service)).

12A.12 The provisions of this clause shall survive the continuance of the Contract indefinitely after its termination and or expiry.

13 Emergencies

13.1 If a member of Orthoderm Private Clinic's staff identifies any clinical or medical need of an HSC Patient for Emergency Treatment which is not otherwise covered by the Individual Care Package, and such Emergency Treatment is in the best interests of that HSC Patient, Orthoderm Private Clinic may, where it possesses the necessary facilities to do so, carry out such treatment as part of the Services, notify the Trust as soon as reasonably practicable and the parties shall use all reasonable endeavours to agree reasonable charges for that Emergency Treatment.

13.2 Where Orthoderm Private Clinic does not possess the necessary facilities to carry out such Emergency Treatment, the Orthoderm Private Clinic shall carry out all emergency transfers of HSC Patients from the establishment or Orthoderm Private Clinic 's premises to another hospital or critical care facility in accordance with Orthoderm Private Clinic's documented contingency emergency transfer arrangements, copies of which Orthoderm Private Clinic shall provide to the Southern Health and Social Care Trust.

13.3 In the event of any such emergency transfer as set out in clause 13.2 Orthoderm Private Clinic shall:

13.3.1 promptly notify the Southern Health and Social Care Trust of such emergency transfer and in any event within 24 (twenty four) hours of the transfer;

13.3.2 use its best endeavours to ensure that the HSC Patient is subject to the same continuous high level of care during his/her transfer to the other hospital or critical care facility as was provided to the HSC Patient at the establishment or Orthoderm Private Clinic’s premises.

14 Death of an HSC patient

14.1 In the event of the death of any HSC Patient occurring at Orthoderm Private Clinic's premises Orthoderm Private Clinic shall:

14.1.1 notify the HSCB and Southern Health and Social Care Trust as soon as possible and no later than 24 (twenty four) hours after the event of death

14.1.2 provide all reasonable support and practical assistance to the next of kin, family and friends.

14.2 Where the provisions of clause (14.1) apply Orthoderm Private Clinic shall use best endeavours to identify and contact the next of kin within 24 hours of the death of that HSC Patient.

14.3 In the event that Orthoderm Private Clinic cannot identify and contact the next of kin or the next of kin have been identified but are unable or unwilling to arrange for the burial or cremation of that HSC Patient then the following provisions shall apply:

14.3.1 Orthoderm Private Clinic shall notify the Contract Manager and shall give all assistance to the Contract Manager as is reasonably necessary to enable the Southern Health and Social Care Trust to make appropriate arrangements for the burial or cremation of the deceased HSC Patient

14.3.2 Orthoderm Private Clinic shall provide all information necessary to assist the Southern Health and Social Care Trust in identifying any next of kin and do all other things necessary to assist the Southern Health and Social Care Trust in discharging its obligations in respect of the deceased HSC Patient.

15 Quality

15.1 Orthoderm Private Clinic shall carry out the Services in accordance with Good Practice in health care and in providing the Services shall comply, in all respects with the standards contained in the ***Independent Healthcare***

Regulations (Northern Ireland) 2005 (refer to http://www.legislation.gov.uk/sr/sr2005/20050174.htm**)**. Orthoderm Private Clinic will also comply with those standards identified in ***'Standards for Better Health (Dept. of Health, 2005) and 'Quality Standards in Health & Social Care (DHSSPS, 2006)*** and the Statement of National Minimum Standards with their own quality standards to the extent that they exceed the standards set out in the Independent Healthcare Regulations (Northern Ireland) 2005 or otherwise set standards acceptable to the Southern Health and Social Care Trust which are not covered by the Independent Healthcare Regulations (Northern Ireland) 2005, and Orthoderm Private Clinic shall review on an ongoing basis the quality of the care provided to HSC Patients under the Contract.

15.2 For the avoidance of doubt nothing in the Contract is intended to prevent the Contract from setting higher quality standards than those laid down in the Independent Healthcare Regulations (Northern Ireland) 2005.

15.3 Where required to do so by the Trust at any time during the Contract, Orthoderm Private Clinic will provide evidence to indicate that they are registered and/or licensed to undertake the range of clinical procedures, interventions and treatments contracted for with the Regulation and Quality Improvement Authority (RQIA) or Care Quality Commission (CQC) or other relevant Regulatory Body.

15.4 It is the responsibility of Orthoderm Private Clinic to have in place procedures to guarantee adherence to the Quality Standards and the quality of facilities, procedures and processes offered.

15.5 Orthoderm Private Clinic shall comply with the standards criteria and recommendations, protocols, procedures and guidance from time to time;

15.5.1 arising from any audit or Serious Adverse Incident;

15.5.2 issued by the National Institute of Clinical Excellence (or any successor to it) and agreed in writing between the Parties;

15.5.3 issued by any relevant Royal College, professional body or equivalent and agreed in writing between the Parties and

15.5.4 any other professional association referred to in the Service Specification

15.6 Orthoderm Private Clinic shall ensure that the Services are carried out to the satisfaction of the Trust in accordance with the Contract and shall ensure that:-

15.6.1 Orthoderm Private Clinic's staff are informed and aware of the standard of performance they are required to provide and are able to meet that standard;

15.6.2 the adherence of Orthoderm Private Clinic's staff to such standards of performance is routinely monitored and that remedial action is promptly taken where such standards are not attained; and

15.6.3 all Services are performed and delivered to the appropriate high standard demonstrable through any audit carried out under clause 17.

15.7 Orthoderm Private Clinic shall on request, make available to the Southern Health and Social Care Trust copies of any patient guide or other written policy, procedure or protocol which Orthoderm Private Clinic is required or recommended to implement and/or maintain under the Independent Healthcare Regulations (Northern Ireland) 2005 or the Service Specification. Orthoderm Private Clinic shall promptly notify the Southern Health and Social Care Trust of any material changes to such guides, policies, procedures and protocols and shall make any changes to such guides, policies, procedures and protocols including without limitation the Consent Policy and Orthoderm Private Clinic 's documented contingency transfer arrangements reasonably requested by the Southern Health and Social Care Trust.

16. Clinical Governance and Audit

16.1 Southern Health and Social Care Trust and Orthoderm Private Clinic shall each comply with its statutory duty of quality and undertake to improve and assure the quality of clinical services for HSC Patients through a framework of clinical governance having regard to any Department of Health or DHSSPSNI guidance on clinical governance including but not limited to:

16.1.1 HSC1999/065, Clinical Governance: Quality in the new NHS and Clinical Governance Reporting Processes (DoH, 2002);

16.1.2 HSS Circulars on Governance in the HSC: Reporting on Controls Assurance Standards; Safety and Quality Alerts, and;

16.1.3 Best Practice, Best Care (DHSSPSNI, 2001), and;

16.1.4 any amendment or re-issue of them from time to time in issue.

16.2 Each Party shall give full co-operation to the other Party and promptly do all things necessary (as and when requested by the other Party) to enable the other Party to comply with its obligations under Section 16.1.

16.3 Both Parties shall appoint a senior clinician or other senior member of Staff and a deputy (and shall notify the other Party of their name and contact details) who shall be responsible for ensuring clinical governance systems are in place and for monitoring the effectiveness of the clinical governance systems.

16.4 Both Parties shall make arrangements for effective monitoring of clinical care and clinical record keeping.

16.5 Both Parties shall ensure that all Staff are made aware of and have access to processes or systems which enable them to raise, in confidence and without prejudice to their position in the organisation, concerns over any aspect of service delivery, treatment or management that they consider to have a

detrimental effect on HSC Patient care or the delivery of Services.

16.6 Orthoderm Private Clinic will be subject to, and willingly participate in inspection as agreed by the RQIA or other Regulatory Body.

16.7 Orthoderm Private Clinic shall on reasonable notice comply with all written requests made by the RQIA and the Care Quality Commission or other Regulatory Body, as reasonably required in connection with the performance of their functions (in relation to Orthoderm Private Clinic as if it were subject to their regulation) for:

16.7.1 entry to Orthoderm Private Clinic's Premises at any reasonable time for the purpose of inspecting the provision of the Services; and

16.7.2 information including but not limited to details of any or all treatments or procedures provided under the Services during any specified period, Orthoderm Private Clinic shall give all such assistance and provide all such facilities as the bodies identified at section 16.7 may reasonably require.

16.8 Orthoderm Private Clinic shall carry out appropriate clinical audits agreed with Southern Health and Social Care Trust and will report and act on any recommendation from such audits.

16.9 Orthoderm Private Clinic shall within a reasonable time after request provide Southern Health and Social Care Trust with the results of any audit, evaluation, inspection, investigation or research undertaken by or on behalf of Orthoderm Private Clinic or any third party of the quality of any or all or the Services, the Service Environment or services of a similar nature carried out by Orthoderm Private Clinic.

16.10 The Contract Manager or any other person authorised to do so by the Trust ("Authorised Person") may visit Orthoderm Private Clinic 's Premises, with or without reasonable notice to carry out an audit and/or inspection of the provision of the Services. Such audits and inspection shall include inter alia the inspection, monitoring and assessment of Orthoderm

Private Clinic ’s Premises, facilities, Staff, records, equipment and procedures. Orthoderm Private Clinic shall give all such assistance and provide all such facilities as the Authorised Person may reasonably require for such audit or inspection.

16.11 Orthoderm Private Clinic shall include within its clinical audit plans and arrangements appropriate arrangements for the audit of the Services provided to HSC Patients. Orthoderm Private Clinic shall participate in a regular audit of clinical practice in respect of patients treated under the Contract. Details of audit arrangements must be supplied to the Southern Health and Social Care Trust in advance of Commencement Date.

16.12 The Trust will hold a regular clinical review meeting with Orthoderm Private Clinic to review clinical performance and identify any performance problems. The frequency of such clinical review meetings will be agreed between the parties prior to the Commencement Date.

16.13 Orthoderm Private Clinic shall comply with all reasonable requests by the Southern Health and Social Care Trust for changes to its clinical audit plans and arrangements in relation to the provision of the Services and shall at the request of the Southern Health and Social Care Trust include a review of the appropriateness of Orthoderm Private Clinic's clinical practices and procedures by a person or organisation nominated by the Southern Health and Social Care Trust.

17 Adverse incidents

17.1 Orthoderm Private Clinic shall comply with the following reporting arrangements in respect of Adverse Incidents.

Orthoderm Private Clinic shall promptly notify the HSCB Commissioning Directorate by using email: adverse.incidents@hscni.net and Southern Health and Social Care Trustusing email:<Trust email address> of any Adverse Incident directly or indirectly involving any HSC Patient within 24 (twenty four) hours and shall provide a written report within a further two working days. Orthoderm Private Clinic shall provide all reasonable assistance to the HSCB and Southern

Health and Social Care Trust in investigating and handling the incident.

17.2 Orthoderm Private Clinic shall promptly provide to the HSCB and Southern Health and Social Care Trust a full copy of any notification made by Orthoderm Private Clinic to the Regulation and Quality Improvement Authority (RQIA) under Regulation 28 of the Independent Healthcare Regulations (Northern Ireland) 2005 (or under other comparable regulatory framework) where such notification directly or indirectly concerns any HSC Patient.

17.3 Orthoderm Private Clinic shall submit a weekly monitoring report on Adverse Incidents for the Southern Health and Social Care Trust and HSCB Commissioning Directorate in the format contained in Schedule 2 to this Contract.

17.4 **Serious Adverse Incidents**:

Where a Serious Adverse Incident is reported (i.e. an adverse incident assessed by the Trust to constitute a Serious Adverse Incident), the incident will be followed up using the HSCB procedure as described at:
http://www.hscboard.hscni.net/publications/Policies/101%20Serious%20Adverse%20Incident%20-%20Procedure%20for%20the%20reporting%20and%20follow up%20of%20SAI%20-%20April%202010%20-%20PDF%20268KB%20.pdf

The HSCB and Southern Health and Social Care Trust may use all or any part or parts of the information provided by Southern Health and Social Care Trust under this clause 18 in any report which the HSCB and Southern Health and Social Care Trust makes to any NHS or HSC body or any department, office or agency of the Crown, or any other body in connection with the serious adverse incident or in relation to the prevention and handling of such incidents to patients generally.

17.5 This clause 17 shall survive the termination or expiry of the Contract.

17.6 **Learning from Adverse Incidents**

17.6.1 With regard to Adverse Incidents, Orthoderm Private Clinic will:

17.6.1.1 implement DHSSPS and National Patient Safety Agency (NPSA) guidance including for the avoidance of doubt, patient safety alerts and other safety solutions and products developed for the HSC; and

17.6.1.2 have local risk management procedures in place to analyse and learn from Adverse Incidents.

18 Patient satisfaction surveys

18.1 Orthoderm Private Clinic shall make available to the Southern Health and Social Care Trust on request the results of any HSC Patient satisfaction surveys carried out by or on behalf of Orthoderm Private Clinic. Orthoderm Private Clinic shall also on request by the Southern Health and Social Care Trust

19.1.1 carry out a survey of HSC Patients' satisfaction with their treatment under the Services

19.1.2 carry out or assist with any HSC Patient satisfaction survey of HSC Patients.

19 Performance Targets and Contract monitoring

19.1 Orthoderm Private Clinic shall comply with the Performance Targets and acknowledges that the HSCB and the Trust may take into account Orthoderm Private Clinic's level of attainment of the Performance Targets in any review of the provision of the Services. Such review is without prejudice to any other remedy or right which the Trust and/or HSCB may have under the terms of the Contract.

19.2 The Parties acknowledge that in order to achieve accurate forecasting, activity monitoring and prompt and accurate payment, there needs to be timely regular exchange of detailed and accurate information. Orthoderm Private Clinic

shall therefore provide the information specified in Schedule 9 and Schedule 10 of the Contract and Appendix 2 - the Service Specification accurately and completely and in accordance with the format, method and timeframes set out therein.

19.3 Orthoderm Private Clinic shall comply with:

19.3.1 all requests for any information reasonably required by the Southern Health and Social Care Trust for purposes connected with the Contract and/or the Services, and

19.3.2 all reasonable requests by the Southern Health and Social Care Trust for review meetings to monitor and assess Orthoderm Private Clinic 's performance of the Services. The review meetings shall be attended by nominated officers as decided by the Southern Health and Social Care Trust and relevant members of Orthoderm Private Clinic's staff involved in the provision of the Services.

19.4 Where the Southern Health and Social Care Trust reasonably believes that Orthoderm Private Clinic has failed to meet the requirements of Schedule 9 and/or Schedule 10 and/or Appendix 2 - the Service Specification with regard to the provision and/or accuracy and/or completeness of information, the Southern Health and Social Care Trust shall inform Orthoderm Private Clinic of this by notice in writing, detailing its intention to withhold the sum specified in clause 19.5, unless the information is rectified and/or provided within 5 working days.

19.5 If:

19.5.1 the information required pursuant to Schedule 9 and/or Schedule 10 of the Contract and/or Appendix 2 - the Service Specification is not provided pursuant to clause 19.2 and/or rectified by Orthoderm Private Clinic within 5 working days pursuant to clause 19.4; and

19.5.2 such information is required under the Contract

and provided that Orthoderm Private Clinic's failure to meet the requirements of Schedule 9 and/or Schedule 10 and/or Appendix 2 - the Service Specification is not due to any act or omission of the Southern Health and Social Care Trust, then the Southern Health and Social Care Trust may withhold 10% of all the monthly sums payable by them to the Provider for the month in respect of which the information has not been received. The Southern Health and Social Care Trust may withhold such sums until the receipt of the relevant information, and the Southern Health and Social Care Trust shall then pay to Orthoderm Private Clinic the withheld sums within 5 working days of the date of such receipt, and no interest shall be payable to Orthoderm Private Clinic on any sum withheld under this clause 19.5 unless it can be established that the money was withheld unjustifiably.

20 Financial audit

20.1 Orthoderm Private Clinic shall maintain accurate accounts and records of all payments, receipts and other financial information relevant to the provision of the Services (collectively referred to as "Financial Records").

20.2 Orthoderm Private Clinic shall allow the Southern Health and Social Care Trust or any person authorised by it to conduct an audit of the Financial Records owned or controlled by Orthoderm Private Clinic at any time on reasonable notice, and in any event not later than 7 (seven) days of the date of the request, to ensure Orthoderm Private Clinic 's compliance with the Contract and shall permit access by the Southern Health and Social Care Trust to the Financial Records for the inspection and making and retaining copies thereof. Orthoderm Private Clinic shall provide all reasonable assistance to the Southern Health and Social Care Trust or the authorised person in the conduct of any such audit or inspection.

20.3 If the Southern Health and Social Care Trust has been overcharged for the services, Orthoderm Private Clinic shall, within 7 (seven) days of receiving written notice of such overcharge from the Southern Health and Social Care Trust,

issue a credit note and reimburse the Southern Health and Social Care Trust the amount of the overcharge and if any audit carried out by the Southern Health and Social Care Trust or the Counter Fraud Unit (refer to Clause 21) or any person authorised by the Southern Health and Social Care Trust shall have revealed an overcharge exceeding 4 per cent of the amount that should have been charged Orthoderm Private Clinic shall in addition, within the 7 (seven) day period, reimburse the Southern Health and Social Care Trust reasonable costs incurred by it in performing the audit.

20.4 If Orthoderm Private Clinic has undercharged for the Services, Orthoderm Private Clinic shall issue an invoice (within 7 days of Orthoderm Private Clinic receiving Southern Health and Social Care Trust notice of undercharge) and Southern Health and Social Care Trust shall (within 7 days of receipt of the invoice) reimburse Orthoderm Private Clinic the amount of the undercharge.

20.5 Orthoderm Private Clinic shall provide all reasonable assistance and co-operation to any auditors carrying out statutory functions in relation to the Southern Health and Social Care Trust.

20.6 For the purposes of:

(a) the examination and certification of the Southern Health and Social Care Trust's accounts or
(b) any examination, efficiency and effectiveness with which the Southern Health and Social Care Trust has used its resources,

the Comptroller Auditor General of the Northern Ireland Audit Office may examine such documents as he may reasonably require which are owned, held or otherwise within the control of Orthoderm Private Clinic and any person acting on its behalf who has such documents and/or other information shall also provide access) and may require Orthoderm Private Clinic to produce such oral or written explanations as he considers necessary.

20.7 This clause 20 shall survive the termination or expiry of the Contract.

21 Counter fraud

21.1 Upon the request of the Southern Health and Social Care Trust or the Counter Fraud and Probity Service of the Business Services Organisation, ("the Counter Fraud Unit" ,the Orthoderm Private Clinic shall ensure that the Counter Fraud Unit is given access as soon as is reasonably practicable and in any event not later than 7 (seven) days from the date of the request to:

21.1.1 all property, premises, information (including records and data) owned or controlled by Orthoderm Private Clinic relevant to the detection and investigation of cases of fraud, bribery and/or corruption directly or indirectly connected to the Contract; and

21.1.2 all members of Orthoderm Private Clinic's Staff who may have information to provide that is relevant to the detection and investigation of cases of fraud, bribery and/or corruption directly or indirectly connected to the Contract.

21.2 Orthoderm Private Clinic shall procure that its chief executive and director of finance and any person or persons in equivalent posts shall be responsible for ensuring that such access together with all reasonable assistance is given to the Counter Fraud Unit in the conduct of any such detection or investigation.

21.3 This clause 21 shall survive the termination or expiry of the Contract.

22 Patient and Client Council (PCC)

22.1 The parties acknowledge that the Patient and Client Council (PCC) has a duty to represent the interests of HSC Patients and the public in relation to the Services.

22.2 Orthoderm Private Clinic shall on reasonable notice comply with all written requests made by authorised members of the PCC as reasonably required in connection with the performance of its functions.

23 Patient advice and liaison

23.1 The Southern Health and Social Care Trust shall provide Orthoderm Private Clinic with details of its patient advice and liaison service or such patient advice and liaison service to which HSC Patients are to have access.

23.2 Orthoderm Private Clinic shall provide details of any patient advice and liaison service to all HSC Patients and shall offer and provide all reasonable assistance to HSC Patients to enable them to contact the service and will provide a named individual, together with contact details, to whom HSC Patients and others may direct enquiries or requests.

23.3 Orthoderm Private Clinic shall co-operate with the HSCB, Southern Health and Social Care Trust, and Patient and Client Council in resolving any problems raised by HSC Patients.

24 Complaints

24.1 Orthoderm Private Clinic shall comply with the complaint reporting arrangements detailed in this clause, and use the complaints reporting template contained in Schedule 4 ofthis Contract. To assure the Trust that appropriate governance arrangements are in place for effective handling management and monitoring of all complaints, the Orthoderm Private Clinic shall supply a copy of Orthoderm Private Clinic 's complaints procedure to the Southern Health and Social Care Trust. This should include the appointment of designated officers of suitable seniority to take responsibility for the management of the in-house complaints handling procedures, the investigation of complaints and the production of leaflets or other literature (available and accessible to patient / clients) that outline the provider's complaints procedure.

24.2 The parties shall each provide to the other the names and contact details of their respective designated complaints managers and shall promptly notify any change of such complaints manager to the other party.

24.3 On receiving any oral or written complaint from or on behalf of an HSC Patient ("the Complainant"), the general principle in the first instance will be that the Orthoderm Private Clinic

shall investigate the complaint and respond directly to the Complainant. Orthoderm Private Clinic shall explain to the Complainant that its decision in no way affects their rights, or the rights of any other person, subsequently to make any complaint (whether of the same or a different nature) in accordance with the Southern Health and Social Care Trust's complaints procedure or any other complaints procedure which they may be entitled to use.

24.3.1 The Orthoderm Private Clinic shall explain to the Complainant that information relevant to their complaint may be shared with the Southern Health and Social Care Trust (and with any other relevant HSC body e.g. HSCB, that may have responsibility for ensuring that the handling of the complaint is in accordance with the Southern Health and Social Care Trust's complaints procedure) and shall obtain appropriate consent for the sharing of such information.

24.3.2 Orthoderm Private Clinic shall notify the Trust of the complaint without delay and in any event within 48 hours.

24.3.3 Where complaints are raised with the Trust, the Trust must establish the nature of the complaint and consider how best to proceed. The Trust may simply refer the complaint to Orthoderm Private Clinic for investigation, resolution and response or it may decide to investigate the complaint itself where the complaint raises serious concerns or where the Trust deems it in the public interest to do so. This may also be considered preferable should the Trust premises and / or staff have been involved. In all cases, appropriate communication should be made with the Complainant to inform them of which organisation will be investigating their complaint.

24.3.4 In complaints investigated by Orthoderm Private Clinic :-

24.3.4.1 A written response will be provided by Orthoderm Private Clinic to the Complainant and copied to the Trust;

24.3.4.2 Where there is a delay in responding within the target timescales set out in the HSC complaints procedure the Complainant will be advised of the delay and where possible provided with a revised date for conclusion of the investigation; and

24.3.4.3 The letter of response must advise the Complainant that they may progress their complaint to the Trust for further consideration if they remain dissatisfied. The Trust will then determine whether the complaint warrants further investigation and, if so, will confirm who should be responsible for conducting it. The Trust will work closely with the ISP to enable appropriate decisions to be made.

24.3.5 The Complainant must also be informed of their right to refer their complaint to the Ombudsman if they remain dissatisfied with the outcome of the complaints procedure. It is possible that referrals to the Ombudsman where complaints are dealt with directly by Orthoderm Private Clinic without Trust participation in local resolution will be referred to the Trust by the Ombudsman for action.

24.4 For the avoidance of doubt, any obligation of Orthoderm Private Clinic arising under clause 24.3 shall not restrict any right of the HSC Patient, or any other person, to make the same complaint directly to the Southern Health and Social Care Trust, nor the right of that Southern Health and Social Care Trust to investigate that or any other complaint.

24.5 Orthoderm Private Clinic shall, without identifying the complainants inform the Southern Health and Social Care Trust at intervals agreed between the parties of the nature of any complaints made by or on behalf of HSC Patients that Orthoderm Private Clinic has received (and which are not subject to the Southern Health and Social Care Trust's complaints procedure) and any action which Orthoderm

Private Clinic has taken in response to such complaints, and in particular confirming that the learning from complaints has been disseminated to all relevant Staff.

24.6 Orthoderm Private Clinic shall co-operate fully with any investigation of any complaint made by or on behalf of an HSC Patient which is carried out by or on behalf of the Southern Health and Social Care Trust or any other HSC body in accordance with the Southern Health and Social Care Trust's complaints system and such co-operation shall include without limitation:

24.6.1 attempting local resolution of the complaint as if the complaint had been made to Orthoderm Private Clinic by or on behalf of an HSC Patient who wished it to be handled in accordance with the Southern Health and Social Care Trust's complaints procedure

24.6.2 attending and participating in meetings with any HSC Patient with or without the Southern Health and Social Care Trust.

24.6.3 providing full written statements and reports and copies of all relevant documents which for the avoidance of doubt may include access to patient/client records as required.

24.6.4 identifying and analysing any pattern of complaints

24.6.5 taking all reasonable steps to rectify the cause of any legitimate complaint identified under the Orthoderm Private Clinic or Southern Health and Social Care Trust's complaints procedure (or otherwise) and to prevent its recurrence;

and Orthoderm Private Clinic shall provide all such assistance and facilities as may be required by those carrying out such investigation.

24.7 Orthoderm Private Clinic shall indemnify the Southern Health and Social Care Trust, the HSCB, any other HSC Body and the Department of Health, Social Services and Public Safety (NI) for all costs and expenses incurred by the Southern Health and Social Care Trust, such other HSC Body and the

Department in connection with investigating and resolving any complaints made by or on behalf of any HSC Patient against Orthoderm Private Clinic in connection with or directly arising from the services procured or delivered by Orthoderm Private Clinic under the terms of this Agreement.

24.8 Orthoderm Private Clinic shall keep records of all events and correspondence relating to all complaints by or on behalf of HSC Patients and shall make copies of such available to the Trust at any time upon request.

24.9 This Clause 24 shall survive the termination or expiry of this Agreement.

25 Chaplaincy

25.1 Orthoderm Private Clinic shall use its best endeavours to make arrangements with the chaplaincy service of the Trust (or such other HSC body as the Southern Health and Social Care Trust may agree or direct) by which HSC Patients and their relatives and carers may avail themselves of the support of that chaplaincy service.

26 Patient Access Standards

26.1 Orthoderm Private Clinic shall ensure that HSC Patients are seen in accordance with HSC Patient Access Standards as detailed in Schedule 3 of the Contract.

27 Patient costs not covered in Fees

27.1 Orthoderm Private Clinic shall provide information accurately and expeditiously to the Southern Health and Social Care Trust or such other authority as may be so requested, concerning any claim made by any HSC Patient in respect of the payment of travelling expenses.

27.2 Orthoderm Private Clinic shall provide information accurately and expeditiously to the Southern Health and Social Care Trust or such other authority as may be so requested, concerning claims made by Orthoderm Private Clinic in respect of invoices submitted for travelling accommodation or other patient related expenses not covered in Schedule of Fees.

28 Patient health records

28.1 Orthoderm Private Clinic shall comply with any duty arising from the HSC Patient's entitlement to confidentiality of his/her patient health record and any other information (including personal data) relating to him/her as an HSC Patient in accordance with statutory requirements and the common law duty of confidentiality.

28.2 Orthoderm Private Clinic shall provide contact names and details of those members of its staff to whom all requests for copies of or access to HSC Patient Health Records should be addressed and shall promptly notify any change in the identity of such contacts to the Southern Health and Social Care Trust.

28.3 Orthoderm Private Clinic shall ensure that Orthoderm Private Clinic Patient Health Record and any HSC Patient Health Record in the custody or control of Orthoderm Private Clinic under the terms of the Contract is available for inspection at any time by the HSCB or Southern Health and Social Care Trust, and Orthoderm Private Clinic shall provide a complete copy of any Provider Patient Health Record requested by the HSCB or Southern Health and Social Care Trust within 48 (forty eight) hours of such request.

28.4 Orthoderm Private Clinic shall use Orthoderm Private Clinic Patient Health Record and any HSC Patient Health Record in the custody or control of Orthoderm Private Clinic under the terms of the Contract and any information relating to any HSC Patient in its possession, custody or control or in the possession, custody or control of any party under Orthoderm Private Clinic 's control solely obtained as a consequence of the delivery of the Services by Orthoderm Private Clinic for the execution of Orthoderm Private Clinic's obligations under the Contract and/or in compliance with any legislative obligations on Orthoderm Private Clinic and/or as otherwise agreed with the Southern Health and Social Care Trust.

28.5 Subject to clause 28.4, Orthoderm Private Clinic shall provide to the Southern Health and Social Care Trust for each HSC Patient, a complete copy of the Provider Patient Health

Record and the originals of any other information in its possession, custody or control relating to that HSC Patient supplied by the Southern Health and Social Care Trust in relation to the HSC Patient:

28.5.1 on completion of the care or treatment of such HSC Patient; or

28.5.2 on the expiry or termination of the Contract; or

28.5.3 when such HSC Patient is withdrawn from treatment under the Services referred to under clause 3

In each case within 48 (forty-eight) hours of the happening of such event.

28.6 Subject to clause 28.5, any HSC Patient Health Record provided by the Southern Health and Social Care Trust are and all other information relating to HSC patients shall at all times remain the property of the Southern Health and Social Care Trust. Orthoderm Private Clinic shall promptly return any HSC Patient Health Record and any other information supplied by the Southern Health and Social Care Trust in relation to the HSC Patient to the Southern Health and Social Care Trust upon request at any time.

28.7 Where Orthoderm Private Clinic is required to retain originals of any of the documents referred to in this clause 28 or in order to comply with any legislative requirement or court order, then it shall provide full copies of all such documents or information at the request of the Southern Health and Social Care Trust.

28.8 This clause 28 shall survive the termination or expiry of this Contract

29 Data protection

29.1 To the extent that Orthoderm Private Clinic qualifies as a data controller under the DPA, or Data Protection (Amendment) Act 2003 in the Republic of Ireland, in relation to personal data Processed by Orthoderm Private Clinic in connection with the Contract, Orthoderm Private Clinic shall comply with the DPA and all associated legislation and codes of practice.

29.2 To the extent that Orthoderm Private Clinic qualifies as a data processor under the DPA, in relation to any personal data Processed by Orthoderm Private Clinic in connection with the Contract, Orthoderm Private Clinic shall comply with the obligations placed on the HSCB and Southern Health and Social Care Trust by the seventh data protection principle ("the Seventh Principle") set out in the DPA, namely:

29.2.1 to maintain technical and organisational security measures sufficient to comply at least with the obligations imposed on the HSCB or Southern Health and Social Care Trust by the Seventh Principle. The HSCB or Southern Health and Social Care Trust may supply in writing specifics of the minimum technical and organisational security measures with which Orthoderm Private Clinic shall comply;

29.2.2 to Process personal data for and on behalf of the HSCB or Southern Health and Social Care Trust for the purpose of performing and in accordance with the Contract and otherwise only on written instructions from the HSCB or Southern Health and Social Care Trust, or to comply with any legislative requirement or for purposes agreed between with the Southern Health and Social Care Trust;

29.2.3 to allow the HSCB or Southern Health and Social Care Trustto audit Orthoderm Private Clinic 's compliance with the requirements of this clause 29 on reasonable notice and/or to provide the HSCB or Southern Health and Social Care Trust with evidence of its compliance with the obligations set out in this clause 29.

29.3 Orthoderm Private Clinic agrees to use all reasonable efforts to assist the HSCB and Southern Health and Social Care Trust to comply with such obligations as are imposed on the HSCB and Southern Health and Social Care Trust by the DPA. For the avoidance of doubt, this includes the obligation to:

29.3.1 provide the HSCB or Southern Health and Social Care Trust with reasonable assistance in complying with any Subject Access Request in respect of which the HSCB

or Southern Health and Social Care Trust is a data controller (a "Relevant Subject Access Request") where certain or all of the personal data being requested is in the control or possession of Orthoderm Private Clinic, its employees, Subcontractors, and/or agents by:

(a) promptly informing the HSCB and Southern Health and Social Care Trust about any Relevant Subject Access Request served on Orthoderm Private Clinic ;

(b) subject to (c) below, not disclosing or releasing any personal data in response to a Relevant Subject Access Request without first consulting with and obtaining the consent of the HSCB and Southern Health and Social Care Trust;

(c) where requested by the HSCB or Southern Health and Social Care Trust to do so, dealing with any Relevant Subject Access Requests on behalf of the HSCB or Southern Health and Social Care Trust in accordance with the requirements of the DPA, keeping the HSCB Southern Health and Social Care Trust informed about Orthoderm Private Clinic 's progress in dealing with any such Relevant Subject Access Request, providing the HSCB and Southern Health and Social Care Trust with copies of any correspondence and documents including legal opinions provided in relation to such Relevant Subject Access Request.

29.3.2 provide each HSC Patient with a Patient Data Protection Notice as soon as reasonably possible; and

29.3.3 inform each of its employees and agents as soon as reasonably possible that their personal data may be passed to the HSCB or Southern Health and Social Care Trust for the purpose of the provision of Services by Orthoderm Private Clinic under the Contract.

29.4 Subject always to Clause 44, if Orthoderm Private Clinic is to require any Sub-Contractor to Process personal data on its behalf, the «Orthoderm Private Clinic»shall:-

29.4.1 require the Sub-Contractor to provide sufficient guarantees in respect of its technical and organisational security measures governing the data processing to be carried out and take reasonable steps to ensure compliance with those measures;

29.4.2 require the Sub-Contractor to Process such personal data only in accordance with the «Orthoderm Private Clinic's» instructions; and

29.4.3 ensure that the Sub-Contractor is engaged under the terms of a written agreement requiring the Sub-Contractor to comply with obligations that are substantially the equivalent of the obligations imposed on Orthoderm Private Clinic in this clause 29.

29.5 The parties shall indemnify each other against all claims and proceedings and all liability, loss, costs and expenses incurred in connection therewith by the other party as a result of any breach of the DPA and/or the provisions of this clause 29 by the party, its employees, Sub-contractors, and/or agents in connection with the Services.

29.5 This clause 29 shall survive the termination or expiry of the Contract.

30 Freedom of information

30.1 Orthoderm Private Clinic acknowledges :-

30.1.1 the Trust is subject to the requirements of FOIA;

30.1.2 the Contract and any other recorded information held by Orthoderm Private Clinic on the Trust's behalf for the purposes of the Contract is subject to the obligations and commitments of the Trust under FOIA; and

30.2.3 the decision on whether any exemption to the general obligations of public access to information applies to any request for information received under FOIA is a decision solely for the Trust.

30.2 Orthoderm Private Clinic shall use all reasonable efforts to assist the Southern Health and Social Care Trust to comply with such obligations as are imposed on the Southern Health and Social Care Trust by FOIA and the Code of Openness in the NHS ("the Code") including, without limitation:

30.2.1 providing the Southern Health and Social Care Trust with reasonable assistance in complying with any request for information served on the Southern Health and Social Care Trust under the FOIA or the Code including providing copies of all information requested by the Trust within 5 working days and without charge;

30.2.2 processing information provided by the Southern Health and Social Care Trust in accordance with a record management system which complies with the Lord Chancellor's records management recommendations and code of conduct under section 46 of FOIA.

30.3 Where it is not itself subject to FOIA, Orthoderm Private Clinic will not itself respond to any request for information received by it (unless directed by the Trust to do so) and will promptly and in any event within 2 working days transfer the request to the Trust.

30.4 Orthoderm Private Clinic shall indemnify the Southern Health and Social Care Trust against all claims and proceedings and all liability, loss, costs and expenses incurred in connection therewith by the Southern Health and Social Care Trust as a result of any breach of this clause 30 by Orthoderm Private Clinic.

30.5 This clause 30 shall survive the termination or expiry of the Contract.

31. Bribery Prevention Measures

31.1. The Provider warrants and undertakes to the Trust that:

a) It will comply with applicable laws, regulations, codes and sanctions relating to anti-bribery and anti-corruption including but not limited to the Bribery Act 2010 (”Anti-Bribery Law”);

b) It will procure that any person who performs or has performed services for or on its behalf (”Associated Person”) in connection with the Contract complies with this Clause.

c) It will not enter into any agreement with any Associated Person in connection with the Contract, unless such agreement contains undertakings on the same terms as contained in this clause;

d) It has and will maintain in place effective accounting procedures and internal controls necessary to record all expenditure in connection with the Contract;

e) From time to time, at the reasonable request of the Trust, it will confirm in writing that it has complied with its undertakings under clauses 31.1 a) – 31.1 d) and will provide any information reasonably requested by the Trust in support of such compliance;

f) It shall notify the Trust as soon as practicable of any breach of any of the undertakings contained within this clause of which it becomes aware.

31.2 Breach of any of the undertakings in this clause shall be deemed to be a material breach of the Contract for the purpose of clause 36.

32 Confidentiality

32.1 Subject to Clause 32.3 below, and in consideration of the Disclosing Party agreeing to disclose to the Receiving Party Confidential Information for the purpose of the Contract, the Receiving Party hereby agrees:

32.1.1 not to disclose the Confidential Information in any way or form at any time to any third party (and to use all reasonable efforts to prevent such publication or

disclosure) except with the prior written consent of the Disclosing Party;

32.1.2 not to use any Confidential Information for any purpose other than in connection with providing Services under and/or performance of the Contract ("the Purpose"), and in particular, not to use the Confidential Information for the Receiving Party's or a third party's benefit or otherwise to the detriment of the Disclosing Party;

32.1.3 to maintain the confidence of the Confidential Information and, without prejudice to the generality of the foregoing to exercise no lesser security measures and degree of care in relation to the Confidential Information than those which the Receiving Party applies to its own Confidential Information and which the Receiving Party hereby warrants as providing adequate protection against any unauthorised disclosure, copying or use;

32.1.4 not to make any copies or reproductions of any Confidential Information except to the extent reasonably necessary for the purpose and all copies made shall be the property of the Disclosing Party;

32.1.5 to return all Confidential Information including, without limitation, all notes, papers, computer programs, data, documentation, plans, drawings and any copies thereof to the Disclosing Party immediately upon receipt of a written request from the Disclosing Party; and

32.1.6 not to export, re-export or use the Confidential Information or any direct product thereof except:

(a) for the purpose of performing the Contract and in accordance with the terms of the Contract; and

(b) in accordance with all applicable laws and regulations.

32.2 Without prejudice to the generality of Clause 32.1, the parties must not disclose to any person (other than a person

authorised by the other party) any Confidential Information acquired by them in connection with the provision of the Services.

32.3 The obligations in clause 32.1 shall not apply to any Confidential Information:

32.3.1 which is or comes into the public domain in any way other than by breach of the Contract;

32.3.2 which the Receiving Party can show by its written or other records was in its possession prior to receipt from the Disclosing Party and which had not previously been obtained from the Disclosing Party or any other party under an obligation of confidence;

32.3.3 where disclosure of which is required by law (including the FOIA and the DPA, any court of competent jurisdiction or any other appropriate regulatory authority or body) provided that:

(a) the Receiving Party has given the Disclosing Party notice no less than two days in advance of such disclosure; or

(b) where it is not practicable to give such notice no less than two days in advance, the Receiving Party has given such advance notice as is possible;, or

(c) where it is not possible to give advance notice, the Receiving Party gives the notice immediately upon disclosure;

32.3.4 which the Receiving Party obtains or proves that it is able to obtain from a source other than from the Disclosing Party without breaching any obligation of confidence; or

32.3.5 which is disclosed to any employee, agent, contractor, consultant, adviser or insurer of the Receiving Party or to any other person, to the extent that it is necessary for the purpose of performing the Contract provided that the Receiving Party ensures that the person

receiving the Confidential Information is made aware of and agrees to be bound by the terms of this clause 32 as if it were a party hereto, and the Receiving Party shall upon being so requested by the Disclosing Party and at its own expense take such steps as the Disclosing Party may require to enforce such obligations of confidence including (where necessary) the institution of legal proceedings; or

32.3.6 which is disclosed by the HSCB or Southern Health and Social Care Trust to the DHSSPSNI , an HSC body, or another public body for purposes connected with the management and administration of the HSC; or

32.3.7 which is disclosed to the RQIA for purposes connected with the regulation, management and administration of Independent Hospitals.

32.4 Subject to clause 32.1 all rights and title in and to the Confidential Information are reserved to the Disclosing Party and no rights or licences other than those expressly set out herein are granted or are to be implied from the Contract.

32.5 No warranty or representation is given or is to be implied as to the accuracy or completeness of the Confidential Information disclosed to the Receiving Party.

32.6 The Receiving Party will indemnify the Disclosing Party against any losses, damages or costs suffered or incurred by the Disclosing Party as a result (whether direct or indirect) of any breach of this clause 32.

32.7 The parties acknowledge that damages would not be an adequate remedy for any breach of this clause 32 by the Receiving Party and in addition to any right to damages the Disclosing Party shall be entitled to the remedies of injunction, specific performance and other equitable relief for any threatened or actual breach of this clause 32, and no proof of special damages shall be necessary for the enforcement of this clause 32.

32.8 This clause 32 shall survive the termination or expiry of the Contract

33 Corporate governance and compliance

33.1 Orthoderm Private Clinic shall comply and shall secure that its staff comply in all respects with all legislation and all future legislation relevant to the operation of the Contract that occurs during the term of the Contract (notwithstanding that the obligations therein may be stricter than in this Contract in which event the legislative obligations take precedence)

33.2 Orthoderm Private Clinic shall indemnify the HSCB Southern Health and Social Care Trust against all claims and proceedings and against all liability, loss, costs and expenses incurred in connection therewith made or brought by any person under equality legislation or any other relevant enactment relating to discrimination in employment in consequence of or in any way arising out of the provision of the Services pursuant to the Contract or otherwise in connection with any act or omission of Orthoderm Private Clinic under the provisions of the Contract.

33.3 Where the Provider, in the opinion of the HSC organisation acting reasonably, fails to deliver the services or part thereof to a standard which is fully in compliance with the contract, this will be regarded as Unsatisfactory Performance.

33.4 Unsatisfactory Performance may include the following (this list is not exhaustive)

33.4.1 failure by Orthoderm Private Clinic to comply with the Quality Standards, the Performance Targets and waiting list times or other provisions set out in the Service Specification;

33.4.2 failure by Orthoderm Private Clinic to provide the volume of activity agreed;

33.4.3 where the level of patient complaints gives cause for concern about the quality of the Services being provided under the Contract;

33.4.4 intervention by the relevant Regulatory Body directly affecting or in the reasonable opinion of the Southern Health and Social Care Trust likely to affect the ability

of the Orthoderm Private Clinic to provide any of the Services specified in the Contract;

33.4.5 failure by Orthoderm Private Clinic to discharge any of its other obligations under the Contract.

33.5 Where Unsatisfactory Performance is identified the Trust may do one or more of the following:

33.5.1 The Trust will bring such Unsatisfactory Performance to the attention of the Provider in writing requiring the Unsatisfactory Performance to be dealt with in a manner described by the HSC organisation.

33.5.2 Where the HSC organisation considers it appropriate, it may issue a Performance Notice in the form set out in Schedule 5 to the Provider setting out the details of the Unsatisfactory Performance, a timescale for rectification and any implications of any failure to rectify the Unsatisfactory Performance in full or in part or to a standard required by the Trust.

33.5.2.1 If the Provider receives a Performance Notice under the terms of the contract it must issue to the Trust, within the timescale specified within the Performance Notice, a Remedial Action Plan setting out how it proposes to rectify the Unsatisfactory Performance as detailed in the Performance Notice.

33.5.2.2 If the Provider's remedial action fails to remedy the Unsatisfactory Performance to the satisfaction of the Trust and the Performance Notice is not in respect of a material breach, the Trust may issue a further Performance Notice.

33.5.2.3 Accumulation of 5 (five) Performance Notices not in respect of material breach within any rolling 12 month period may of itself be considered to be a material breach of the Providers obligations.

33.5.2.4 If the Provider has committed any material breach of its obligations under the contract and has not

remedied that material breach within the timescale given within the Performance Notice then one or more of the following may occur:

33.5.2.4.1 Up to 100% of the sums payable under the contract may be withheld until the remedies specified in the Performance Notice and/or Remedial Action Plan have been implemented, and no interest shall be payable to the Provider on any sum withheld under this clause unless it can be established that the money was withheld unjustifiably or

33.5.2.4.2 The contract may be suspended or terminated in whole or in part

33.6 Where the Trust has already made payment to the Provider with respect to the services which constituted Unsatisfactory Performance whether material or non-material, the HSC organisation may request that such payments be reimbursed to the Trust within 30 (thirty) days from request and the Provider must comply with any such request or the Trust may deduct the payment from future payments or

33.7 Suspend all or part of the contract or

33.8 Terminate all or part of the contract either immediately or on a date as notified by the Trust if the Unsatisfactory Performance is in the opinion of the Trust of a serious nature to warrant the same.

33.9 If the Orthoderm Private Clinic receives a Performance Notice under the terms of the Contract it must issue to the Southern Health and Social Care Trust, within the timescale specified in the Performance Notice, a remedial action plan ("Remedial Action Plan") setting out how it proposes to rectify the subject matter of the Performance Notice within a reasonable timescale. The parties shall then meet as soon as possible to agree the Remedial Action Plan. In the event that the Provider fails to comply with the Remedial Action Plan or fails to rectify the subject matter of the Remedial Action Plan within the

agreed timescale, the Trust shall then be entitled to exercise its rights under clause 33.6.

33.10 If the Orthoderm Private Clinic has committed any material breach of its obligations under the Contract and has not remedied that breach within the timescale given within the Performance Notice then up to 20% of the monthly sums payable under the Contract in each month may be withheld until the remedies specified in the Performance Notice and/or Remedial Action Plan have been implemented, and no interest shall be payable to Orthoderm Private Clinic on any sum withheld under this clause 33.6 unless it can be established that the money was withheld unjustifiably.

34 Insurance and liability

34.1 Without prejudice to its liability for breach of any of its obligations under the Contract, the Orthoderm Private Clinic shall be liable to HSCB and Southern Health and Social Care Trust for, and shall indemnify and keep HSCB and Southern Health and Social Care Trust fully indemnified against:

34.1.1 any loss, damages, costs, expenses, liabilities, claims, actions and/or proceedings (including the cost of legal and/or professional services) whatsoever in respect of:-

34.1.1.1 any loss of or damage to property (whether real or personal); and

34.1.1.2 any injury to any person, including injury resulting in death; and

34.1.2 any Losses of the Southern Health and Social Care Trust that result from or arise out of the negligence or breach of Contract of the Orthoderm Private Clinic or the Staff, servants or agents or Sub-contractors of the Orthoderm Private Clinic in connection with the performance of the Contract or the provision of the Services including (without limitation) the Orthoderm Private Clinic use of Goods or other materials or products or the actions or omissions of the Staff, servants or agents or Sub-contractors of Orthoderm Private Clinic in the provision of the Services, except insofar as such loss, damage or injury has been caused by any act or

omission by, or on the part of, or strictly in accordance with the express instructions of the Southern Health and Social Care Trust, or its employees.

34.2 For the avoidance of doubt, the indemnity under clause 34.1 shall apply in full where any claim whether for clinical negligence or otherwise has been settled by HSCB or Southern Health and Social Care Trust provided that Orthoderm Private Clinic was notified of the claim within 28 days of its receipt by HSCB or Southern Health and Social Care Trust and HSCB or Southern Health and Social Care Trust obtained legal advice before settlement of the said claim.

34.3 The Orthoderm Private Clinic shall put in place and maintain in force and shall procure that each of its Sub-contractors put in place and maintain in force throughout the duration of the Contract at their own cost policies of insurance in respect of:- 34.3.1 employers' liability; 34.3.2 clinical negligence;34.3.3 public liability; and 34.3.4 professional negligence and any other insurance policy which is appropriate for the Services provided under the Contract (together the "Insurance Policies"). The Insurance Policies must be sufficient to meet all the potential liabilities of the Orthoderm Private Clinic under the Contract. The Insurance Policies shall have the interest of the HSCB and Southern Health and Social Care Trust endorsed upon them or shall otherwise expressly by their terms confer their benefits upon the HSCB and Southern Health and Social Care Trust as loss payees. Each such policy shall in any event have minimum cover of £5 Million in respect of any one claim or incident.

34.4 Orthoderm Private Clinic shall where requested by Southern Health and Social Care Trust upon the commencement of the Contract and in any event within 5 working days of a written request from, Southern Health and Social Care Trust provide documentary evidence to Southern Health and Social Care Trust that the Insurance Policies required under clause 35.3 are fully maintained and that any premiums due on foot of such policies are fully paid.

34.5 For the avoidance of doubt, Orthoderm Private Clinic and its Sub-contractors shall be liable to make good any deficiency in the event that the proceeds of any Insurance Policy are

insufficient to cover the settlement of any claim relating to the Contract or the insurer refuses to indemnify the Orthoderm Private Clinic or its Sub-contractors for any reason whatsoever.

34.6 The Orthoderm Private Clinic warrants that it shall ensure and that it shall procure that its Sub-Contractors ensure that the Insurance Policies required under clause 34.3 are not rendered void, voidable, unenforceable, or suspended or impaired in whole or in part and that the Insurance Policies remain valid at all relevant times.

34.7 Upon the expiry or termination of the Contract, the Orthoderm Private Clinic shall (and shall use its reasonable endeavours to procure that each of its Sub-contractors shall) procure that any ongoing liability it has or may have in negligence to any HSC Patient or Southern Health and Social Care Trust arising out of the care and treatment of a HSC Patient under the Contract shall continue to be covered by a valid and extant insurance policy for the period of 21 years from termination or expiry of the Contract save where it is reasonably considered that such liability has ceased to exist at an earlier date.

34.8 In connection with the Services, unless the Southern Health and Social Care Trust and the Orthoderm Private Clinic otherwise agree in writing, Orthoderm Private Clinic shall not require or request, and shall ensure that no other person shall require or request, any HSC Patient to sign any document whatsoever containing any waiver of the liability of the Orthoderm Private Clinic to that HSC Patient.

34.9 The Trust shall be liable for and shall indemnify Orthoderm Private Clinic against any loss, damages, costs, expenses, liabilities, claims, actions and/or proceedings (including the cost of legal and/or professional services) whatsoever in respect of

34.9.1 any loss of or damage to property (whether real or personal); and

34.9.2 any injury to any person, including injury resulting in death;

that result from or arise out of the negligence or breach of Contract of the Southern Health and Social Care Trust in connection with the performance of the Contract or the actions or omissions of the employees or agents of Southern Health and Social Care Trust, except insofar as such loss, damage or injury has been caused by any act or omission by, or on the part of Orthoderm Private Clinic its employees, agents or Sub-contractors.

34.10 Orthoderm Private Clinic shall indemnify the HSCB and Southern Health and Social Care Trust against any Employment Claim brought against Southern Health and Social Care Trust at any time by any person in respect of their employment or engagement by Orthoderm Private Clinic in connection with the provision of the Services under the Contract. For the purposes of this clause, "Employment Claim" shall mean any action, proceedings or claim alleging breach of contract, loss of office, unfair dismissal, redundancy, loss of earnings, discrimination or otherwise and all other damages, penalties, awards, legal costs, expenses and any other liabilities incurred by Southern Health and Social Care Trust in connection with such an action, proceedings or claim.

34.11 Nothing in the Contract shall exclude or limit the liability of either Party for death or personal injury caused by the negligence of that party or for fraud or fraudulent misrepresentation.

34.12 Each Party shall at all times take all reasonable steps to minimise and mitigate any loss for which one Party is entitled to bring a claim against the other pursuant to the Contract.

34.13 This clause 34 shall survive the termination or expiry of the Contract. Orthoderm Private Clinic shall retain all documentation relevant to this clause 34 and the insurance policies referred to in this clause for a minimum of 21 years from the date of termination of this Contract.

35 Dispute resolution procedure

35.1 Except where expressly provided otherwise in the Contract and other than in relation to any matter in which the Southern Health and Social Care Trust has a discretion which is exercised in accordance with the terms of the Contract and

which shall be final and conclusive, if any dispute arises out of the Contract the parties will use all of their respective endeavours to resolve it by negotiation between the Authorised Officer and the Contract Manager, negotiating in good faith.

35.2 If after 20 Business Days, the dispute has not been resolved, either Party may refer the matter to more senior personnel within each organisation to attempt to resolve, negotiating in good faith.

35.3 If after 20 Business Days, these further negotiations fail to resolve such dispute the parties will attempt to settle it by mediation with a mutually agreed independent mediator and if the Parties to the Contract do not agree on the identity of the mediator and still wish to proceed with the mediation then either Party shall request the Law Society of Northern Ireland to appoint a mediator and the outcome of such mediation shall be binding.

36 Termination

36.1 Either party may terminate the Contract at any time on one month's written notice to the other.

36.2 Either party shall be entitled to terminate the Contract forthwith by written notice to the other (the "Defaulting Party") if:

36.2.1 the Defaulting Party shall fail to make any payment due under the Contract and such failure is not remedied within 30 (thirty) days of receipt of a notice from the other party requiring payment to be made; or

36.2.2 the Defaulting Party is in material breach of the Contract and, where the breach is capable of remedy, such failure has not been remedied within 30 (thirty) days of receipt of a Performance Notice from the other party pointing out the breach and requesting its remedy; or

36.2.3 an Event of Force Majeure persists for more than 30 (thirty) working days without the parties agreeing alternative terms pursuant to clause 39.

36.3 The Southern Health and Social Care Trust shall be entitled to terminate the Contract forthwith by written notice to Orthoderm Private Clinic if:

36.3.1 Orthoderm Private Clinic passes a resolution for winding up (otherwise than for the purposes of a solvent amalgamation or reconstruction) or a court makes an order to that effect; or

36.3.2 Orthoderm Private Clinic ceases to carry on its business or substantially the whole of its business; or

36.3.3 Orthoderm Private Clinic becomes or is declared insolvent, or convenes a meeting of or makes or proposes to make any arrangement or composition with its creditors; or

36.3.4 if a liquidator, receiver, administrator, administrative receiver, manager, trustee or similar officer is appointed over any of its assets; or

36.3.5 if circumstances shall arise that entitle the courts or a creditor to appoint an administrative receiver, or which entitle the courts to make a winding-up order or administration order; or

36.3.6 Orthoderm Private Clinic's registration under the Independent Healthcare Regulations (Northern Ireland) 2005 (or other comparable legislation for Orthoderm Private Clinic's country of origin) is revoked or amended such that Orthoderm Private Clinic is no longer able to provide (whether temporarily or permanently) any or all of the Services; or

36.3.7 Orthoderm Private Clinic is convicted of any offence in relation to the provision of the Services; or

36.3.8 Orthoderm Private Clinic is convicted of any offence under the Independent Healthcare Regulations (Northern Ireland) 2005 (or other comparable legislation for Orthoderm Private Clinic 's country of origin); or

36.3.9 there is a change of ownership or control of Orthoderm Private Clinic ;

provided always that such termination shall not prejudice or affect any right of action or remedy that shall have accrued or shall accrue thereafter to either party.

36.4 Without prejudice to any other right or remedy of the parties, if:

36.4.1 Orthoderm Private Clinic does not provide the Services at the times or within the timescales specified in the Service Specification (if any) or as agreed between the Southern Health and Social Care Trust and Orthoderm Private Clinic from time to time; or

36.4.2 Orthoderm Private Clinic does not treat the volume of HSC Patients as set out in the Service Specification or as agreed to be treated from time to time, provided that if the agreed volume (if any) of HSC Patients are not referred, any shortfall in the numbers of HSC Patients referred shall be deemed to have been treated; or

36.4.3 Orthoderm Private Clinic does not provide the Services in accordance with the provisions of the Contract or as agreed between the Southern Health and Social Care Trustand Orthoderm Private Clinic from time to time; or

36.4.4 any Goods supplied by Orthoderm Private Clinic are found to be affected by any form of contamination, infection, disease or any other defect or disorder whatsoever which affects or may affect the provision of the Services, or differ in any material way from the requirements of the Contract;, or

36.4.5 any clinical treatment or procedure performed as part of the Services fails to any material extent by reason of any act, default or omission of Orthoderm Private Clinic or anyone else involved in or employed or engaged by Orthoderm Private Clinic in the provision of the Services which is not the result of any action or inaction required by or carried out by or at the request of the Southern Health and Social Care Trust.

the Southern Health and Social Care Trust may without prejudice to any other right or remedy:

(a) require Orthoderm Private Clinic to provide or provide again (as the case may be) without further charge to the Southern Health and Social Care Trust the Services in accordance with the terms of the Contract within such reasonable time as the Southern Health and Social Care Trustmay specify;

(b) without terminating the whole of the Contract terminate the Contract in respect of part of the Services only and thereafter provide or procure the provision of such part of the Services itself;

(c) itself provide or procure the provision of the Services until it is satisfied that Orthoderm Private Clinic is able to carry out the Services in accordance with the Contract;

(d) terminate the Contract.

36.5 If, pursuant to clause 36.5 or as a result of terminating the Contract in pursuance of its rights under clauses 36.2 or 36.3, the Southern Health and Social Care Trust:

36.5.1 procures the Services or part of them from an alternative supplier; or

36.5.2 executes the Services or part of them itself;

then, where the cost to the Southern Health and Social Care Trust of procuring such Services from an alternative supplier or executing such Services itself exceeds the amount that would have been payable to Orthoderm Private Clinic for providing the same Services, the Southern Health and Social Care Trust shall be entitled to recover from Orthoderm Private Clinic such excess together with all reasonable administration costs in addition to any other sums payable by Orthoderm Private Clinic to the Southern Health and Social Care Trust in respect of any termination or pursuant to clause 36.4.

36.6 Termination of the Contract for any reason shall not affect any rights or liabilities which have accrued prior to the date of termination.

36.7 This clause 36 shall survive the termination or expiry of the Contract as shall any other provision expressly stated to so survive or which is required to survive by necessary implication.

37 Consequences of expiry or termination

37.1 Upon the expiry or termination of the Contract:

37.1.1 the Southern Health and Social Care Trust shall use all reasonable endeavours to ensure that no further HSC Patients are referred to Orthoderm Private Clinic ;37.1.2Orthoderm Private Clinic shall immediately cease its treatment of HSC Patients unless:

(a) the parties agree having taken into account any relevant clinical advice that it would be impractical to cease any or all of such treatments; or

(b) the parties agree having taken into account any relevant clinical advice that the treatment of any HSC Patient should not so cease; or

(c) where, in accordance with Clause 37.2 and Clause 37.3, it would be clinically inappropriate to cease any or all of such treatments in the reasonable opinion of either party.

37.2 Where in the reasonable opinion of Orthoderm Private Clinic having taken into account any relevant clinical advice it is not clinically appropriate immediately to cease the treatment of an HSC Patient Orthoderm Private Clinic shall promptly and in any event within 24 (twenty four) hours notify the Southern Health and Social Care Trust of its decision giving reasons and Orthoderm Private Clinic shall continue to treat such HSC Patient in accordance with the terms and conditions of the Contract unless the Southern Health and Social Care Trust notifies Orthoderm Private Clinic that the treatment of such HSC Patient must cease.

37.3 Where in the reasonable opinion of the Southern Health and Social Care Trust having taken into account relevant clinical advice it would not be clinically appropriate immediately to cease the treatment of an HSC Patient, or pending any such

cessation, Orthoderm Private Clinic shall continue to treat HSC Patients in accordance with the terms of the Contract until either the treatment finishes or the Southern Health and Social Care Trust determines it is clinically appropriate to stop such treatment and the Southern Health and Social Care Trust shall pay for the provision of such Services at the rates in force in the Schedule of Fees prior to the termination or expiry of the Contract.

37.4 The parties shall use all reasonable endeavours to minimise any inconvenience caused to or likely to be caused to HSC patients or prospective HSC Patients as a result of the expiry or termination of the Contract.

37.5 Any rights, duties or obligations of either party which are expressed in the Contract to survive the expiration or termination of the Contract, together with all indemnities, shall continue after termination of the Contract takes effect and the parties shall remain liable to each other for breach thereof in accordance with the general law, subject to such limitations of liability as are provided in the Contract which shall continue in effect post termination.

38 Notices

38.1 Any notices required to be given under the Contract must be in writing and may be served by personal delivery, post (special or recorded delivery or first class post), electronic mail or facsimile at the address set out at the beginning of the Contract or at such other address as each party may give to the other for the purpose of service of notices under the Contract.

38.2 Notices shall be deemed to be served at the time when the notice is handed to or left at the address of the party to be served (in the case of personal delivery) or the day (not being a Saturday, Sunday or public holiday) next following the day of posting (in the case of notices served by post) or at 10 a.m. on the next day (not being a Saturday, Sunday or public holiday) following despatch if sent by facsimile transmission.

38.3 To prove service of a notice, it shall be sufficient to show in the case of a notice delivered by hand that the same was duly

addressed and delivered by hand and in the case of a notice served by post that the same was duly addressed prepaid and posted special or recorded delivery or by first class post. In the case of a notice given by facsimile transmission, it shall be sufficient to show that it was despatched in a legible and complete form to the correct telephone number without any error message on the confirmation copy of the transmission.

38.4 Notices sent by electronic mail shall be deemed to be served 4 hours after sending, provided the email is not returned undelivered, or sooner where the other Party acknowledges receipt of such email.

39 Force Majeure

39.1 The following events shall be events of force majeure ("Events of Force Majeure"):-

39.1.1 war, civil war, conflict or terrorist attack arising within and affecting the United Kingdom;

39.1.2 nuclear, chemical or biological contamination of Orthoderm Private Clinic 's property arising from any of the events at clause 39.1.1 above;

39.1.3 strikes or lock outs beyond Orthoderm Private Clinic 's reasonable control;

39.1.4 riot, flood or earthquake.

39.2 If an Event of Force Majeure occurs during the Contract Period which directly causes a party to be materially prevented or delayed in the performance of any of its obligations hereunder, the parties may agree in writing such terms as are appropriate for the continued performance of the Contract. If no such terms are agreed within 30 (thirty) working days of the commencement of such Event of Force Majeure, and such Event of Force Majeure is continuing or its consequence remains such that Orthoderm Private Clinic is materially prevented or delayed in the performance of its obligations the parties may agree that the Contract shall terminate, subject to the provisions of clause 36. Failure by Orthoderm Private Clinic to comply with its contractual obligations by reason of an Event of Force Majeure shall not

constitute breach of contract. Nothing in this clause shall limit the obligations of the Provider to use its best endeavours to fulfill its obligations under the Contract.

40 Third party rights

40.1 A person who is not a party to the Contract has no right under the Contracts (Rights of Third Parties) Act 1999 to enforce or enjoy the benefit of this Contract, however to the extent that it applies in its favour, it may be enforced by HSCB. Except insofar as is stated in this clause 40, the Contract is intended and agreed to be solely for the benefit of Orthoderm Private Clinic the HSCB and Southern Health and Social Care Trust and no third party shall acquire any benefit, claim or rights of any kind whatsoever pursuant to, under, by or through the Contract.

40.2 No variation to the Contract and no supplemental or ancillary agreement to the Contract shall create any such rights unless expressly so stated in any such agreement by the parties to the Contract. This does not affect any right or remedy of a third party which exists within statute.

41 Waiver

41.1 The rights and remedies of either party in respect of the Contract shall not be diminished, waived or extinguished by the granting of any indulgence, forbearance or extension of time by such party to the other nor by failure of, or delay by the said party in ascertaining or exercising of any such rights or remedies or in insisting upon strict performance of any provision of the Contract. The waiver by either party of any breach of the Contract shall not prevent the subsequent enforcement of any subsequent breach of that provision and shall not be deemed to be a waiver of any subsequent breach of that or any other provision.

41.2 No waiver of any provision of the Contract shall be effective unless it is agreed by both parties in writing.

42 Entire Agreement

42.1 The Contract constitutes the entire agreement and understanding of the parties and supersedes any previous

contract or agreement between the parties relating to the subject matters of the Contract.

42.2 Each of the parties acknowledges and agrees that in entering into the Contract it does not rely on and shall have no remedy in respect of any statement, representation, warranty or understanding (whether negligently or innocently made) of any person (whether party to the Contract or not) other than as expressly set out in the Contract as a warranty.

42.3 Nothing in this clause shall exclude any liability for fraud or any fraudulent misrepresentation.

43 Severability

43.1 If at any time any part of the Contract (including any one or more of the clauses of the Contract or any sub-clause or paragraph or any part of one or more of these clauses) is held to be or becomes void or otherwise unenforceable for any reason under applicable law, the same shall be deemed omitted from the Contract and the validity and/or enforceability of the remaining provisions of the Contract shall not in any way be affected or impaired as a result of that omission.

44 Assignment, Sub-contractors etc

44.1 Save as is reasonably required to fulfil the terms of the Contract (including without limitation Orthoderm Private Clinic 's right to provide the Services using clinical and non-clinical staff engaged by Orthoderm Private Clinic (including agency nurses)) neither Orthoderm Private Clinic nor the Southern Health and Social Care Trust shall assign, delegate, sub-contract, transfer, charge or otherwise dispose of all or any of its rights or obligations under the Contract without the prior written consent of the other party such not to be unreasonably withheld or delayed.

44.2 Orthoderm Private Clinic shall at all times be fully responsible for the acts and omissions of its Sub-contractors and other persons engaged by it in the provision of the Services under the Contract (including for the avoidance of doubt any individuals provided by locum or other agencies whose services Orthoderm Private Clinic uses) as if such act or

omission had been omitted or committed by Orthoderm Private Clinic itself and shall procure that such Sub-contractors and other persons shall abide by the terms of the Contract as if they were a party hereto.

44.3 Any positive obligation or duty on the part of Orthoderm Private Clinic under the Contract includes an obligation or duty to ensure that all Sub-Contractors comply with that positive obligation or duty. Any negative duty or obligation on the part of Orthoderm Private Clinic under the Contract includes an obligation or duty to ensure that all Sub-Contractors comply with that negative obligation or duty.

44.4 The Contract shall be binding on and shall endure to the benefit of Orthoderm Private Clinic and the Southern Health and Social Care Trust and their respective successors and permitted transferees and assigns.

45 Exclusion of partnership

45.1 Nothing in the Contract shall create, or be deemed to create, a partnership or joint venture or relationship of employer and employee or principal and agent between the parties.

46 Remedies

46.1 Save as may be expressly set out in the Contract, no remedy conferred by any provision of the Contract is intended to be exclusive of any other remedy and each and every remedy shall be cumulative and shall be in addition to every other remedy given hereunder or existing at law or in equity, by statute or otherwise.

46.2 Neither the expiration nor the termination of the Contract shall prejudice or affect any right of action or remedy which shall have accrued or shall thereafter accrue either to the Southern Health and Social Care Trust or to Orthoderm Private Clinic .

47 Inducements to purchase

47.1 Orthoderm Private Clinic shall not offer to the Southern Health and Social Care Trust or its representatives as a variation of the Contract or as an agreement collateral to it, any advantage other than a cash discount against the fees.

47.2 The Southern Health and Social Care Trust shall be entitled to terminate the Contract and to recover from Orthoderm Private Clinic the amount of any loss resulting from such termination in the following circumstances:

47.2.1 if Orthoderm Private Clinic shall have offered or given or agreed to give to any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do, or for having done or forborne to do, any action in relation to the obtaining or execution of their Contract or any other contract with the Southern Health and Social Care Trust or any HSC body, or for showing or forbearing to show favour or disfavour to any person in relation to the Contract or any other contract with the Southern Health and Social Care Trust or any HSC body;

47.2.2 if the like acts shall have been done by any person employed by it or acting on its behalf (whether with or without the knowledge of Orthoderm Private Clinic);

47.2.3 if in relation to the Contract or any other contract with the Southern Health and Social Care Trust or any HSC body, the Orthoderm Private Clinic or any person employed by it or acting on its behalf shall have given any fee or reward to any officer of the Southern Health and Social Care Trust or any other HSC body which shall have been exacted or accepted by such officer under colour of his office or employment and is otherwise than such officer's proper remuneration.

48 Publicity

48.1 Orthoderm Private Clinic shall not make any public statement relating to the existence or performance of the Contract without the prior written consent of the Southern Health and Social Care Trust save where it may be required to do so in compliance with any legal obligation (other than a contractual obligation).

49 Service variations and additional services

49.1 The Southern Health and Social Care Trust may at any time on at least 1 (one) month's written notice request that Orthoderm Private Clinic implements any variation of or addition to the Services. Such notice shall give details of the required variation or addition and the date on which it is to take effect. Without restricting the Southern Health and Social Care Trust in any way from requiring Orthoderm Private Clinic to implement any variation or addition, the Southern Health and Social Care Trust will take due account of any representations made by Orthoderm Private Clinic concerning such addition or variation, but Orthoderm Private Clinic agrees to comply with such variation or addition to the satisfaction of Southern Health and Social Care Trust unless:

49.1.1 the proposed variation or addition materially adversely affects the health and safety of any person, or gives rise to a breach of law; or

49.1.2 the Southern Health and Social Care Trust unreasonably refuses to give effect to any necessary and unavoidable adjustment to the Fees which arises as a direct result of such variation or addition (but for no other reason whatsoever); or

49.1.3 such variation or addition is not reasonably ancillary to the Services and/or within Orthoderm Private Clinic 's capabilities or competencies as a supplier of the Services.

49.2 For the avoidance of doubt if Orthoderm Private Clinic is unwilling or unable to provide any requested additional service on terms acceptable to the Southern Health and Social Care Trust, the Southern Health and Social Care Trust may place the additional service with a third party service provider and the continuation of the Contract shall not be affected.

49.3 Orthoderm Private Clinic may at any time request that the Southern Health and Social Care Trust consider whether to request a variation or addition to the Services.

50 Non-solicitation

50.1 During the life of the Contract none of the parties to the Contract shall for the purpose of fulfilling its obligations under the Contract:

50.1.1 solicit any medical, nursing or other clinical staff employed by the parties, with a view to that person being engaged or employed by the either party without the other party's express prior consent, such consent not to be unreasonably withheld; or

50.1.2 entice or encourage or endeavour to entice or encourage any medical, nursing or other clinical professional to reduce their working hours with the other party.

50.2 The parties shall not be considered to be in breach of its obligations in clauses 50.1.1 and 50.1.2 where an individual becomes an employee of, or engaged by, Orthoderm Private Clinic as a result of a response by that individual to an advertisement placed by or on behalf of either party for the recruitment of clinical or nursing staff or consultants and where it is apparent from the wording of the advertisement, the manner of its publication or otherwise that the principal purpose of the advertisement was equally likely to attract applications from individuals who were not employees of either party.

50.3 Orthoderm Private Clinic shall notify the Southern Health and Social Care Trust of any substantive increase or proposed increase in the number of Staff employed or engaged by Orthoderm Private Clinic where such increase is wholly or mainly required or designed to enable Orthoderm Private Clinic to meet its obligations under the Contract or the Contract together with any other or any other agreement or agreements with the Southern Health and Social Care Trust or any other HSC body to treat HSC Patients

51 Governing law and jurisdiction

51.1 The Contract shall be considered as a Contract made in Northern Ireland and shall be subject to the laws of Northern Ireland.

51.2 Subject to the provisions of clause 35 (Dispute Resolution) of the Contract, both parties agree that the courts of Northern Ireland shall have exclusive jurisdiction to hear and settle any action, suit, proceeding or dispute in connection with the Contract.

IN WITNESS WHEREOF the parties have signed this Contract on the date first shown above.

SIGNED for Southern Health and Social Care Trust

---------- Date ----------
Shane Devlin, Chief Executive

SIGNED for Orthoderm Private Clinic Ltd

---------- Date ----------
Andrea Pollock, Manager

SCHEDULE 1 Fee Schedule / Price List

Service Area(s):

Outpatient Urology Oncology Reviews	Contract ID: SHSCT 24/01: 20/21

Provider	**Patient Type**			**Cost (£)** per patient
Orthoderm Private Clinic	Outpatient	Inpatient / Daycase	Other	
Number of Cases			236	

Diagnostic/Investigations	
Nominated Consultants / Health Professional Staff	
To be advised	

***** Note: Clinicians listed above must be approved by Southern Health and Social Care Trust prior to commencing treatment of patients under this contract***

Please specify all Service Delivery Location(s) for this contract work
Orthoderm Private Clinic Hillsborough

Price list below contains the prices to be applied

The prices listed below include all costs anticipated for the completion of the procedures.

Orthoderm Private Clinic
Price List – Outpatient Urology Oncology Reviews

Pre-operative Assessment / Diagnostics
Providers identify the price of diagnostics including reporting consumables and laboratory tests.

Service	Price Per Patient (£)
Outpatient Urology Oncology Reviews	Commercially Sensitive Information redacted by the USI.

Notes:

The procedures above are representative of the case mix but not exhaustive.

In the event of an outpatient assessment / diagnostic investigation / procedure being identified as required which is not outlined in the referral or listed above, Orthoderm Private Clinic must seek prior approval from the Trust (See Point 3.2.4 in Service Specification for further information).

In instances where no price is listed, SHSCT will not pay in excess of regional tariff.

SCHEDULE 2 ADVERSE INCIDENT REGISTER

Adverse Incident (AI) Register for Contract ID: SHSCT 24/01: 20/21
Date:

AI No	Patient ID	Patient Name	Patient Address	Date of Incident	Nature of Incident	Time/Date notified to Board (NB- within 24 hrs)	Action taken	Comments/Current status

The register to be e-mailed each week to the HSCB Commissioning Directorate by using email: adverse.incidents@hscni.net and Southern Health and Social Care Trust using email:

Personal Information redacted by the USI

SAI Criteria

The following criteria will be used by the Trust to determine whether or not an Adverse Incident constitutes a Serious Adverse Incident (SAI).

SAI criteria

- Serious injury to, or the unexpected/ unexplained death of:
    - A service user (including those events which would be reviewed through a significant audit event)
    - A staff member in the course of their work
    - A member of the public whilst visiting an HSC facility.
- Any death of a child in receipt of HSC services (up to eighteenth birthday). This includes hospital and community services, a looked after child or a child whose name is on the Child Protection Register;
- Unexpected serious risk to a service user and/or staff member and/or member of the public;
- Unexpected or significant threat to provide service and/or maintain business continuity;
- Serious self harm or serious assault (including homicide and sexual assaults)
    - On other service users
    - On staff or
    - On members of the public

  by a service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and known to/referred to mental health and related services (includes CAMHS, psychiatry of old age or leaving and aftercare services) and or learning disability services, in the 12 months prior to the incident;
- suspected suicide of a service user who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and known to/referred to mental health and related services (includes CAMHS, psychiatry of old age or leaving and aftercare services) and or learning disability services, in the 12 months prior to the incident;
- serious incidents of public interest of concern relating to:

- any of the criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner.

[1] Source DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse__incidents_and_risk_-_guidance.pdf

SCHEDULE 3 Summary of Patient Access

Booking Process

The Northern Ireland health system has been working to develop good practice guidelines for patient access. Independent Sector Providers are expected to ensure systems and processes are developed in line with these guidelines.

In particular, Orthoderm Private Clinic are expected to ensure reasonable notice and choice of appointment dates are given to HSC Patients. A reasonable offer is defined as one which gives the patient a minimum of 3 weeks' notice and a choice of 2 appointment dates.

The attached flowchart (Diagram 1) describes the booking process to facilitate delivery of these standards.

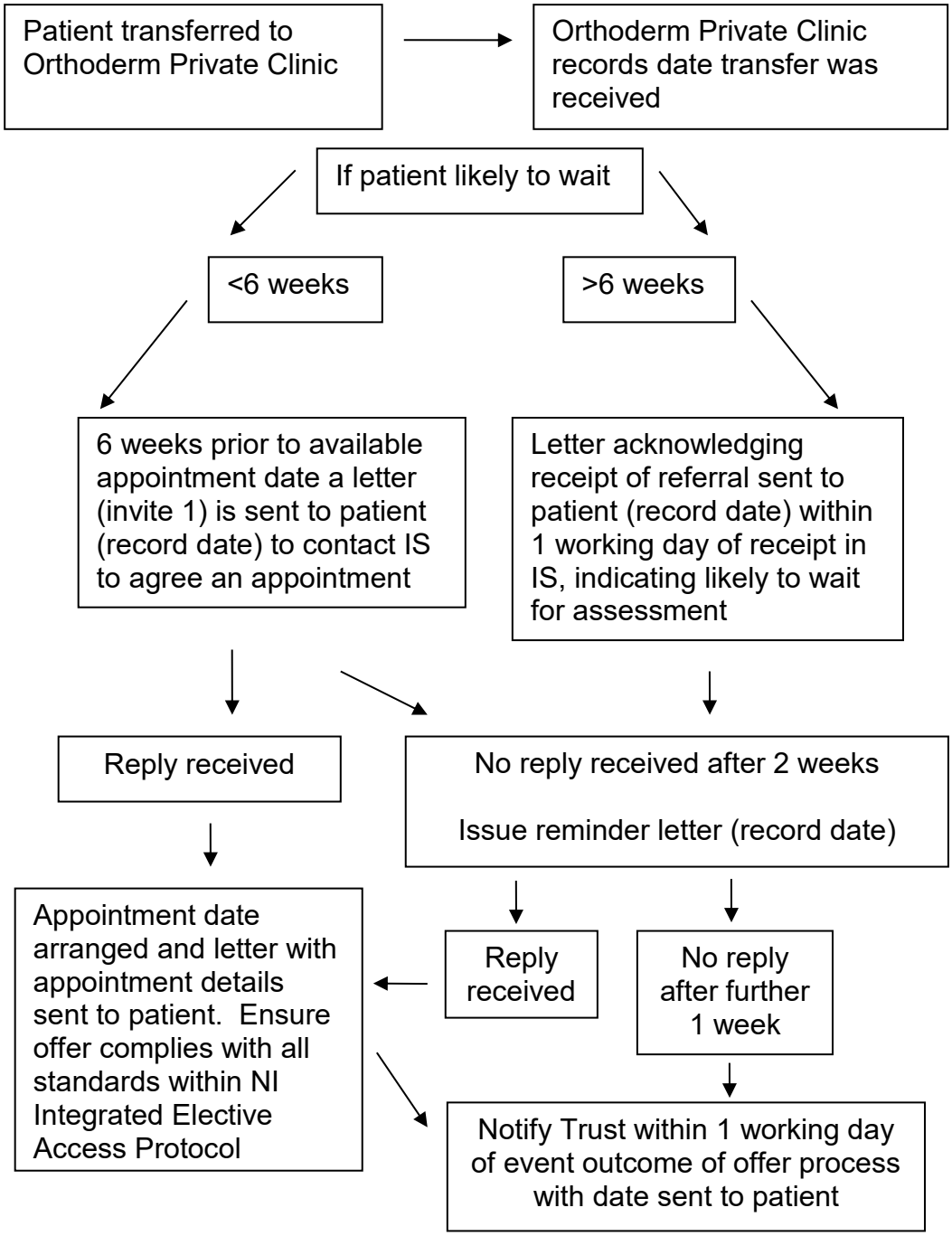
Orthoderm Private Clinic may also contact HSC Patients by telephone to arrange their appointment/ admission dates. Where they are unable to contact the HSC Patient by phone, the letter based booking process should be implemented. In the case of all booking systems, whether letter or telephone, Independent Sector Providers should clearly document both the verbal and written processes, including all dates offered/ refused and the relevant outcomes. This information should be communicated to HSC Trusts in line with Contract requirements to facilitate robust management of HSC Patients in line with the IEAP.

Orthoderm Private Clinic are expected to notify HSC Trusts of event outcomes within 1 working day and Trusts will then follow the standards contained in the IEAP with regard to the management of HSC Patients who either attend or fail to attend their appointments.

In relation to HSC Patients who have negotiated a date, and subsequently cancel, Orthoderm Private Clinic are expected to re-negotiate one further date with HSC Patients. If a second appointment date is cancelled, Orthoderm Private Clinic should inform Trusts within 1 working day. Orthoderm Private Clinic need to track events, including appointment dates offered to HSC Patients.

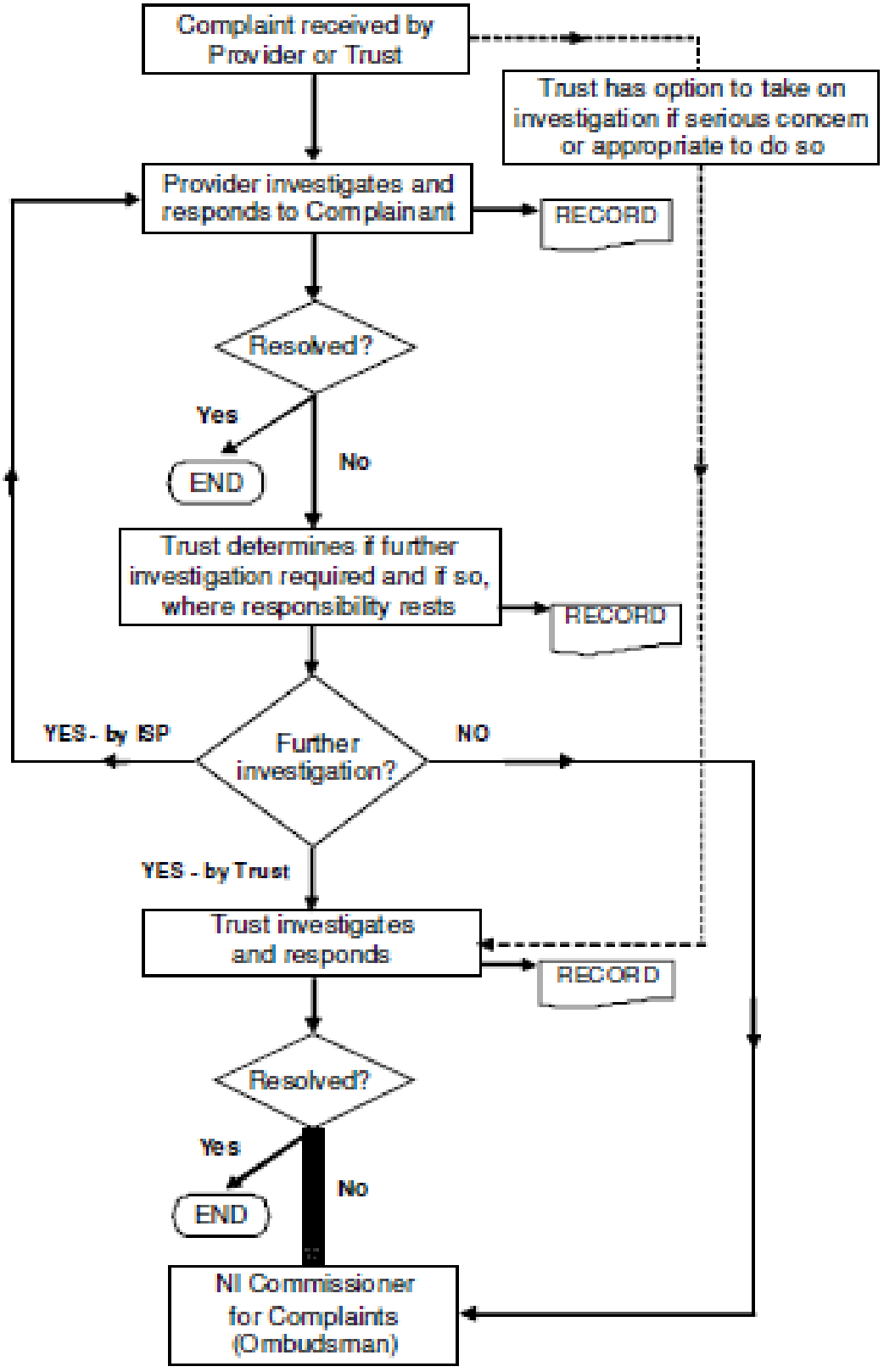
Diagram 1

PARTIAL BOOKING PROCESS – FLOWCHART FOR BOOKING TRANSFERRED PATIENT TO ORTHODERM PRIVATE CLINIC



SCHEDULE 4 Complaints Process

INDEPENDENT SECTOR PROVIDER (ISP) COMPLAINTS FLOWCHART



Independent Sector Complaints Report Proforma

Subject Area	Description
ISP Provider	Name of ISP Provider
File Reference	Trust File Reference
Date received	Date complaint received at ISP
Date acknowledged	Date complaint acknowledged by ISP
Date closed	Date the outcome of the complaint following investigation has been communicated to the patient.
Site/Location	General facility complaint relates to ie Ulster Hospital, RVH
Location Exact	Specific location to which complaint refers ie Ward, Downeshire Hospital
Specialty	Specialty to which complaint relates – A&E, Urology etc.
Category of complaint	As per CH8 categories
Summary of complaint	Anonymised account
Summary of investigation	Anonymised account
Actions taken	Actions taken by Trust as a result of their investigation – anonymised in terms of patient information
Lessons learned	i.e. staff training required, new protocol drafted etc.
Current Stage	Stage complaint is at – ongoing, closed, Ombudsman

Returns must be completed weekly and emailed to the referring body

Trust Contact Point: Personal Information redacted by the USI

SCHEDULE 5 Performance Notice

For Issue from the Southern Health and Social Care Trust to Orthoderm Private Clinic

[ON THE HEADED PAPER OF THE Southern Health and Social Care Trust

[*Covering letter to be issued with this notice*]

PERFORMANCE NOTICE

Reference:
[*Insert the date reference (Year Month Day) add .1 or .2 etc if more than one issued on the same day*]

This Performance Notice dated [*insert date*] is issued by the Southern Health and Social Care Trust to Orthoderm Private Clinic (the "Provider") under clause 33 (Corporate Governance and Compliance) of the Contract for the Provision of Health Services between Orthoderm Private Clinic and the Southern Health and Social Care Trust.

This Performance Notice is being issued because:

[*detail:*

- *the exact reasons for the notice in accordance with clause 33.4*
- *refer to any previous correspondence*
- *refer to any contractual Performance Target(s) breached*
- *reference the source documentation / report(s) used to make the decision to issue the Performance Notice.*
- *the time period within which Orthoderm Private Clinic is required to resolve the performance deficiency (not more than 3 months)*

The Southern Health and Social Care Trust considers that the above demonstrates a material failure by Orthoderm Private Clinic to meet the requirements of the Contract.

Orthoderm Private Clinic is reminded that under clause 33.4 of the Contract, failure to rectify the performance to which this notice relates

within the time period specified in this Performance Notice, may result in the activation of clause 33.6 (penalties for non compliance).

SCHEDULE 6 Integrated Elective Access Protocol

See separate document and appendices – attached as Appendix 1.

SCHEDULE 7 Contact / Liaison Parties

Orthoderm Private Clinic
Ms Andrea Pollock
Tel: Personal Information redacted by the USI
E-Mail: office@orthoderm.co.uk

Southern Health and Social Care Trust:
Martina Corrigan
Tel: Personal Information redacted by the USI
E-mail: Personal Information redacted by the USI

HSCB:
IS Procurement Section, Planning & Contracts Department.

SCHEDULE 8 Summary of Responsibility for Administrative Arrangements

		Responsibility		
		Trust	**Provider**	**Named Contact(s)**
PATIENT SELECTION/ INFORMATION				
1.	Patient selection/screening			Martina Corrigan
2.	Transfer of referral letters/notes Transfer of x-rays and/or other diagnostics			Martina Corrigan
3	Provision of information to patients			Andrea Pollock
4	Provision of information to GPs			Andrea Pollock
5.	Letters of invitation			Andrea Pollock
6	Appointment arrangements (inc partial booking)			Andrea Pollock
7	Patient transport			Andrea Pollock
OUTPATIENT ASSESSMENT				
8	Provision of facilities			Andrea Pollock
9.	Outpatient assessment			Andrea Pollock
10.	Nursing care			Andrea Pollock
11	Administrative arrangements for outpatient clinics			Andrea Pollock
12	Diagnostics			Andrea Pollock
13	Assessment outcome to patient			Andrea Pollock
14	Assessment outcome to GP			Andrea Pollock
TREATMENT CONSEQUENCE				
NON SURGICAL				
15	Outpatient physiotherapy			N/A
16	Home visit occupational therapy			N/A
SURGICAL				

		Responsibility		
		Trust	**Provider**	**Named Contact(s)**
17	Booking and consent to treatment			Andrea Pollock
18	Provision of surgery facilities			Andrea Pollock
19	Provision of support/clinical staff			Andrea Pollock
20	Equipment provision			Andrea Pollock
21	Consumables provision			Andrea Pollock
22	Infection control			Andrea Pollock
23	Hotel services			Andrea Pollock
24	Special diets provision			Andrea Pollock
25	AHP - physiotherapy			N/A
26	- radiology (except CT - and MR)			Andrea Pollock
27	CT and MR			Andrea Pollock
28	Pharmacy			Andrea Pollock
29	ECG			Andrea Pollock
30	Pathology			Andrea Pollock
31	Prostheses supply			Andrea Pollock
32	Unrelated interventions (medical/surgery)			Andrea Pollock
33	ICU contingencies/arrangements			Andrea Pollock
34	Management information			Andrea Pollock
35	Discharge arrangements			Andrea Pollock
36	Patient transport home			Andrea Pollock
POST OPERATIVE CARE				
37	Physiotherapy/walking aids			N/A
38	Aids to daily living			N/A
39	Consumables (three days minimum)			Andrea Pollock

		Responsibility		
		Trust	**Provider**	**Named Contact(s)**
40	Take home medicines			Andrea Pollock
41	GP Letter - district nursing			Andrea Pollock
42	Case note update/return			Andrea Pollock
43	Follow up appointment(s) booking			Andrea Pollock
44	Other postoperative arrangements			Andrea Pollock
45	Readmission (if related to surgery)			Andrea Pollock
OTHER ADMINISTRATION				
46	DNA notification			Andrea Pollock
47	Inpatient death policy	Agreed Policy between Trust and Orthoderm Private Clinic		
48	Adherence to HSC standards			Andrea Pollock
49	Patient questionnaire			Andrea Pollock
50	Complaints policy/Patient liaison			Andrea Pollock
51	Clinical audit			Andrea Pollock
52	Records management			Andrea Pollock

SCHEDULE 9 PATIENT MASTER DATABASE

1 Patient Master Database ("Database")
(Also referred to as the Update Spreadsheet/Report or Patient Pathway Report)

A Patient Master Database will be maintained for the Contract. This Database (the format of which is contained described below) will be jointly maintained by Orthoderm Private Clinic and Trust staff and will be updated:

- Twice weekly – Monday and Thursday by 12 midday
- If a Public Holiday falls on a Monday, the Trust will expect this on a Tuesday
- If a Public Holiday falls on a Thursday, the Trust will expect this on a Friday.

This Database will be used as the reference document to monitor all changes in HSC Patient status and both the Trust and Orthoderm Private Clinic will cooperate in maintaining it in an accurate and up to date form.

The Database should be held as an Excel spreadsheet and updated and passed to the Trust as per the timescale above.

Template for Patient Master Database

(Also referred to as Update Spreadsheet/Report, Patient Pathway Report)

ALL sections must be completed per specific contract requirements

		Field	Comments
PATIENT DATA			
1		Hospital Number	Should be assigned by Trust and used by both Trust and provider (but see (2) below)
2		Health & Care Number	Optional field but where entered by Trust it must be used in preference to (1) above
3		Unique Identifier for Contract Period	This should be used to identify patients being transferred for specific contract periods
4		Patient Forename	
5		Patient Surname	
6		Address 1	
7		Address 2	
8		Postcode	
9		Date of Birth	
10		Sex	
11		Phone Number	
12		Mobile Number	
13		GP Name	
14		GP Cipher Code	
15		Hospital Site	
16		Specialty	
17		Consultant	
18		Clinical information	Free field to allow any relevant clinical information to be included (e.g. history, body part)
19		Date of referral	Date of referral by GP/other
20		Referrer	
21		Date passed to Provider	Date patient data passed to Orthoderm Private Clinic for action
PATIENT OFFER DATA			
22		Offer Date for First Appointment *(written communication)*	The date the provider made contact with the patient to make an offer
23		Outcome of First Offer	• No response • Patient Accepted Offer • No longer requires appointment *(date required)* • Refused offer – date and reasons to be given • Patient deceased • Other – must be specified
24		Disposal of First Offer	• Appointment made • Second offer made • Discharged – date and reasons • Returned to Trust – date and reasons
25		First appointment date	Actual appointment date accepted by patient

26		Offer Date for Second Appointment *(written communication)*	The date the provider made contact with the patient to make an offer
27		Outcome of second Offer	• No response • Patient Accepted Offer • No longer requires appointment • Refused offer – dates reasons to be given • Patient deceased
28		Disposal of Second Offer	• Appointment made • Discharged – date and reasons • Returned to Trust – date and reasons
29		Second appointment date	Actual appointment date accepted by patient
OUT-PATIENT APPOINTMENT DATA			
30		First outpatient appointment Date	Actual date of appointment
31		First outpatient appointment: Consultant Name	
32		1st outpatient appointment: Specialty of clinic	
33		First outpatient appointment Outcome	Possible outcomes: • Attended • Cancelled by patient - date of cancellation and cancellation reason • Cancelled by Provider – date of cancellation and cancellation reasons • DNA *Where the appointment is cancelled by patient, the date the patient cancels the appointment will be the reset date for PAS*
34		First outpatient appointment Disposal	Possible disposals: • Added to elective waiting list – details of procedure, urgency category and intended management must be provided • Discharge • DNA – Discharged • DNA – Appointment re-booked with date of appointment • Review appointment – timeframe for review must be stated, eg, 6 weeks, 3 months • Referred to other Clinic – Reasons for referral and specialty must be stated • Sent for diagnostics/Awaiting Results – Investigation/test must be stated **If a patient is being discharged at a later date following appointment, eg, on receipt of investigation results, the date the decision to discharge was made must also be given*
35		Second outpatient appointment Criteria	A second outpatient appointment should only be carried out where: • a valid reason for inability to attend first

			outpatient clinic resulted in DNA/CNA; • an investigation requires second appointment; or • for further review before final determination of outcome • by approval of Head of Service/Contract owner
36		Second outpatient appointment: Consultant	
37		Second outpatient appointment: specialty	
38		Second outpatient appointment Outcome	Possible outcomes: • Attended • Cancelled by patient - date of cancellation and cancellation reason • Cancelled by Provider – date of cancellation and cancellation reasons • DNA *Where the appointment is cancelled by patient, the date the patient cancels the appointment will be the reset date for PAS*
39		Second outpatient appointment Disposal	Possible disposals: • Added to elective waiting list – details of procedure, urgency category and intended management must be provided • Discharge • DNA – Discharged • DNA – Appointment re-booked with date of appointment • Review appointment – timeframe for review must be stated, eg, 6 weeks, 3 months • Referred to other Clinic – Reasons for referral and specialty must be stated • Sent for diagnostics/Awaiting Results – Investigation/test must be stated **If a patient is being discharged at a later date following appointment, eg, on receipt of investigation results, the date the decision to discharge was made must also be given*
INVESTIGATIONS DATA			
40		Investigations required	
41		Date referred for investigation	
42		Date of investigation	
43		Outcome of Investigation	Possible outcomes:

		(Attendance)	• Attended • Cancelled by patient - date of cancellation and cancellation reason • Cancelled by Provider – date of cancellation and cancellation reasons • DNA *Where the appointment is cancelled by patient, the date the patient cancels the appointment will be the reset date for PAS*
44		Date Investigations Reviewed by Clinician	
45		Disposal of Investigation	Possible disposals: • Added to elective waiting list – details of procedure, urgency category and intended management must be provided • Discharged to GP - no further intervention required • Returned to Trust - reasons to be given • DNA – Discharged • DNA – Appointment re-booked with date of appointment • Review appointment – timeframe for review must be stated, eg, 6 weeks, 3 months • Referred to other Clinic – Reasons for referral and specialty must be stated • Sent for further diagnostics/Awaiting Results – Investigation/test must be stated *If a patient is being discharged at a later date following appointment, eg, on receipt of investigation results, the date the decision to discharge was made must also be given
PRE-OP ASSESSMENT DATA			
46		Offer Date for First Pre-Op Assessment Appointment	The date the provider made contact with the patient to make an offer
47		Outcome of First Pre-Op Assessment Offer	• No response • Patient Accepted Offer • No longer requires appointment • Refused offer – reasons to be given • Patient deceased • Other – must be specified
48		Date of first pre-op assessment appointment	
49		Disposal of First pre-op assessment offer	• Appointment made • Second offer made • Discharged – date and reasons Returned to Trust – date and reasons
50		Outcome of First Pre-Op	Possible outcomes:

		Assessment Appointment	• Attended • Cancelled by patient - date of cancellation and cancellation reason • Cancelled by Provider – date of cancellation and cancellation reasons • DNA *Where the appointment is cancelled by patient, the date the patient cancels the appointment will be the reset date for PAS*
51		Disposal of First pre-op assessment Appointment	• Patient Fit to Proceed • DNA – Discharged • DNA – Appointment re-booked with date of appointment • Referred for specialist Advice – Reasons for referral and specialty must be stated • Sent for diagnostics/Awaiting Results – Investigation/test must be stated • Suspended - Date of Suspension, duration of Suspension, reasons for suspension required
52		Offer Date for Second Pre-Op Assessment Appointment	The date the provider made contact with the patient to make an offer
53		Outcome of Second Pre-Op Assessment Offer	• No response • Patient Accepted Offer • No longer requires appointment • Refused offer – reasons to be given • Patient deceased • Other – must be specified
54		Date of second pre-op assessment appointment	
55		Disposal of Second Pre-Op Assessment offer	• Appointment made • Second offer made • Discharged – date and reasons • Returned to Trust – date and reasons
56		Outcome of Second pre-op assessment Appointment	• Attended • Cancelled by patient - date of cancellation and cancellation reason • Cancelled by Provider – date of cancellation and cancellation reasons • DNA *Where the appointment is cancelled by patient, the date the patient cancels the appointment will be the reset date for PAS*
57		Disposal of pre-op assessment Appointment	• Patient Fit to Proceed • DNA – Discharged • DNA – Appointment re-booked with date of appointment • Referred for specialist Advice – Reasons for

			referral and specialty must be stated • Sent for diagnostics/Awaiting Results – Investigation/test must be stated • Suspended - Date of Suspension, duration of Suspension, reasons for suspension required
PROCEDURE/TREATMENT DATA			
58		Waiting List Add Date	Date decision taken to add patient to the waiting list, eg, at the time of out-patient attendance, at the point of reviewing investigation results *Where a patient has been referred as a direct elective patient, this will be the current waiting list date*
59		Urgency Categorisation	Urgent or Routine *Where a patient has been referred as a direct elective patient, this data will be provided on referral information*
60		Intended Management	In-patient or Day Case *Where a patient has been referred as a direct elective patient, this data will be provided on referral information*
61		Date First offer of To Come In (TCI) Date made	
62		First TCI Date offered	Actual Admission Date
63		Outcome of First TCI Offer	• No response • Patient Accepted Offer • No longer requires appointment • Refused offer – date and reasons to be given • Patient deceased • Other – must be specified
64		Disposal of First TCI Offer	• TCI date agreed • Offer refused – date and reasons to be given • Procedure/treatment no longer required • Patient Returned to Trust for Treatment – Reasons to be given
65		Date Second offer of To Come In (TCI) made	
66		Second TCI Date Offered	Actual Admission Date
67		Outcome of Second TCI Offer	• TCI date agreed • Offer refused – date and reasons to be given • Procedure/treatment no longer required • Patient Returned to Trust for Treatment – Reasons to be given
68		Disposal of Second TCI Offer	• TCI date agreed

			• Offer refused – date and reasons to be given • Procedure/treatment no longer required • Patient Returned to Trust for Treatment – Reasons to be given
69		Admission Date	
70		Date of treatment	
71		Discharge Date	
72		Outcome of treatment	• Procedure/Treatment Completed • Procedure/Treatment Abandoned (during elective stay) – reasons to be given • Cancelled by patient – date and reasons to be given • Cancelled by provider – date and reasons to be given • DNA • Other – please specify with reasons
73		Disposal	• Discharged to GP - no further intervention required • Returned to Trust - reasons to be given • DNA – Discharged • DNA – procedure re-booked with new date • Review appointment – timeframe for review must be stated, eg, 6 weeks, 3 months • Referred to other Clinic – Reasons for referral and specialty must be stated • Sent for further diagnostics/Awaiting Results – Investigation/test must be stated
74		Actual procedure	
75		Site of treatment	
76		Date Discharge letter sent to GP	
POST – OPERATIVE ARRANGEMENTS			
77		Offer Date for First Review Appointment	The date the provider made contact with the patient to make an offer
78		Date of First Review Appointment	The actual appointment date
79		Outcome of First Review Offer	• No response • Patient Accepted Offer • No longer requires appointment • Refused offer – date and reasons to be given • Patient deceased • Other – must be specified
80		Disposal of First Review Offer	• Appointment made • Second offer made • Discharged – date and reasons • Returned to Trust – date and reasons
81		Outcome of First Review	Possible outcomes:

		Appointment	• Attended • Cancelled by patient - date of cancellation and cancellation reason • Cancelled by Provider – date of cancellation and cancellation reasons • DNA *Where the appointment is cancelled by patient, the date the patient cancels the appointment will be the reset date for PAS*
82		Disposal of First Review Appointment	<u>Possible disposals</u>: • Discharged to GP • DNA – Discharged • DNA – Appointment re-booked with date of appointment • Review appointment – timeframe for review must be stated, eg, 6 weeks, 3 months referral and specialty must be stated • Sent for diagnostics/Awaiting Results – Investigation/test must be stated • Returned to Trust – reasons to be given **If a patient is being discharged at a later date following appointment, eg, on receipt of investigation results, the date the decision to discharge was made must also be given*
83		Offer Date for Second Review Appointment	The date the provider made contact with the patient to make an offer
84		Date of Second Review Appointment	The actual appointment date
85		Outcome of Second Review Offer	• No response • Patient Accepted Offer • No longer requires appointment • Refused offer – date and reasons to be given • Patient deceased • Other – must be specified
86		Disposal of Second Review Offer	• Appointment made • Second offer made • Discharged – date and reasons • Returned to Trust – date and reasons
87		Outcome of Second Review	<u>Possible outcomes:</u>

		Appointment	• Attended • Cancelled by patient - date of cancellation and cancellation reason • Cancelled by Provider – date of cancellation and cancellation reasons • DNA *Where the appointment is cancelled by patient, the date the patient cancels the appointment will be the reset date for PAS*

SCHEDULE 10 PATIENT MINIMUM DATASET

Patient Minimum Dataset

(Also referred to as the Clinical Coding Form)

Information relating to surgical procedures and treatment of outpatient with procedure must be provided to the Trust for the purposes of Clinical Coding.

For all HSC Patients undergoing surgical procedures, Orthoderm Private Clinic must complete and return the Patient Minimum Dataset Form (see below) to the Trust's Clinical Coding Department within 1 week of HSC Patient discharge, ensuring full compliance with Trust information requirements.

NOT APPLICABLE: For all HSC Patients undergoing a procedure as part of the outpatient consultation or in the outpatient setting at a later point, Orthoderm Private Clinic must complete and return Patient Minimum Dataset Form(see below) to the Trust's Independent Sector Team within 1 week of HSC Patient discharge, ensuring full compliance with Trust information requirements.

This information should also be supplied as part of the Patient Health Record which is returned to the Trust by Orthoderm Private Clinic following treatment.

NB: Failure to provide the Patient Minimum Dataset in accordance with this Contract may result in delay in processing or in non-payment of an invoice.

Patient Minimum Dataset
(also known as Clinical Coding Form)

ALL sections must be completed fully.

For each patient:	**For each admitted episode within spell:**
Patient ID	Consultant
HSC number	Consultant function
Date of birth	Consultant specialty
Sex	Start date
Postcode of usual address	End date
GP	Primary diagnosis
Referrer	Secondary diagnosis
	Primary procedure
For each outpatient appointment:	Procedure (others)
	Procedure date (for each procedure)
Consultant	Site of treatment (at start of episode)
Consultant function	
Consultant specialty	**For any period of augmented care**:
Primary diagnosis	
Secondary diagnosis	Start date
Attended/did not attend	Augmented care period source
First attendance	Intensive care level days
Medical staff type	High dependency care level days
Outcome of attendance	Number of organ systems supported (IC only)
Attendance date	Augmented care planned indicator
Primary procedure	Augmented care outcome indicator
Procedure (other)	Augment care period disposal
Site of treatment	End date
	Specialty function code
For each admitted spell	Augmented care location
Start date	
Admission method	
Discharge destination	
Discharge method	
Discharge date	

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

APPENDIX 1

SERVICE SPECIFICATION FOR PROVISION OF UROLOGY FROM INDEPENDENT SECTOR PROVIDERS

1.0 INTRODUCTION

The Southern Health and Social Care Trust (hereafter referred to as the Trust) on behalf of the Northern Ireland Health & Social Care Board (hereafter referred to as HSCB) requires outpatient assessments to be provided to oncology outpatients currently waiting to have a review outpatient appointment before 31 December 2020.

2.0. BACKGROUND

2.1. The Trust does not have the capacity to deliver all the activity needed in 2020/2021 and wishes to establish arrangements with a healthcare organisation to work in partnership.

3.0. SERVICE SCOPE

3.1. The Provider selected should ensure that services should be provided in accordance with:

3.1.1. the agreed level of activity detailed in the indicative activity plan , 3.2, below;

3.1.2. the contract terms and conditions as per the Independent Sector Treatment contract enclosed, and in accordance with best clinical practice guidelines;

3.2 Indicative Activity Plan

3.2.1 It is planned that in the first instance the **indicative** volume for this service is approximately:

236 outpatient assessments which will determine a management plan for all of these patients.

There should be two outcomes:

(a) patients are discharged back to the care of their GP
(b) patients who require follow up will have a detailed management plan sent to the Trust's Urology Oncology Multi-disciplinary Team who will be responsible for action of the recommendations.

3.2.2 All outpatient activity is required to be completed in line with the timescales outlined within the Contract Award Letter. To this end the

Trust will agree with the provider the completion date for each cohort of patient transfers as they are dispatched

3.4 **PRICES**

3.4.1 N/A

3.4.2 Prices submitted must include all costs anticipated for the completion of the outpatient consultation and identified procedures and any relevant aftercare costs. This includes for example the elements listed below, albeit **this list is not exhaustive:**

- Administration costs;
- All professional fees;
- Cost of facilities hire/lease or running costs and all goods and services;

.

Any costs anticipated for patients that Do Not Attend on the day without prior notice should also be identified individually.

3.4.3 **Any costs not included in the submitted schedule cannot later be claimed.**

4.0. CONTRACT ACTIVITY AND CASE-MIX REQUIRED

On receipt of confirmation of acceptance of patients, the Trust will inform the patients and their GPs within one working day that they have been selected for transfer and should expect contact to be made from the Provider. The Provider should allow this one day before sending out their written invitation communication to patients. All patients must receive a dated, written invitation from Providers, including the Provider's full address and contact details, even if Providers choose to make initial contact by telephone. All communication with patients regarding offers of assessment or treatment must fully comply with the Integrated Elective Access Policy (See Appendix 5 of the Contract).

- **The Outpatient pathway will typically include the following:**

4.1. First Outpatient consultation to be scheduled before the end of December 2020. The Service provision assumptions are as follows:

- **Outpatients –** All new patients passed to the Provider by the Trust will be invited to an outpatient consultation with an appropriate specialist consultant urologist in accordance with the DHSSPS Access protocol and within the time frame specified by the Trust.

- The Provider shall deliver the service in line with the provisions of **The Integrated Elective Access Policy (or IEAP) (DHSSPS, 2008) - see Appendix 5 of the Contract.**

5.0 LOCATION OF SERVICE DELIVERY

5.1 The service will be provided from suitably equipped and accessible medical premises as agreed by the Trust.

5.2 It is the policy of the Southern Health and Social Care Trust that Independent Sector providers will not access Trust premises. **Providers therefore must provide details in their submission of the location that the service will be carried out.**

5.3 If a Provider is using facilities not registered to them they must provide with their submission a copy of their leasing agreement with the registered organisation.

5.4 Services cannot be sub-contracted without prior approval of the Trust. Any Provider considered for sub-contracting must be on the HSCB regional eligible provider list.

6.0 CARE PATHWAYS

6.1 Referral Process

6.1.1 Referrals to the service will be made from the Southern Trust. The Trust will advise patients and patients General Practitioners that individuals have been referred for management to an Independent Sector Service.

6.1.2 The Trust will issue a list of patients from the active review out-patient oncology waiting list to be managed by the Independent Sector provider in chronological order with reference to the Integrated Elective Access Policy. Patients should be partially booked ensuring reasonable notice of 3 weeks of appointment and confirmation of appointment in writing.

6.1.3 Providers must ensure that patients with any special requirements eg disabled access; access to interpreters is accommodated.

6.1.4 All DNAs and CNAs must be recorded with reasons noted. The expectation is that this contract should operate with a maximum of 5% DNA and under 6% CNA rate. **Therefore payments for DNAs will be capped at 5% of the total volume of patients. Payments for DNAs over this volume will not be made.**

7.0 ADMINISTRATIVE SUPPORT

The service provider will be responsible for ensuring adequate secretarial and administrative support is in place to facilitate efficient administration of services. This includes:

- Receiving and recording referral to Provider on their systems within 3 working days and whether the patient was accepted or returned to Trust.

- Ensuring appointments are made as appropriate, with 3 weeks reasonable notice and confirmation of appointment/offer in accordance with Integrated Elective Access Policy (IEAP). Out-patient appointments must be partially booked in accordance with IEAP guidelines.

- The provider must have sufficient communication systems to deal with patient enquiries/calls and telephone numbers must be clearly communicated to patients.

- All relevant information and documentation necessary for patients appointments is available prior to attendance

- Meeting and greeting patients on arrival for their appointment/surgery

- Maintain appropriate and accurate patient records as the record holder as per Data Protection legislation, in relation to all patient episodes/attendances e.g.

    - Nursing notes
    - Medical notes
    - Patient Master Data Base (see Annex 3)
    - Patient Minimum Data Set (see Annex 3)
    - Management plan for patients

    NB this is not an exhaustive list

- Robust mechanisms are in place for the timely recording of outcomes following every patient attendance and that this is communicated back to the Trust Independent Sector Team on a regular basis in line with key performance indicators (Annex 2).

- Full compliance with the template for the Patient Master Database in terms of information requirements about patient outcomes and disposals (see Annex 3 & 3A – Information Requirements. Please note that these documents replace Schedule 2 and Appendix 1 of the contract).

- Return of Patient Master Database to Trust Independent Sector Team at least twice per week with updated outcomes – Monday and Thursday at 12 midday at a minimum. Where a Public Holiday falls on a Monday, the Trust will expect an update on the Tuesday, where the Public Holiday falls on a Thursday, the Trust will expect an update on the Friday.

- Return of Out-Patient Clinical Coding Forms (see Annex 3) to the referring Trust's Independent Sector Team within 1 week of patient discharge from Provider facility, ensuring full compliance with Trust information requirements

8.0 EQUIPMENT

8.1 The Provider will ensure that all equipment used is suitable for the provision of the required services and complies with all relevant law and Good Healthcare Practice relating to Health & Safety.

8.2 The provider shall ensure that all equipment used is regularly maintained and stored in accordance with the manufacturer's instructions.

8.3 The Provider shall ensure an audit of compliance with all appropriate standards and regulations should be carried out by a competent person external to the provider and be available for review if required.

8.4 **Cleaning Equipment -** The Provider shall ensure all equipment is cleaned as specified by and in accordance with current legislation appropriate to the Jurisdiction e.g.:

- DoH HTM 20/30 and/or HTM 20/10 and/or HTM 01/06
- The cleaning manufacturer
- The Medical Devices Agency
- COSHH requirements
- Any superseding requirements.

9.0 STAFF

9.1 The Provider shall meet the following required staffing checks

- Curriculum Vitae – When completing the Provider Submission Template (Appendix 2) the Provider is required to complete the Summary Sheet (Annex B) detailing the consultant urologist who they propose to engage for treatment of patients under the contract. The Trust requires copies of CVs which must include details of their experience in managing and treating the specific urological conditions and subspecialist areas/sites in Schedule 1.

- The Service Provider shall be responsible for ensuring that the Consultant Urologists are competent, hold current professional GMC

registration and licence to practice in UK or equivalent registration with IMC for Republic of Ireland Providers, and hold indemnity insurance. They should also be fully accredited by the Royal College Special Advisory Committee or equivalent.

- The Provider will comply with Royal College, General Medical Council (GMC), Nursing & Midwifery Council (NMC), Royal College of Nursing (RCN) or equivalent bodies relevant to the jurisdiction and any other relevant professional body code of practice for clinical documentation and management of patients.

- Staff training – The provider must ensure that the mandatory, compulsory and local training of all staff groups is up to date, maintained and recorded.

- It must be highlighted if:-

    - Staff have ever been referred to the Independent Safeguarding Authority (ISA) or DHSSPS as a result of misconduct involving children and/or vulnerable adults;

    - Staff are currently the subject of a referral to, or an investigation by, a regulatory body;

    - Staff are currently the subject of police investigation or have any prosecutions pending; and

    - Staff have ever been convicted, charged, prosecuted, cautioned or bound over for any offence, no matter how minor.

9.0 PROCEDURES AND PROTOCOLS

11.1 The Provider shall within a reasonable time after request, make available to the Trust copies of any patient guide or other written policy, procedure or protocol which the Provider implements.

The Provider shall promptly notify the Trust of any material changes to such guides, policies, procedures and protocols as have been made available to the Trust

11.2 As a minimum the Provider must comply with the requirements of all existing relevant appropriate legislation, guidelines and policies relevant to their jurisdiction and in particular, but not exclusively, the following:

Trust policies:

- Protocol in relation to safeguarding and protecting the welfare of children and vulnerable adults;
- Accident and Incident reporting and review policy;
- Infection Control Policies;

- Medicines Policies;
- MRSA Policy;
- Pathology protocols including IRMER regulations;
- Health and Safety Policies;
- Complaints Policy;
- Patient Confidentiality, Data Protection Policy and Freedom of Information Act (2000).
- Recording Keeping

Legislation

- Health and Safety Legislation
- Data Protection Act 1998
- Freedom of Information Act 2000
- Section 75 of the Northern Ireland Order 1998
- Sex Discrimination (NI) Orders 1976 and 1988,
- Fair Employment and Treatment (NI) Order 1998,
- Disability Discrimination Act 1995, Section 49A of the Disability Discrimination Order 2006
- Race Relations (NI) Order 1997
- Human Rights Act (1998)
- Article 3 of the Audit and Accountability (NI) Order 2003
- Equal Pay Act (Northern Ireland) 1970 (amended 1984)
- Employment Equality (Sexual Orientation) Regulations (Northern Ireland) 2003 and 2006
- Employment Equality (Age) Regulations NI 2006
- Fire Prevention and Precautions Legislation
- and any enactments amending, extending or replacing them

Guidelines

- Safer services report
- Guidelines for the prevention, detection and investigation of abuse of vulnerable adults
- Professional guidelines and policies
- Our duty to care
- NMC guidance on record keeping
- NMC guidance on administration of medications

12.0 STANDARDS AND QUALITY INDICATORS

The provider will be expected to comply with the relevant quality and safety indicators.

In addition the provider will be expected to comply and provide information which will meet the baseline performance targets, Quality, Performance and productivity standards detailed in Annex 2.

13.0 GENERAL STANDARDS

In addition to the above the Service Provider will be expected to comply with the following standards and quality indicators and to present evidence that standards are being met:

- Essence of Care benchmarking
- UKCC Standards for Record Keeping (2008)
- Relevant NICE guidance
- The Health Code (2006)
- Essential steps to Safe, Clean Hospitals (2006)
- Compliance with local policies and guidelines
- Compliance with agreed local care pathways
- Compliance with confidentiality, data protection and information governance requirements

14.0 DISCRIMINATION

Neither party shall discriminate unlawfully within the meaning and scope of any Law, relating to discrimination (whether relating to race, gender, disability, religion or otherwise) in employment or performance of the Services and each Party shall take all reasonable steps to ensure observance of this by its employees, Staff and agents and (in the case of the Provider) its Sub-contractors.

15.0 COMPLAINTS AND ADVERSE INCIDENTS

15.1 The Provider shall comply with the Northern Ireland Health and Social Care Board and Trust complaints procedure(s) and Adverse Incidents and Serious Adverse Incidents (SAI) procedures including reporting to equivalent bodies relevant to the jurisdiction.

15.2 Further information on Complaints and SAI handling is contained within the Service Level Agreement.

16.0 REPORTING, ANALYSING & LEARNING FROM PATIENT SAFETY INCIDENTS

With regard to Patient Safety Incidents, the Provider will follow the procedure for the reporting and follow up of Serious Adverse Incidents April 2010 and report to equivalent bodies relevant to the jurisdiction.
The provider will

- implement DHSSPS and National Patient Safety Agency (NPSA) guidance including for the avoidance of doubt, patient safety alerts and other safety solutions and products developed for the HPSS;

- have local risk management procedures in place to analyse and learn from patient safety incidents; and

- produce a Monthly monitoring report on SAI for the Commissioner as part of the monitoring arrangements in this document.

17.0 INFORMATION REQUIREMENTS

17.1 The Provider and Trust acknowledge that in order to achieve accurate activity monitoring and prompt and accurate payment, there is a need for timely regular exchange of detailed and accurate information. Accordingly the Provider shall ensure that the specified returns on patient activity and outcomes are provided to the Trust as per Annex 3 attached.

17.2 The Provider shall maintain accurate accounts and records of all payments, receipts and financial and other information relevant to the provision of the Services (in this Section collectively referred to as "Financial Records"). This is set out in detail in Section 21 of the Contract.

18.0 PERFORMANCE INDICATORS AND MONITORING ARRANGEMENTS

18.1 The performance of the Provider will be monitored against specified Performance Indicators as outlined in Annex 3 & 3A, which replaces Schedule 2 and Appendix 1 of the contract.

18.2 The performance of the Provider will be monitored at agreed intervals. Meetings will take place between the Provider and the Trust at least quarterly and more frequently if deemed necessary by the Trust. Meeting will cover service quality, clinical and contract governance and other issues.

18.3 The Trust needs to be able to assure itself that the services it purchases for its patients are provided to the specified levels of quality and quantity as set out in the relevant contract documentation. A Contracts Compliance Reporting System to ensure that concerns raised are followed up and resolved to the satisfaction of the Trust will be followed by Providers.

18.4 Each Party may, where it has a query regarding the other Party's performance under this Agreement, issue a Contract Query in writing setting out the nature of the query. Each Party is obliged to reply in writing to any Contract Query within 14 days of its issue unless otherwise agreed in writing between the Parties. The Trust where it has reasonable evidence that the performance of the Provider fails to meet with requirements under the contract in relation to one or more of the areas set out below may issue a written Performance Notice in respect of a Service setting out the matter or matters giving rise to such Performance Notice and containing a reminder of its implications:

- where there has been a failure to meet the Quality Standards or the Performance Indicators;
- where the Provider fails to provide the volume of activity agreed;
- where there has been a negative audit finding;

- where the percentage of Patient complaints upheld gives cause for concern;

- if there is intervention by the Independent Regulator directly affecting or, in the reasonable opinion of the Trust, likely to affect the ability of the Provider to provide any of the Services;

- where the Provider fails to reply to a Contract Query or;

- where the Provider fails to discharge any of its other obligations under this document or any other reason which may cause the Trust reasonable concern or which could bring the Provider or Trust into disrepute.

Within 7 days of its issue the Parties shall meet to discuss the subject matter of any Warning Notice and agree a plan of action to remedy the subject matter of the Performance Notice including a timetable and method for review of the planned remedial action. (See Section 34 and Schedule 7 of the Contract)

19.0 PRICES AND PAYMENT

All fees will be displayed within Schedule 3 of the contract.

20.0 JURISDICTION

This service specification and accompany contract shall in all respects be governed by the laws of N Ireland and the parties hereby agree that the courts of N Ireland shall have exclusive jurisdiction to hear and determine any dispute arising out of or in connection with this contract.

Schedule 1

Service Description

No assumption should be made about access to NI HPSS Trust premises as part of the pricing submission. The costs associated with such an arrangement should be incorporated into the prices submitted.

Where a provider does not have premises they will have to demonstrate that they have an access agreement commensurate with the volume of patients in any subsequent offer of contract.

Outpatient: including Goods and Services; consumables, laboratory tests

The agreed price for the delivery of this service is detailed in the Terms and Conditions of Contract.

Service	HRG Price

ANNEX 1

Baseline Performance Targets, Quality, Performance and Productivity Indicators

Performance Indicator	Indicator	Threshold	Method of Measurement
Access	Patients offered appointment which is within 21 days of the referral received	98%	Provider data
Referrer Communication	Outcome of patient appointments communicated to the referring clinician within 1 working day •	100%	Provider data
• **Service Quality**	% patients satisfied with the service	95%	Provider data
•	• Number of incidents reported	Benchmarked	Provider data
•	• % patients DNA'd	5%	Provider data
Activity Data and Performance Reports	To be provided to Board / Trusts monthly by the 7th working day of the following month in support of invoices	•	Provider data

The monitoring will be for the period of the contract and the provider is expected to be able to evidence compliance with each of the standards listed.

Information Requirements ANNEX 2

Please note that this document replaces Schedule 2 of the Contract.

1 Patient Master Database
(Also referred to as the Update Spreadsheet/Report or Patient Pathway Report)

A Patient Master Database will be maintained for the contract. This database (Annex 3A) will be jointly maintained by provider and Trust staff and will be updated:

- Twice weekly – Monday and Thursday by 12 midday
- If a Public Holiday falls on a Monday, the Trust will expect this on a Tuesday
- If a Public Holiday falls on a Thursday, the Trust will expect this on a Friday.

This database will be used as the reference document to monitor all changes in patient status and both the Southern Health and Social Care Trust and the IS Provider will cooperate in maintaining it in an accurate and up to date form.

The database should be held as an Excel spreadsheet and updated and passed to the Trust as per the timescale above.

2 NA

3 Complaints Register

A Complaints Register (Appendix 2 of the Contract) must be maintained. This register will be maintained by the IS Provider. It will be updated and passed to the HSCB and Southern Health and Social Care Trust on a weekly basis.

4 Adverse Incident Register

An Adverse Incident Register (Appendix 3 of the Contract) must be maintained. This register will be maintained by the IS Provider. It will be updated and e-mailed to the HSCB at [redacted] and Southern Health and Social Care Trust on a weekly basis.

Personal Information redacted by the USI

5 Patient Minimum Dataset

(Also referred to as the Clinical Coding Form)

Information relating to surgical procedures and treatment of outpatient with procedure must be provided to the Trust for the purposes of Clinical Coding.

For all patients undergoing a procedures as part of the outpatient consultation or in the outpatient setting at a later point, Providers must complete and return Outpatient Clinical Coding Forms (see Annex 3C) to the referring Trust's Independent Sector Team within 1 week of patient discharge, ensuring full compliance with Trust information requirements.

This information should also be supplied as part of the patient health record which is returned to the Trust following treatment.

ANNEX 3A

Template for Patient Master Database

(Also referred to as Update Spreadsheet/Report, Patient Pathway Report)

ALL sections must be completed per specific contract requirements

Please note that this document replaces Appendix 1 of the Contract

		Field	Comments
PATIENT DATA			
1		Hospital Number	Should be assigned by Trust and used by both Trust and provider (but see (2) below)
2		Health & Care Number	Optional field but where entered by Trust it must be used in preference to (1) above
3		Unique Identifier for Contract Period	This should be used to identify patients being transferred for specific contract periods
4		Patient Forename	
5		Patient Surname	
6		Address 1	
7		Address 2	
8		Postcode	
9		Date of Birth	
10		Sex	
11		Phone Number	
12		Mobile Number	
13		GP Name	
14		GP Cipher Code	
15		Hospital Site	
16		Specialty	
17		Consultant	
18		Clinical information	Free field to allow any relevant clinical information to be included (e.g. history, body part)
19		Date of referral	Date of referral by Trust
20		Referrer	
21		Date passed to Provider	Date patient data passed to Provider for action
PATIENT OFFER DATA			
22		Offer Date for First Appointment *(written communication)*	The date the provider made contact with the patient to make an offer
23		Outcome of First Offer	• No response • Patient Accepted Offer • No longer requires appointment *(date required)* • Refused offer – date and reasons to be given • Patient deceased • Other – must be specified
24		Disposal of First Offer	• Appointment made • Second offer made • Discharged – date and reasons • Returned to Trust – date and reasons

25		First appointment date	Actual appointment date accepted by patient
OUT-PATIENT APPOINTMENT DATA			
26		First outpatient appointment Date	Actual date of appointment
27		First outpatient appointment: Consultant Name	
28		1st outpatient appointment: Specialty of clinic	
29		First outpatient appointment Outcome	Possible outcomes: • Attended • Cancelled by patient - date of cancellation and cancellation reason • Cancelled by Provider – date of cancellation and cancellation reasons • DNA *Where the appointment is cancelled by patient, the date the patient cancels the appointment will be the reset date for PAS*
30		First outpatient appointment Disposal	Possible disposals: • Management Plan for Action – details of procedure, urgency category and intended management must be provided • Discharge to GP and copy to Trust • DNA – Appointment re-booked with date of appointment
31		Second outpatient appointment Criteria	A second outpatient appointment should only be carried out where: • a valid reason for inability to attend first outpatient clinic resulted in DNA/CNA; • for further review before final determination of outcome • by approval of Head of Service/Contract owner
32		Second outpatient appointment Outcome	Possible outcomes: • Attended • Cancelled by patient - date of cancellation and cancellation reason • Cancelled by Provider – date of cancellation and cancellation reasons • DNA *Where the appointment is cancelled by patient, the date the patient cancels the appointment will be the reset date for PAS*
33		Second outpatient appointment Disposal	Possible disposals: Possible disposals:

			• Management Plan for Action – details of procedure, urgency category and intended management must be provided • Discharge to GP and copy to Trust • DNA – Appointment re-booked with date of appointment
83		Offer Date for Second Review Appointment	The date the provider made contact with the patient to make an offer
84		Date of Second Review Appointment	The actual appointment date
85		Outcome of Second Review Offer	• No response • Patient Accepted Offer • No longer requires appointment • Refused offer – date and reasons to be given • Patient deceased • Other – must be specified
86		Disposal of Second Review Offer	• Appointment made • Second offer made • Discharged – date and reasons • Returned to Trust – date and reasons
87		Outcome of Second Review Appointment	<u>Possible outcomes:</u> • Attended • Cancelled by patient - date of cancellation and cancellation reason • Cancelled by Provider – date of cancellation and cancellation reasons • DNA *Where the appointment is cancelled by patient, the date the patient cancels the appointment will be the reset date for PAS*