**Audit Title:** Audit of Prescribing of anti-androgen medicine 'Bicalutamide'

**Directorate:** Acute Services ■ Children & Young People ☐ Older Persons & Primary Care ☐
Mental Health & Disability ☐ Corporate request ☐

**Division:**

| **Auditor's name: Mr Mark Haynes**<br><br>**Contact details: (email)** Personal Information redacted by the USI | **Audit Supervisor's Name : Not Applicable** |
|---|---|

**Is this a:** National audit ☐ Regional audit ☐ Trust audit ■ International audit ☐

Proposed audit commencement date 27th October 2020 Proposed audit completion date …/…/….

## Audit Aims

To ensure that the anti-androgen medicine 'Bicalutamide' has been prescribed as licensed and in line with NICE guideline NG131 Prostate Cancer: Diagnosis and Management

## Audit Objectives

- To ensure that where Bicalutamide is prescribed only where indicated and as per licensed usage
- To ensure that where Bicalutamide is prescribed this is prescribed in the correct therapeutic dosages
- To ensure that patients prescribed Bicalutamide is appropriately reviewed as part of the patients ongoing care
- To ensure that any deviations from prescribing guidance is based on sound evidence based clinical rationale

## Audit Standards

The following audit standards obtained from NICE guideline [NG131] Prostate cancer: diagnosis and management

Published date: 09 May 2019.

| Audit Criteria | Target | Exceptions | Source of Evidence |
|---|---|---|---|
| Bicalutamide prescribed as per indicated conditions in NICE NG131 | 100% | Clinical rationale for deviation from guidance | NICE guideline NG131 Prostate Cancer: Diagnosis and Management |
| Therapeutic doses of anti-androgen monotherapy with bicalutamide are prescribed at recommended dose (150 mg). | 100% | Discussions with patient / Clinical rationale | NICE guideline NG131 Prostate Cancer: Diagnosis and Management |

## Audit Methodology

The following audit methodology will be followed:

- HSCB to provide information on primary care prescriptions of the medication Bicalutamide
- Southern Health and Social Care Trust patients to be identified and a consultant led review of prescribing to take place to identify prescribing of Bicalutamide that is outside of that prescribed in NICE guideline NG131 Prostate Cancer: Diagnosis and Management

## Rationale for the audit (please tick all that apply)

Topic is included in the Directorate's clinical audit work-plan ☐ Compliance with standards & guidelines ■

# Clinical and Social Care Audit Registration Form

| | | | |
|---|---|---|---|
| National Healthcare Quality Improvement Partnership (HQIP) audit | ☐ | Regional RQIA/GAIN audit | ☐ |
| Other national / international audit | ☐ | Trust based audit topic important to team/division | ■ |
| Clinical risk | ■ | Recommendation from national / regional report | ☐ |
| Serious Adverse Incident or Adverse Incident review | ■ | Clinician / personal interest | ☐ |
| Incident reporting | ☐ | Educational audit | ☐ |

Other – please specify .....

**Level 1** ☐ **Level 2** ■ **Level 3** ☐ **Level 4** ☐

Has this audit been approved based on the priority level? Yes ■ No ☐

Level 1 - Approval required by Associate Medical Director or Clinical Director or Directorate Governance Forum
Level 2 - Approval required by Associate Medical Director or Clinical Director or Directorate Governance Forum
Level 3 – Approval required by Supervising Consultant
Level 4 – Approval required by Supervising Consultant
Please be advised that the audit cannot proceed without approval as above.

Please Note: The Information Team have advised they will not release data to the requestor unless the clinical audit has been approved as above.
The clinical audit team will also advise contact with Information Governance for any advice required.

The clinical audit team can be contacted via:
Email: Personal Information redacted by the USI
Tel:

Raymond Haffey
Terri Harte
Sandra McLoughlin

Personal Information redacted by the USI

Mary Markey
Roisin Feely
Philip Sullivan

Personal Information redacted by the USI

*In submitting this audit registration form, I agree to share the audit findings, recommendations and audit summary template with:the Audit Supervisor, appropriate Divisional/Directorate Committee and the Trust's Clinical audit team*

**Please submit your audit registration form to:** Personal Information redacted by the USI

**Priority levels for clinical audit**

| Level | Audit type - projects identified through | |
|---|---|---|
| Level 1 audits, "external must dos" (where the service is applicable to SHSCT) | • National audits (NHS England Quality Accounts List (HQIP), including the National Confidential Enquiry into Patient Outcomes and Deaths (NCEPOD) / Other Confidential Inquires | 1 |
| Level 2 audits, other national audits and 'internal must dos' | • National audits not contained within the HQIP list, or other clinical audits arising from:<br>• Clinical risk<br>• Serious untoward incident / internal reviews<br>• National Institute of Clinical Excellence Standards & Guidelines<br>• Complaints<br>• Re-audit<br>• Regional audits initiated by RQIA / GAIN | 2 |
| Level 3 audits, 'divisional priorities' | • Local topics important to the division | 3 |
| Level 4 audits | • Clinician / personal interest<br>• Educational audits | 4 |

# FAQs Urology October 2020

## Why has the Southern Trust decided to look back at Urology patients?

Clinical concerns were raised regarding the work of one Consultant Urologist in June 2020 when two patients were identified has having not been listed on to the Trust Patient Administration System in a timely manner. This was alerted as a potential patient safety issue due to potential delays in treatment and prompted a wider review of the Consultant's workload to establish if there were additional service impacts.

## What happened when concerns were raised?

Following the identification of clinical concerns, the Trust provided information about the Consultant's practice to the General Medical Council. In addition to this, restrictions were placed on the Consultant's practice by the Trust so they could no longer undertake clinical work and could not access patient information. The Department of Health were provided with details of the case via the 'Early Alert' mechanism.

A further review of the Consultant's workload over an 18 month period - January 2019 to June 2020 – has been on-going since June, with expert independent advice sought to inform the scope and scale of the work.

## Why is the Trust only looking at cases between January 2019 and June 2020?

The Trust has agreed with the Health and Social Care Board, Public Health Agency and Department of Health to a chronological and incremental approach when reviewing the Consultants workload. In the first instance the Trust has reviewed cases in this 18 month period. The scope and scale of any further review may be extended. This will be based on our internal review of patient records and advice from the Royal College of Surgeons.

## What issues have the Trust now identified?

The Trust has reviewed all of the Consultants elective and emergency activity that occurred between January 2019 and June 2020. The review has progressed to diagnostic testing conducted including radiology, pathology and cytology to ensure appropriate action has been taken on each result. Of these patients who have been reviewed, there have been **nine** cases which are now part of an independently chaired Serious Adverse Incident Review process.

The Trust has also recently identified concerns regarding medication prescribing, as a result 26 patients have been reviewed by our Urology team.d

## How many patients are involved in the review process?

## Were all the patients treated by the same doctor?

All the patients included in this review were under the care of the same Consultant.

## Have all patients who are affected been told?

The initial review of paper records identified concerns regarding **11 cases**. These patients have been advised, clinical management plans are in place, and urgent issues actioned.

A further 236 oncology patients are being reviewed by an independent Urology consultant to ensure that their management plans and treatments are in line with guidance. These patients have been/are being contacted directly.

**Have patients come to harm?**

There are **nine cases** which are now part of a Serious Adverse Incident Review. A review of each of the **nine** patients care has been commissioned and is being led by an Independent Chair supported by a Consultant Urologist Expert. Each of these patients has been contacted by the Trust to inform them of the review process, arrangements have been made for patients in this group who need review appointments.

**How will patients affected by this be notified?**

Patients who have been identified as requiring review were contacted directly by the Trust as soon as issues with their care were identified.

**Can the Trust reassure patients that the Urology service is safe, and that patients are receiving appropriate care?**

Yes, our Urology team based in Craigavon Area Hospital provide care for thousands of patients each year and the current review is focused on a small proportion of these cases.

**Have concerns previously been raised about this consultant**

Part of the review process will look at all aspects of care provided, including a review of complaints received.

**How many patients have been identified as potentially being affected?**

To date the Trust review has identified **nine** patients that elements of their care require a Serious Adverse Incident review to take place. As the Trust review progresses there may be additional cases identified.

**Have any of these patients died or been harmed as a result of being this doctor's patient?**

The Serious Adverse Incident review process will seek to identify issues with the care provided to each patient to ascertain if harm occurred and what actions require to be taken to prevent this recurring in future.

**Why hasn't the Trust identified the doctor involved?**

The Trust has provided information regarding the doctor's identity to relevant professional and government agencies.

**Is the doctor still working for the Trust?**

The doctor is no longer working for the Trust or employed in Health and Social Care Services.

**How long did this doctor work for the Trust?**

The Doctor was employed by the Southern Health and Social Care Trust for 28 years.

**Will this doctor face disciplinary or legal action as a result of this review?**

The doctor is no longer an employee of the Trust therefore and future action would be the responsibility of the General Medical Council.

**Will there be a PSNI investigation into this?**

The remit of the review is to examine care provided by the Consultant using a chronological and incremental approach when reviewing the Consultants workload. This review is review in line with Department of Health, Public Health Agency and Health and Social Care Board processes.

**Were any concerns raised about this doctor before the dates being looked at in this review i.e. before January 2019?**

The General Medical Council are currently investigating professional aspects of the Consultants practice, an outcome will be provided by the General Medical Council in due course.

**What action(s) were taken as result of these concerns?**

As above

**Will the Trust now review all patient care provided by this doctor to all patients during his employment at The Trust?**

Any potential extension of the Trust review will be based on the outcomes of the current January 2019 to June 2020 review. A decision on this will be made in agreement with the Health and Social Care Board, Public Health Agency and Department of Health and will consider specialist advice from The Royal College of Surgeons.

**Kelly, Elaine**

**From:** Carroll, Ronan
**Sent:** 07 October 2020 10:36
**To:** Kingsnorth, Patricia; Corrigan, Martina
**Subject:** FW: IEAP referral
**Attachments:** Integrated Elective Access Protocol - April 2008.pdf; Integrated Elective Access Protocol Draft30June - OSL comments 01.07.20.doc

Update

## 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.

*Ronan Carroll*
*Assistant Director Acute Services*
*Anaesthetics & Surgery*
*Mobile* Personal Information redacted by the USI

**From:** Clayton, Wendy
**Sent:** 07 October 2020 10:34
**To:** Carroll, Ronan
**Subject:** IEAP referral

IEAP April 2008 – Page 34 3.4.5

IEAP June (this is only draft can't find final one) – 2.3.4 page 23

Thanks

Regards

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

*Angela Muldrew*
*RISOH Implementation Officer/Service Administrator*
*Tel. No.* Personal Information redacted by the USI

# Urology Oversight Group Minutes

## Tuesday 3rd November 2020, 4:30pm

## Via Zoom

| | Item | Actions |
|---|---|---|
| 1 | **In Attendance**<br>Stephen Wallace — Melanie McClements<br>Martina Corrigan — Mark Haynes<br>Damian Gormley — Jane McKimm<br>Siobhan Hynds — Ronan Carroll<br>Vivienne Toal — Maria O'Kane<br>Patricia Kingsnorth | |
| 2 | **Apologies**<br>None | |
| 3 | **Review of Action Log**<br>Group agreed | |
| 4 | **DoH Oversight Meeting Update (30th October 2020)**<br>Melanie updated on the DoH assurance meeting that took place on the 30th October. Meeting will be 2 weekly; this was chaired this week by Jackie Johnson. The Trust was commended on good work to date and progress. Group felt the Thursday meeting should continue to meet with current membership and will inform the DoH assurance group. The group felt the SAI process was not the best process moving forward. The focus of this incident is not the best process going forward. DoH / PHA to come back with a decision. The group felt external views on the process would be crucial. The group asked if there was any opportunities to act earlier in the summer by the Trust. Group discussed private practice and the challenges surrounding this. Dr O'Kane referenced MDM issues that were faced. It has been confirmed that the Minister will be making a statement to the assembly on the 10th November 2020. The group also required to consider family liaison roles. This is including psychology support. The status of impact to date included services that were stood down to conduct the review. The Trust has been asked to develop an IPT to state impact of incident. David Gordon felt we are moving towards a wider recall. Question was asked regarding who will front the media communications.<br><br>Mark Haynes referenced the clinical review process suggested at the meeting and how that will interface with the current work ongoing and what outputs.<br><br>The group discussed what are reasonable timescales for conducting processes such as triage, Mark Haynes stated these should be discussed with the external experts in the first instance to ascertain what is reasonable and what delay is reasonable. | **Martina / Stephen to contact Bernie Owens to form Trust oversight team**<br><br>**Thursday meeting to discuss clinical review process**<br><br>**Mark Haynes to discuss reasonable triage and administration response times with external experts** |
| | **Professional Governance** | |
| 4 | **Response from Tughans re Trust Letter**<br>Vivienne Toal discussed the letter received from Tughans. The letter largely forms a request for information. Stephen and Vivienne to draft a response to the Tughans response. Jane McKimm asked has the solicitors contacted the DoH directly, group unsure. | **Stephen and Vivienne to draft a response** |
| 5 | **GMC Discussions**<br>Dr O'Kane referred to the attached correspondence. Dr O'Kane has advised that the GMC have been asked explicitly to consider interim orders. | 20201013_LtrGENERAL MEDICAL COUNCI |

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|---|---|---|
| | Dr O'Kane explained that a conversation was had with Dr Fitzpatrick, NHS Resolutions to update on the case progression. Dr Fitzpatrick advised that NHS Resolutions would end at this stage. Dr O'Kane also advised that the chair and legal team of the Neurology Inquiry had been contacted to discuss potential early learning from the neurology review that can be incorporated into strengthening our assurance processes. | |
| **6** | **Administration Review Update**<br>Martina Corrigan advised a meeting to review the administration review will be meeting tomorrow to progress. Melanie McClements asked for a summary document to be brought back for next week, with a plan for the final report to be issued on GMC.<br><br>Mark Haynes referenced the work required regarding MDM processes and the importance of improving these. Dr O'Kane stated that she would be happy to endorse any improved processes for MDM that could be created. Patricia Kingsnorth stated that breast care have a failsafe nurse to ensure that actions to not get dropped. Melanie McClements stated that there is potential for regional learning from SAIs to improve processes. | **Melanie McClements to present summary report next week**<br><br>**Mark Haynes to identify model for MDM improvement** |
| **7** | **Mileage Claims**<br>Vivienne stated claims have been validated and payments are being processed via payroll currently, circa 270 miles. | |
| | **Serious Adverse Incident (SAI) Reviews** | |
| **8** | **Process for Managing SAI's going forward**<br>Melanie McClements asked what process should govern new SAI's. Dr O'Kane stated that there is a requirement from the PHA and HSCB to indicate what process should be followed going forward new SAIs. Melanie McClements asked is the 3 month timescale achievable; Patricia Kingsnorth felt this was possible. Dr O'Kane stated that if there is a move outside of process PHA need to provide written confirmation. | **Thursday meeting to discuss clinical review process** |
| **9** | **Original SAI's – Deceased Service User Family Contact**<br>Mark Haynes stated that the decision to inform to the final family could be guided by the process to notify patients who are part of the review process, e.g. if there care had an adverse outcome they would be told, if there was not an adverse outcome they would be told. | |
| **10** | **Initial Feedback from SAI Chair**<br>Discussed under item 6 | |
| **11** | **Family Liaison Role**<br>Melanie McClements stated that Patricia had informed that family liaison requirement was low at this stage. Patricia stated that some families will require psychological support especially those that are being spoken to about medication errors. Mark Haynes stated that each service user was required to be told of incidents face to face, Dr O'Kane suggested that a leaflet would be required to assist with sharing of information.<br><br>Group discussed the potential of contracting Inspire to offer additional support for both staff and patients. | **Vivienne to follow up with Inspire re additional support** |
| | **Management of Patient Reviews** | |
| 12 | **IPT for Review Process**<br>Mark Haynes stated the impact is difficult to quantify with lack of clinic space and disruption to services. Melanie McClements asked how many of the 2336 patients identified to date how many patients have been identified that will require review. Martina Corrigan was unsure as this work is ongoing. Mark Haynes stated that if we are |  <br>IPT for urology required.msg<br>**Ronan /** |

| | | |
|---|---|---|
| | required to arrange face to face for all patients who AOB has saw t[illegible] would be enormous. If these were triaged by exception, those which there are concerns regarding this is much more manageable. | **to follow up with Aldrina Magwood and Carol Cassells** |
| **13** | **Additional Subject Matter Expertise / Consultant Reviews**<br>Mark Haynes to contact Professor Sethia to arrange additional subject matter expertise. | KS CV 2020.doc |
| **14** | **Bicalutamide Patient Review**<br>Mark Haynes has started reviewing patients on Monday. Mark Haynes confirmed that the patient identified by the spotter practice as a long term bicalutamide prescription was prescribed appropriately | Clinical And Social Care Audit Registrati |
| **15** | **Engagement of ISP to undertake waiting list work**<br>Work continuing, 26 patients has refused as they did not wish to travel. | |
| **16** | **Telephone Support Service / Patient Triage Update**<br>Five calls this week, 147 in total, 5 have been required to be reviewed. One required reviewed. Martina Corrigan stated that more backup will be required following the ministerial statement which potentially could increase call volume. | **Martina / Melanie to discuss before next week** |
| | **Communications** | |
| **17** | **Ministerial Update Statement 10th November 2020**<br>Date noted by the group. Jane McKimm stated it was still unknown what the Minister will include in his statement, hopefully this will be clearer on Thursday / Friday | |
| **18** | **Media / Assembly Questions** | FAQs urology 02112020.docx |
| | **Any Other Business** | |
| **19** | **Any Other Business** | |
| | **Date of Next Meeting** | |
| **20** | **Via Zoom – 10th November 2020** | |

Southern Health and Social Care Trust

*Quality Care - for you, with you*

30th October 2020 Ref: MOK/ec

**Via email** [redacted]

Chris Brammall
Investigation Officer
General Medical Council
3 Hardman Street,
Manchester

Dear Mr Brammall,

**RE: GENERAL MEDICAL COUNCIL - MR AIDAN O'BRIEN GMC NO.** [redacted]

Further to your email dated 8th October 2020 requesting further information regarding concerns raised in relation to Mr Aidan O'Brien, Consultant Urologist employed by the Southern Health and Social Care Trust, please see below itemised responses and where noted, attached items. Further to the below information and attached items a verbal update was provided to Joanne Donnelly Employer Liaison Advisor, General Medical Council on the 23rd October 2020.

A copy of correspondence was issued via the Trust Directorate of Legal Services to Mr O'Brien's solicitor on 25th October 2020 and is attached as Appendix A, this provides additional information regarding:

- Information regarding media interest in the case
- Details of additional concerns raised regarding Mr O'Brien's practice including concerns regarding the prescribing on the anti-androgen Bicalutamide
- The Chief Medical Officer decision to issue a Professional Alert as per guidance found in DHSSPS Circular HSS (TC8) 6/98

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: [redacted] Email: [redacted]

It is my opinion, that given the information known to date that the General Medical Council should consider implementing interim orders restricting Dr O'Brien's practice at the earliest opportunity.

| | |
|---|---|
| **Any update that you may have the possible RCS lookback / patient recall exercise and information that may have arisen out of any review** | The Trust is continuing to progress with a review of Mr O'Brien's activity since January 2019 to identify any additional issues with the quality of care delivered.<br><br>The Trust is liaising with the Department of Health Northern Ireland, Health and Social Care Board and Public Health Agency to guide the review process. The Trust has also consulted with the Royal College of Surgeons who have provided guidance on developing the review criteria.<br><br>To date as a result of this review further issues have been identified which have required screening as potential Serious Adverse Incidents, in total nine of these incidents have been deemed as meeting Serious Adverse Incident criteria.<br><br>The Trust has also been made aware of the scale Mr O'Brien's significant private practice activity via discussions with GPs in the Southern Area. Mr O'Brien's private practice was conducted from his home; therefore all records of this activity will solely be in his position. The Trust has no access or information on the scale of this activity, the Trust has made the Department of Health Northern Ireland, Health and Social Care Board and Public Health Agency aware of this area of activity. Given Mr O'Brien's residence being located close to the border with the Republic of Ireland, the Trust has concerns there may be private practice issues involving patients from this jurisdiction. |

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| | In addition to this GP colleagues have commented that on occasion they have referred patients to the Southern Health and Social Care Trust to later receive correspondence from Mr O'Brien regarding the same patient on documentation referring to the individual as a private patient.<br><br>The Northern Ireland Minister for Health has issued a written statement to the Northern Ireland Assembly on 27th October 2020 regarding this issue; this can be found attached as Appendix B. The concerns have also received media coverage via the Irish News and BBC Northern Ireland websites. Mr O'Brien has not been named in any public releases.<br><br>The Minister for Health plans to make a statement in the Assembly on the 10th November.<br><br>The Department of Health Northern Ireland has established an Departmental Oversight Group to provide assurance surrounding all elements of each ongoing process, a letter outlining this is attached as Appendix C. |
| **An update about the new MHPS investigation that was being considered due to the additional concerns about Mr O'Brien that arose recently** | The Trust sought advice from the Department of Health Northern Ireland regarding the new MHPS investigation. The Trust has been advised that as the process did not commence when Mr O'Brien was an employee that the investigation should not be pursed.<br><br>The Trust is no longer his designated body and I am no longer his responsible officer. A response received from Mr O'Brien's solicitor (Appendix D) also indicates that Mr O'Brien will not engage with any Trust MHPS process as he is no longer employed by the Trust. The Trust response to this correspondence is attached as |

| | |
|---|---|
| | Appendix E. |
| **Any updates concerning the SAI reviews for service user A and service user B as identified in the new concerns that were recently sent to the GMC** | The Trust has discussed the identified Serious Adverse Incidents with the Department of Health Northern Ireland, Health and Social Care Board and Public Health Agency.<br><br>As a result the Trust and PHA have appointed an independent chairperson to conduct these Serious Adverse Incident reviews with subject matter expert support provided by an independent Consultant Urologist nominated via the British Association of Urological Surgeons (BAUS). A wider review panel to support this has been appointed and work is preparing to commence.<br><br>Further to this the Trust has identified a further seven Serious Adverse Incidents relating to patients on Mr O'Brien's caseload. Case summaries for these patients are attached as Appendix C.<br><br>The Departmental Oversight Group is considering going forward whether all of these should progress as individual SAIs or become part of a different process such as an inquiry.<br><br>During the initial stages of the Serious Adverse Incident reviews patient safety concerns have been raised by the chairperson in relation to the prescribing of Bicalutamide, an antiandrogen medication that is primarily used to treat prostate cancer, which should be prescribed at 150mg for a maximum of 8-10 weeks (and kept under review during that period) to patients prior to starting radiotherapy.<br><br>The concern is with regard to patients that have been managed on Bicalutamide for extended periods, in |

| | |
|---|---|
| | excess of 8-10 weeks, without review during that period, and at 50mg, which is associated with making prostate cancer worse. It is also associated with a variety of harmful side-effects. The context is complex as Dr O'Brien would have advised the prescribing requirements, the GP would issue the prescription, and the pharmacist would dispense.<br><br>The Trust is currently identifying those patients who are prescribed this medication and providing review appointments as a matter of urgency. |
| **The outcome (or a copy of) the independent review into the administrative procedures that was due to be concluded by September 2020 (when this becomes available)** | The independent review into administrative procedures commenced in August 2020. Further details on standard operating processes for administration of patient information has been requested to complete this work prior to acceptance of completion. This will be shared with the GMC on finalisation, this is expected 16th November 2020. |

I trust this provides the necessary detail required. Should you have any queries, please do not hesitate to contact me.

Yours sincerely

Personal Information redacted by the USI

**Dr Maria O'Kane**
**Medical Director**

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by the USI Email: Personal Information redacted by the USI

## Kelly, Elaine

**From:** McClements, Melanie
**Sent:** 03 November 2020 15:50
**To:** Cassells, Carol; Magwood, Aldrina; Wallace, Stephen; Carroll, Ronan; Corrigan, Martina; Haynes, Mark; Toal, Vivienne; Hynds, Siobhan; Kingsnorth, Patricia
**Cc:** O'Neill, Helen; OKane, Maria; Devlin, Shane
**Subject:** IPT for urology required

Hi Carol and Aldrina

At the DOH assurance group on Friday we were asked to do an IPT detailing the impact **financial and otherwise** of the Urology SAI etc. concerns to consider:

- **Pt impact to date**, stood down clinics, theatre lists etc.;
- **Future look** at impact as patients who would have been appointed next are likely to be displaced for reprioritised cases from this current review;
- **Clinical and operational** resource required to date and going forward – Urologist time, CNS,, HOS, admin, information line etc….
- Contracted **oncology reviews**;
- **SAI** resource;
- **Family liaison**;
- **Psychology** input;
- **3rd sector** support from **charities** etc.
- **Anything else you can think of…**
-

Can we discuss at urology meeting this afternoon?

Carol and Aldrina can you support us with this? Thanks Mel

# Curriculum Vitae

**Professor Krishna K Sethia**

**Consultant Urological Surgeon**

**Norfolk & Norwich NHS Trust**
**Colney**
**Norwich NR4 7UZ**

**1 February 2020**

| | | |
|---|---|---|
| **NAME** | | Krishna Kumar **SETHIA** |
| **ADDRESS** | HOME | Personal Information redacted by the USI |
| | WORK | Norfolk & Norwich NHS University Trust<br>Colney<br>Norwich NR4 7UZ |
| **TELEPHONE** | HOME<br>MOBILE | Personal Information redacted by the USI |
| **Email** | | Personal Information redacted by the USI |
| **NATIONALITY** | | British |
| **DATE OF BIRTH** | | Personal Information redacted by the USI |
| **MARITAL STATUS** | | Personal Information redacted by the USI |
| **GENERAL MEDICAL COUNCIL** | | Full Registration Personal Information redacted by the USI |
| **MEDICAL DEFENCE** | | Medical Protection Society |

| | | |
|---|---|---|
| **QUALIFICATIONS** | MA (Oxford) | 1986 |
| | MBBS (London) | 1979 |
| | FRCS (England) | 1984 |
| | DM (Oxford) | 1988 |
| | FRCSEd | 2006 |

**EDUCATION**

Eton College, Windsor, Berks

Exeter College, Oxford

Guys Hospital Medical School, London SE1

**PRESENT APPOINTMENTS**

Consultant Urologist
Norfolk & Norwich NHS Trust
Colney
Norwich NR4 7FP

Honorary Professor
University of East Anglia, Norwich

Chairman
British Journal of Urology International

**PREVIOUS APPOINTMENTS**

Medical Director, Norfolk & Norwich University NHS Trust (2009-2015)

Hon Treasurer, British Association of Urological Surgeons (2003-2006)

Director of Surgical Division, Norfolk & Norwich University NHS Trust (2003-2007)

Manpower Planning Officer, British Association of Urological Surgeons (2000-2006)

Member of and Examiner for the Intercollegiate Board in Urology (2000-2008)

Vice-Chairman of Specialist Advisory Committee in Urology, Royal College of Surgeons (2003-2006)

Clinical Director, Urology & Nephrology, Norfolk & Norwich University NHS Trust (1997-2002)

Member of Council, British Association of Urological Surgeons (1997-2002)

Honorary Lecturer, Institute of Urology (1996-1999)

Norwich District Ethics Committee (1994-1998)

R& D Committee, Norfolk & Norwich NHS Trust (1996-1998)

Lead Doctor in Urology, Waveney Cancer Centre (1998 -2003)

Senior Registrar in Urology, Freeman Hospital, Newcastle (1988-1990)

**EXPERIENCE**

**1. Clinical**

Having completed training posts in Oxford and Newcastle I was appointed to a Consultant Urologist post in Norwich in 1990. As well as providing a general urological service I developed special interests in urological cancers (especially bladder and prostate) and andrology and during the 1990's I developed the Norwich unit into a tertiary referral centre for both these subspecialties. I also established the superregional service for the management of patients with cancer of the penis.

Together with the specialist urological cancer nursing team for which I secured the initial funding I set up a local patient support group for men with prostate cancer and their families.

My clinical commitments inevitably decreased when I became Medical Director but since relinquishing that post in I have increased my clinical practice. I continue to develop the urological cancer services in Norwich. My current main interests are in the management of superficial bladder tumours, penile cancers and the diagnosis of prostate cancer. I continue to run the specialist andrology service for the region.

**2. Hospital Management**

**a. Director of Surgery (2003-2007)**

As Director of Surgery I was responsible for the organisation of surgical services, clinical governance in surgery and ensuring that access targets were met. My specific achievements in my 4 year tenure were;

1. Reorganisation of the theatre schedules and surgeon timetables to create 25% more operating time in the week and increased theatre utilisation to over 90%.
2. Introducing centralised pre-operative assessment for all surgical patients.
3. Building of a unit to ensure that all patients were admitted on the day of surgery rather than the night before.
4. Achieving all access targets.
5. Increasing day-case surgical rates to the best quartile in the country.
6. Achieving cost-savings to plan.

**b. Medical Director (2009 to 2015)**

**1. Clinical Governance**

In my time as Medical Director I was involved in two reorganisations of clinical governance the second of which was designed to take account of all the Francis, Keogh and Berwick reports and CQC requirements. I was chairman of the Clinical Safety and Clinical Effectiveness Sub-Boards and of meetings of all Directorate Governance Leads.

**2. Quality Improvement.**

Five years ago I instigated a programme of annual safety improvement projects based on IHI methodology. Over 250 clinicians were eventually involved and significant changes to practice have resulted. Projects I have led or been involved in with other Executive Directors by 2015 had achieved significant improvements including

a. No hospital-acquired MRSA bacteraemias for 3 years
b. 85% reduction in C difficile infection over 3 years
c. Significant reduction in medication prescribing errors
d. Compliance with the WHO checklist
e. Compliance with thromboprophylaxis assessment. Hospital granted exemplar status.
f. Improved Early Warning Score completion and response to triggers.
g. Declining cardiac arrest calls outside critical care
h. Central line infection rates of under 1/1000 hospital days

**c. Operational**

As Medical Director

a. I shared responsibility for day-to-day operational performance.
b. I led a project to enlarge and redesign the emergency areas of the NNUH. We have established a regular GP presence in the emergency department.
c. I completed a review of critical care capacity and formulated plans for an increase thereof.
d. I regularly met and represented the hospital with the local Clinical Commissioning Groups and played an active role in contract negotiations.

**d. Revalidation**

a. I was Responsible Officer for over 800 doctors working at the Norfolk & Norwich Hospital.
b. I was responsible for introducing the policies and processes for enhanced appraisal and, with the help of a Revalidation Lead, ensured that the Trust was prepared for medical revalidation.

**e. University**

a. In 2009 together with the Medical School I instigated a strategy to increase research activity in the hospital by appointing a series of clinical academics with focussed areas of interest.
b. I established a Joint Research Committee which includes doctors, nurses, allied health professionals and university staff.
c. I helped establish a joint research office with UEA for managing clinical research.
d. Together with the Dean of Health I have supervised the development of the Norwich Clinical Trials Unit and Clinical Research facilities which now have full NIHR registration.
e. I promoted joint projects involving the hospital and other Institutes on the Norwich Research Park. I was the hospital representative on the NRP Scientific Board.
f. I supported the UEA project to obtain a new Medical School Building (BCRE) including a Biorepository.
g. In 2013, I was author of and together with the CEO led the Norfolk & Norwich Hospital successful bid to host the NIHR Eastern Clinical Research Network
h. I was involved with the Norwich bid to build a new Institute for Food and Health to include clinical gastroenterology.
i. I represented the hospital on the UEA/NNUH Joint Board University/NNUH (chaired by the Vice-Chancellor and Trust CEO)

**f. Other hospitals**

I have actively encouraged clinical collaborations with neighbouring hospitals (Kings Lynn and James Paget). To date this has resulted in an **i**ncreasing number of consultant joint appointments. I was instigated and was involved with projects to

a. Standardise clinical guidelines between the Trusts
b. Establish joint formularies
c. Establish a single Drugs, Therapeutics and Medicines Management Committee
d. Integrate clinical teams

**3. National Associations / Committees**

**i. British Association of Urological Surgeons**

**a. Council Member (1997-2002)**
**b. Manpower Planning Officer (200-2007)**
**c. Treasurer (2005-2008)**

For the past 18 years I have contributed to the development of BAUS and British Urology. Particular achievements have been:

1. As a major contributor to the development of different types of Consultant Urologists trained to have skills matching service need.
2. Regular liaison with National Workforce Planning Groups to ensure training numbers correct.
3. Responsibility for the reorganisation of BUAS into a charitable company limited by guarantee.
4. Rewriting of the M&A's and Rules of the Association.
5. Rewriting of all protocols for Governance within the organisation.
6. Establishing the budgeting process for the Association.
7. Creating a Strategic Plan for the Association.

**ii. SAC in Urology (2000-2006), Vice-Chairman (2003-2006)**

Apart from the normal duties of an SAC member I have made a particular contribution in:

i. The revision of the curricula in Urology
ii. Supervision and planning of urological manpower.
iii. Review of section 14 applications to PMETB

**iii Examiner for Intercollegiate Board in Urology (2000 to 2008)**
**Member of Intercollegiate Board in Urology (2003 -2008)**
**Examiner for International Urology exam (2018- present)**

As a member of the Intercollegiate Board I was responsible for exam design, standard-setting and ensuring educational validity. I personally rewrote over 25% of the then clinical question bank. In 2018 I was again appointed an examiner for the joint colleges international exam in urology.

**4. British Journal of Urology International (BJUI)**

Having been a Trustee for 7 years I was appointed Chairman of the BJUI in 2015.

For the past 5 years I have led the development of a comprehensive educational on-line programme which will serve international CPD and CME requirements. This involves collaboration with the Urological Societies of Australia and New Zealand, Hong Kong, Canada, India, Indonesia, Malaysia, Korea and the Republic of Ireland. The education programme was launched in January 2016 and has accreditation from the Edinburgh College of Surgeons (RCSEd). It has been now used by all UK urological trainees and widely in Asia and Australasia. We are working with the GMC and urology SAC to establish it as the standard for knowledge for all trainees.

**5. Teaching experience**

In the 1990's I was responsible for Higher Surgical Training in Urology in Norwich. I established and ran an annual residential regional teaching course which has remained an important part of our specialist registrar programme and is consistently highly-rated by trainees. I continue to contribute to this.
For the past 60 months I have been working with the RCSEd to develop a surgical training programme for Myanmar. This is being expanded to involve all the surgical specialties in the country.

**6. Research experience**

Following appointment as a consultant I was PI in several clinical trials within the Urology department.
For most of my career my other research activity has involved facilitating researchers in collaborations with University departments.
I took responsibility for establishing and organising the Norwich contribution to the national 100,000 Genome project.
In the past 12 years I have been involved in supervising 3 PhD and one MD student.

**8. Medicolegal**

For the past 17 years I have provided medicolegal opinions. I have been instructed by solicitors for acting both for the plaintiff and the defence (current ration 30:70). I currently provide approximately 80 reports per year. I am prepared to travel anywhere in the UK to see patients. I regularly attend case conferences with barristers and I have experience of giving expert evidence in Court.

**9. Other**

In the past 7 years I have been invited to perform 3 major reviews of urology department's performance and organisation in the UK.
I am experienced in reviewing serious incidents which I have done both for the Royal College of Surgeons and when requested by individual Trusts.

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**EDITORIAL ACTIVITY**

I am a regular reviewer for the British Journal of Urology International, Current Opinions in Urology, the Journal of Clinical Urology and the Journal of Sexual Medicine.

# FAQs Urology October 2020

## Why has the Southern Trust decided to look back at Urology patients?

Clinical concerns were raised regarding the work of one Consultant Urologist in June 2020 when two patients were identified has having not been listed on to the Trust Patient Administration System in a timely manner. This was alerted as a potential patient safety issue due to potential delays in treatment and prompted a wider review of the Consultant's workload to establish if there were additional service impacts.

## What happened when concerns were raised?

Following the identification of clinical concerns, the Trust provided information about the Consultant's practice to the General Medical Council. In addition to this, restrictions were placed on the Consultant's practice by the Trust so they could no longer undertake clinical work and could not access patient information. The Department of Health were provided with details of the case via the 'Early Alert' mechanism.

A further review of the Consultant's workload over an 18 month period - January 2019 to June 2020 – has been on-going since June, with expert independent advice sought to inform the scope and scale of the work.

## Why is the Trust only looking at cases between January 2019 and June 2020?

The Trust has agreed with the Health and Social Care Board, Public Health Agency and Department of Health to a chronological and incremental approach when reviewing the Consultants workload. In the first instance the Trust has reviewed cases in this 18 month period. The scope and scale of any further review may be extended. This will be based on our internal review of patient records and advice from the Royal College of Surgeons.

## What issues have the Trust now identified?

The Trust has reviewed all of the Consultants elective and emergency activity that occurred between January 2019 and June 2020. The review has progressed to diagnostic testing conducted including radiology, pathology and cytology to ensure appropriate action has been taken on each result. Of these patients who have been reviewed, there have been **nine** cases which are now part of an independently chaired Serious Adverse Incident Review process.

The Trust has also recently identified concerns regarding medication prescribing, as a result 26 patients have been reviewed by our Urology team.d

## How many patients are involved in the review process?

## Were all the patients treated by the same doctor?

All the patients included in this review were under the care of the same Consultant.

## Have all patients who are affected been told?

The initial review of paper records identified concerns regarding **11 cases**. These patients have been advised, clinical management plans are in place, and urgent issues actioned.

A further 236 oncology patients are being reviewed by an independent Urology consultant to ensure that their management plans and treatments are in line with guidance. These patients have been/are being contacted directly.

**Have patients come to harm?**

There are **nine cases** which are now part of a Serious Adverse Incident Review. A review of each of the **nine** patients care has been commissioned and is being led by an Independent Chair supported by a Consultant Urologist Expert. Each of these patients has been contacted by the Trust to inform them of the review process, arrangements have been made for patients in this group who need review appointments.

**How will patients affected by this be notified?**

Patients who have been identified as requiring review were contacted directly by the Trust as soon as issues with their care were identified.

**Can the Trust reassure patients that the Urology service is safe, and that patients are receiving appropriate care?**

Yes, our Urology team based in Craigavon Area Hospital provide care for thousands of patients each year and the current review is focused on a small proportion of these cases.

**Have concerns previously been raised about this consultant**

Part of the review process will look at all aspects of care provided, including a review of complaints received.

**How many patients have been identified as potentially being affected?**

To date the Trust review has identified **nine** patients that elements of their care require a Serious Adverse Incident review to take place. As the Trust review progresses there may be additional cases identified.

**Have any of these patients died or been harmed as a result of being this doctor's patient?**

The Serious Adverse Incident review process will seek to identify issues with the care provided to each patient to ascertain if harm occurred and what actions require to be taken to prevent this recurring in future.

**Why hasn't the Trust identified the doctor involved?**

The Trust has provided information regarding the doctor's identity to relevant professional and government agencies.

**Is the doctor still working for the Trust?**

The doctor is no longer working for the Trust or employed in Health and Social Care Services.

**How long did this doctor work for the Trust?**

The Doctor was employed by the Southern Health and Social Care Trust for 28 years.

**Will this doctor face disciplinary or legal action as a result of this review?**

The doctor is no longer an employee of the Trust therefore and future action would be the responsibility of the General Medical Council.

**Will there be a PSNI investigation into this?**

The remit of the review is to examine care provided by the Consultant using a chronological and incremental approach when reviewing the Consultants workload. This review is review in line with Department of Health, Public Health Agency and Health and Social Care Board processes.

**Were any concerns raised about this doctor before the dates being looked at in this review i.e. before January 2019?**

The General Medical Council are currently investigating professional aspects of the Consultants practice, an outcome will be provided by the General Medical Council in due course.

**What action(s) were taken as result of these concerns?**

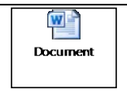
As above

**Will the Trust now review all patient care provided by this doctor to all patients during his employment at The Trust?**

Any potential extension of the Trust review will be based on the outcomes of the current January 2019 to June 2020 review. A decision on this will be made in agreement with the Health and Social Care Board, Public Health Agency and Department of Health and will consider specialist advice from The Royal College of Surgeons.

# Incident Management

| ID | Element | Actions Required | Responsible | Date for Completion | Attachments | Complete |
|---|---|---|---|---|---|---|
| 1 | GMC Request for Information 8th October 2020 | Further communication received from the GMC asking for update on issues. Draft corresepondence created for review. GMC to be advised of decision not to progress with MHPS review based on DoH advice. | M O'Kane / S Wallace | 6th November | | |
| 2 | MHPS Investigation (New) | AOB is no longer professionally accountable to the SHSCT and Dr O'Kane is not responsible officer - this has been the case since 29th July 2020.<br><br>Response from AOB solictor 9th September stating that as MHPS did not start prior to AOB's retirement that there are no grounds for continuing the process. DLS advice has been dou on AOB solictor communcation. DoH have also advised that given AOBs retirement MHPS should not be followed.<br><br>GMC to be updated | M O'Kane / S Hynds / S Wallace | 30th September | | Complete |
| 3 | Mileage Claims | AOB has submitted mileage claims for previous 8 years prior to retirement. AOB's contract states that this should be monthly submissions. SH stated that communications had been issued to staff at regular intervals to remind of the importance of prompt submission. Group agreed that April 2020 would be reasonable for consideration following verification. | M McClements / R Carroll / M Corrigan | 20th October | | In progress |
| 4 | Administration Review | Dr Rose McCullagh and Dr Mary Donnelly are conducting an administrative process review as specified in the 2018 MHPS review outcome.<br><br>Group to be convened to progress wider aspects of the admin review. To consider additional quality assurance mechanisms | R McCullagh / M Donnelly | 20th October | | In progress |
| 5 | Screening of potential SAIs | Nine SAIs screened as meeting SAI criteria. | M Haynes / M Corrigan / P Kingsnorth | 20th October | | In progress |
| 6 | SAI Reviews | Required:<br>- Communications with service users / families who are subject to SAIs - all nine new SAI service users / families contacted to inform of SAI progress. 4/5 original SAI service users contacted also<br>- Discussion with DH to take place regarding progression of SAI's including discussions required with Trust staff, chair of MDM etc and ongoing family liaison arrangements. | M Haynes / M Corrigan / P Kingsnorth | | | |
| 6 | Trust External Communications | Jane to speak to David DoH on coordinated Communications strategy.<br><br>- Trust to decide on public communicaions arrangements<br>- HSCB offered Comms manager support<br>- FAQ document to be developed to support media communications | Martina, Patricia and Ronan | 3rd November | | In progress |
| | Family Liaison | Family liaison person to be identified - MMcC has two persons who potentially can fulfil this role in mind. MMcC Discussions to take place with respective line managers to progress | | | | |
| 7 | Additional Subject Matter Expertise | Further to this we have identified via RCS and BAUS another Subject Matter Expert Professor Krishna Sethia who is willing to engage with us. | | 20th October | | In progress |

| | | | | | | |
|---|---|---|---|---|---|---|
| 8 | Engagement of ISP to undertake waiting list work | Draft contract engagement document developed- pathways for service access are mapped. Documentation with contracts team for approval | M Haynes / M Corrigan | 20th October |   | In progress |
| 9 | Review Scope | *Action plan to review key areas of concern developed by Urology Team<br>- Review of stent removals Jan 2019 - June 2020 160 pts<br>- Review of elective activity Jan 2019 - June 2020 352 pts<br>- Review of pathology results Jan 2019 August 2020 168 pts<br>- Review of Radiology requests Jan 2019 - August 2020 1028 pts episodes<br>- Review of MDM episodes Jan 2019 - July 2020 271 pts<br><br>Initial concerns found in a review of 270 patients has found issues with clinical skills where deviations from guideline based treatments. There is a requirement to understand the volume of patients who may be in this group.<br><br>Additional SME Consultant Urologist Krishna Sethia has been identified as another avialable subject matter expert. | M McClements / M Haynes / M Corrigan / R Carroll | 1st September | | In progress |
| 10 | Bicalutamide Concerns | PK provided an update on SAI independent expert who has stated that Bicalutamide management in at least one case likely contributed to the death of one service user. The group discussed actions required to ensure that patient safety is maintained. The group dicussed the challenge with identifying patients who have been prescribed by AOB and those that are prescribed in secondary care. An update is being sought from Tracey Boyce and Joe Brogan to identify prescribing patterns. Group agreed this required addressing as a matter of urgency<br><br>No information recieved from the PHA / HSCB re primary care prescribed Bicalutamide | M McClements / R Carroll | | | |
| 10 | Clinician Early Alert | M O'Kane / S Wallace to discussed Clinician Early Alert with DoH. DoH advised that informal communication with other Trust MDs and HRODs would be appropriate. MOK has completed this action. | Dr Maria O'Kane / S Wallace | 20th October | | Complete |
| 12 | Communication with DoH / Minister | Group agreed that date of 19th October 2020 for release should be postponed. Group suggested MD communicates with CMO to ask to postpone date. | M O'Kane | 14th October | | |
| 14 | Telephone Support Service | Telephone Support Service developed.<br>Attached Powerpoint | M McClements / R Carroll / M Corrigan / M Haynes | 20th October | | |
| 16 | Early Alert to DoH | Early Alert issued to DoH and HSCB regarding Bicalutamide | Dr Maria O'Kane / S Wallace | 16th October | | Complete |
| 17 | Information on Appraisal, Job Planning, Litigation and Complaints | Information on apprisal, job planning and complaints collated | S Wallace | 7th August | Information Collated - saved in shared folder | Complete |

# Incident Oversight Group

**Tuesday 8th December 2020, 4:00pm**

**Via Zoom**

## AGENDA

| | | |
|---|---|---|
| 1 | Apologies | |
| 2 | Minutes | MINUTES - Incident Group 01.12.2020 DF |
| 3 | DoH Oversight Meeting Update (4th December 2020) | |
| | | |
| 4 | Private Practice<br>- Private Practice Audit<br>- Private Practice Patients transferred to HSC | |
| 5 | Update on Radiology and MDM Review | |
| 6 | IPT for Review Process | Urology Inquiry IPT - draft 7 (8 december |
| 7 | Additional Subject Matter Expertise<br>- British Association of Urological Surgeons<br>- British Association of Urological Nurses | Independent Consultant Urology S |
| 8 | Royal College of Surgeons Engagement | Terms of Reference CLINICAL RECORD RI |
| 9 | Bicalutamide Patient Review | Clinical And Social Care Audit Registrati |
| 10 | Engagement of ISP to undertake waiting list work | |
| 11 | Telephone Support Service / Patient Triage Update | |
| **Professional Governance** | | |
| 12 | GMC Discussions | |
| 13 | Litigation / DLS Update | |
| 14 | Grievance Process | |
| 15 | Professional Alert Letter | |
| 16 | Administration Review Update | |
| **Serious Adverse Incident (SAI) Reviews** | | |
| 17 | Update on Current SAI Progress | |
| 18 | Initial SAI Recommendations | Action plan [redacted].docx |
| 19 | Structured Judgement Review Process | |
| 20 | Family Liaison Role | |
| **Communications** | | |
| 21 | Media / Assembly Questions | |
| **Any Other Business** | | |

| | | |
|---|---|---|
| 22 | Coronial Processes | |
| 23 | Letter to Staff re AOB Patient Reviews |  07.12.2020 - Memo - Identification of Varia  UROLOGY PATIENT REVIEW FORM v1.do |
| 24 | Declaration re CURE |  DECLARATION OF INTERESTS FORM.do |
| 25 | Securing Records for Public Inquiry | |
| **Date of Next Meeting** | | |
| 23 | Via Zoom – 15th December 2020 | |

# Urology Oversight Group Minutes

## Tuesday 8th December 2020, 4:00pm

## Via Zoom

| | Item | Actions |
|---|---|---|
| 1 | **In Attendance**<br>Stephen Wallace — Melanie McClements<br>Martina Corrigan — Dr Maria O'Kane<br>Dr Damian Gormley — Jane McKimm<br>Siobhan Hynds — Mr Mark Haynes<br>Patricia Kingsnorth | |
| 2 | **Apologies**<br>Vivienne Toal<br>Ronan Carroll | |
| 3 | **Weekly DoH Update**<br>Melanie updated on the meeting. Main update was to suggest that the SJR methodology would be a potentially viable vehicle going forward. Public Inquiry isn't likely to commence until March 2021. DOH meetings will now be two weekly. Prof Krishna to quality assure work to date. Second victim discussion regarding supports required. | |
| | **Management of Patient Reviews** | |
| 4 | **Private Practice**<br>Martina updated on another case identified via GP practice. DLS have identified that AOB has still been liaising with DLS regarding medico-legal cases. Further information on this has been sought. | **DLS to update on AOB work** |
| 5 | **Update on Radiology and MDM Review**<br>No update this meeting, to follow next week | **Update next meeting** |
| 6 | **IPT for Review Process**<br>Martina reviewed IPT with the HSCB and costed at 2.3 million for 15 months. Costs in year to be met with 200k urology funding. Further funding required for 2021/22 via IPT process. | **To be discussed at HSCB meeting** |
| 7 | **Additional Subject Matter Expertise**<br>Group reviewed the role description and agreed content. | |
| 8 | **Royal College of Surgeons Engagement**<br>Group reviewed the terms of reference, broadly agreed content. Sampling strategy to be agreed. Group felt 5 years may be appropriate. | |
| 9 | **Bicalutamide Patient Review**<br>No further update | |
| 10 | **Engagement of ISP to undertake waiting list work**<br>Martina and Mark to speak to Patrick Keane to agree if he will be willing to engage beyond December. | **Martina / Mark to discuss with** |

| | | |
|---|---|---|
| 11 | **Information Telephone Line**<br>Martina stated that the information line has been quiet this week. Martina referenced a recent communication from a patient who received a letter from an unknown source regarding the care provided by AOB asking to contact the information line, this was not issued by the SHSCT.<br><br>Group discussed producing a holding letter to patients regarding those patients who will not be part of the review going forward. Group agreed holing letters should be issued. | **Holding letter to patients to be issued** |
| **Professional Governance** | | |
| 12 | **GMC Discussions**<br>Maria updated on the meeting with the GMC ELA. AOB will be going to interim orders on 15th December 2020. | |
| 13 | **Litigation / DLS Update**<br>Next meeting – update covered in item 4 | |
| 14 | **Grievance Process**<br>Next meeting | |
| 15 | **Professional Alert Letter**<br>Next meeting | |
| 16 | **Administration Review Update**<br>Next meeting | |
| **Serious Adverse Incident Reviews** | | |
| 17 | **Update on Current SAIs**<br>Communications are ongoing, a letter has been drafted to AOB via Tughans to invite AOB to take part. Summary position is expected on Friday. Maria asked that for responses are to be submitted by set deadlines. | **Patricia to write to AOB on SAI Chair behalf** |
| 18 | **Initial SAI Recommendations**<br>Recommendations are in progress, update to be provided at a future meeting | **SJR model to be discussed with the HSCB** |
| 19 | **Structured Judgement Review Process**<br>Next meeting | |
| 20 | **Family Liaison Role**<br>Liaison role closes on Friday this week. | |
| **Communications** | | |
| 21 | **Media / Assembly Questions**<br>No update this week | |
| **Any Other Business** | | |
| 22 | **Coronial Processes**<br>Next meeting | |
| 23 | **Letter to Staff re AOB Patient Reviews**<br>Letter agreed | |
| 24 | **Declaration re CURE** | |
| 25 | **Securing Records for Public Inquiry** | |
| **Date of Next Meeting** | | |
| 26 | **Via Zoom – 15th December 2020** | |

Southern Health and Social Care Trust

# PROPOSAL FOR STRUCTURED CLINICAL RECORD REVIEW

*DRAFT V1 - 17th February 2021*

## Background

1. On the 23rd November 2021 the Minister for Health gave direction for the initiation of a Public Inquiry regarding the Clinical Practice of Mr Aidan O'Brien, Consultant Urologist.

2. Although yet to be developed, the terms of reference for Public Inquiry will consider Mr O'Brien's practice across all of his clinical activity. This will likely include reviews involving individual patient cases where a potential adverse outcome was identified.

3. While ensuring that the work of the Public Inquiry is not disrupted or delayed, in the interests of maintaining patient safety it remains incumbent on the Trust to ensure that where potential patient safety incidents are identified, a proportionate patient safety review should take place to inform learning and develop safer systems in a timely manner.

4. Remaining cognisant of regional parameters and requirements for the identification, review and learning from Adverse and Serious Adverse Incidents (SAI) as set out in the HSCB *Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016)* the Trust has sought to provide an alternative, proportionate and robust review structure that can be utilised to review SAI's in a timely manner.

5. Any patient safety review process will function and report within the existing clinical governance arrangements for the Trust and as such be subject to quality assurance processes and an appropriate level of scrutiny.

## Title of Review Structure

6. The Trust is mindful that any proposed alternative review structure should be demarcated clearly as different to the SAI process. It is therefore important that for clarity for service users, staff and the public that the title should articulate this clearly.

**Proposal 1 – The name of the review mechanism will be titled STRUCTURED CLINICAL RECORD REVIEW (SCRR)**

## Underpinning Review Methodology

7. To ensure confidence in the SCRR process an adoption of a robust and validated method will be required. To this end, the Trust has spoken to the Royal College of Physicians with a view to adapting the underpinning principles and methodology found in the Structured Judgement Review (SJR) Process.

8. The Royal College of Physicians SJR combines clinical-judgement based review methods with a standard format. The format requires reviewers to make safety and

quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase.

9. As an outcome of the SJR the result is a short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.

10. The objective of the SJR method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process.

11. In order to answer these questions, there is a need to look at: the whole range of care provided to an individual; holistic care approaches and the nuances of case management and the outcomes of interventions.

12. The Trust proposes developing an adapted form from the base Royal College of Physicians SJR template and seeking Royal College of Surgeons agreement. The Trust envisages that the tool will be developed in two sections to consider both inpatient and outpatient care provided.

**Proposal 2 – The underpinning methodology will be based on the Royal College of Physicians Structured Judgement Review tool**

## Identification of Cases for Structured Clinical Record Reviews

13. The inclusion criteria and thresholds for cases in the SCRR process will remain in keeping with those set out in the HSCB *Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016)* with particular reference to section 4.2 of the document which outlines the following specific criteria:
    - Serious injury to, or the unexpected/unexplained death of a service user
    - 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

14. Where appropriate the Trust will continue to screen adverse incidents, complaints and returns from patient record reviews for consideration of inclusion in the SCRR process.

**Proposal 3 – The Trust will maintain the same screening criteria, thresholds and processes for SCRR as is currently in place for SAIs**

## Conducting Structured Clinical Record Reviews

15. The Trust recognises the requirement to conduct SCRR in a timely manner to identify and action learning and system changes as appropriate. In this regard the Trust

proposes engaging the services of an independent Consultant Urologist via the Royal College of Surgeons to conduct the SCRR process who has training, knowledge and experience in applying Structured Judgement Review methodology.

16. To support the process for conducting the SCRR the Trust clinical governance teams will source and share records electronically and support the development of 'timelines' that will support the reviewer in their task completing the SCRR.

**Proposal 4 – The Trust will seek to engage an Independent Consultant Urologist Subject Matter Expert to conduct SCRR's and ensure that appropriate clinical governance support is available to facilitate each review**

## Engaging Patients and Families in Structured Clinical Record Reviews

17. The Trust places paramount importance on the need to fully involve patients and families are engagement in the SCRR process. The Trust recognises that the communication of the SCRR process to patients and families is crucial in terms of setting expectations of outcomes and how this will relate to the work of the Public Inquiry.

18. To support this work the Trust has appointed a dedicated Urology Service User Liaison Officer to communicate and support patients and families who are part of the SCRR process.

19. The outline proposed family engagement strategy is as follows:

    a. Once the requirement for an SCRR is identified, the patient or family is notified via phone-call and then follow up letter informing of the decision to conduct a SCRR. Communication will include details of what the review process is, what the expected outcomes will be and how this process links to the Public Inquiry. The communication will also contain the contact details of the Service User Liaison Officer who can offer individual patient and family support.
    b. The review will be conducted by the independent Consultant Urologist and the judgement and outcomes recorded.
    c. The Service User Liaison Officer will share the report's findings with the patient and family for their review and comment.
    d. The Service User Liaison Officer will return feedback to the Consultant Urologist from the family if received.
    e. A final copy of the SCRR will be shared with the family and arrange any required further follow-up or discussions required with the Trust Urology service.

**Proposal 5 – The Trust will utilise the Service User Liaison Model to engage patients and families with set milestones as outlined**

## Timescales for Completion of Structured Clinical Record Reviews

20. Although to be formally agreed it is expected that each SCRR should be completed within 8 weeks in line with the regional timescales for Level 1 Significant Event Audits..

**Proposal 6 – The timescale for completion of each SCRR should be a maximum of 8 weeks**

## Initiating Learning and Change from the SRCC

21. The Trust will incorporate the learning and findings from SCRR's into existing clinical governance streams. This includes ensuring that:
    a. Where actionable outcomes are identified, these are taken forward to improve services
    b. learning for regional bodies is shared via HSCB
    c. assurance on action closure is provided to the UAG
    d. Where a SRCC identifies the requirement for a more in-depth review, this is flagged for consideration at the Trust and HSCB weekly meeting.

**Proposal 7 – The process of learning and change from SRCC will be embedded in Trust clinical governance structures and appropriate escalations for learning and if required further review is considered**

# Incident Oversight Group

**Monday 1st March 2021, 8:00am**

**Via Zoom**

## AGENDA

| | Item | Attachments |
|---|---|---|
| 1 | Apologies | |
| 2 | Minutes | MINUTES - Incident Group 17.02.2021.dc |
| | **Management of Patient Reviews** | |
| 4 | Private Practice<br>- Private Practice Audit | |
| 5 | Update on Radiology and MDM Review | UROLOGY PATIENT REVIEW FORM v5.do |
| 6 | IPT for Review Process | Urology Inquiry IPT - draft 8 15.12.2020.c |
| 7 | Additional Subject Matter Expertise<br>- British Association of Urological Surgeons<br>- British Association of Urological Nurses | |
| 8 | Royal College of Surgeons Engagement<br>- Selection of Records<br>- Costing | |
| 9 | Bicalutamide Patient Review | |
| 10 | Engagement of ISP to undertake waiting list work | |
| 11 | Telephone Support Service / Patient Triage Update | |
| 12 | MDM Processes | |
| | **Professional Governance** | |
| 13 | GMC Discussions | |
| 14 | Litigation / DLS Update | |
| 15 | Grievance Process | |
| 16 | Administration Review Update | Admin Review Process V10 18 Feb 2 |
| | **Serious Adverse Incident (SAI) Reviews** | |
| 17 | Update on Current SAI Progress<br>- Screening<br>- Initial Feedback on outcomes from Dr Hughes | |
| 18 | Initial SAI Recommendations | Action plan Personal .docx |

| | | |
|---|---|---|
| 19 | Structured Judgement Review Process | DRAFT Structured Clinical Record Review DRAFT - PROPOSAL FOR STRUCTURED CI |
| 20 | Family Liaison Role | |
| **Communications** | | |
| 21 | Media / Assembly Questions | |
| **Any Other Business** | | |
| 22 | Complaints | |
| 24 | Coronial Processes | |
| 25 | Counter Fraud | |
| 26 | Declaration re CURE | |
| 27 | Securing Records for Public Inquiry | |
| **Date of Next Meeting** | | |
| 28 | Via Zoom – 1st March 2021 | |

# Incident Oversight Group

**Wednesday 17th February 2021, 17:00**

**Via Zoom**

## MINUTES

| | Item | Actions |
|---|---|---|
| | **In Attendance**<br>Melanie McClements<br>Patricia Kingsnorth<br>Dr Maria O'Kane<br>Dr Damian Gormley<br>Martina Corrigan<br>Ronan Carroll<br>Siobhan Hynds<br>Stephen Wallace | |
| **1** | **Apologies**<br>None received | |
| **2** | **Minutes**<br>Minutes agreed | |
| **3** | **Team Working - Maxine Williamson**<br>Deferred to next meeting | |
| | **Management of Patient Reviews** | |
| **4** | **Private Practice Audit**<br>No update this meeting | |
| **5** | **Update on Radiology and MDM Review**<br>No update this meeting | |
| **6** | **IPT for Review Process**<br>No update this meeting | |
| **7** | **Additional Subject Matter Expertise**<br>- **British Association of Urological Surgeons**<br>Stephen has contacted BAUS re additional SME<br><br>- **British Association of Urological Nurses**<br>Martina is pursuing a meeting with BAUN to discs requirements | |
| **8** | **Royal College of Surgeons Engagement**<br>- **Selection of Records**<br>Martina has spoken to medical records, plan to arrange transfer and location of records to be finalized this week. Mechanisms to add the records to Egress is ongoing.<br><br>- **Costing**<br>Stephen to provide a costing proposal to DoH for approval as this is outside of regional procurement limitations. | |

| | | |
|---|---|---|
| 9 | **Bicalutamide Patient Review**<br>No update this meeting | |
| 10 | **Engagement of ISP to undertake waiting list work**<br>No update this meeting | |
| 11 | **Telephone Support Service / Patient Triage Update**<br>No update this meeting | |
| 12 | **MDM Processes**<br>No update for this week | |
| | **Professional Governance** | |
| 13 | **GMC Discussions**<br>No update for this week | |
| 14 | **Litigation / DLS Update**<br>No update this meeting | |
| 15 | **Grievance Process**<br>No update this meeting | |
| 16 | **Administration Review Update**<br>The admin review is being finalized this week. The review outcomes have been shared with the senior team for comment. Group discussed the requirement for a more sophisticated electronic note tracking system and potential this may have been considered previously. Martina to follow up.<br><br>Melanie asked the group to review the administrative review and feed back to Martina and Ronan | **Martina to follow up on previous business case re notes tracking system**<br><br>**Group members to feed back to Martina and Ronan** |
| | **Serious Adverse Incident (SAI) Reviews** | |
| 17 | **Update on Current SAI Progress**<br>Patricia advised the SAI work is progressing towards completion on the 28th February.<br><br>Reports are aimed to be ready for next week. | |
| 18 | **Initial SAI Recommendations**<br>No update this meeting | |
| 19 | **Structured Judgement Review Process**<br>No update this meeting | |
| 20 | **Family Liaison Role**<br>Fiona has commenced meeting with families, group discussed the continuation of psychological support for families. | |
| | **Communications** | |
| 21 | **Media / Assembly Questions**<br>No new business received | |
| | **Any Other Business** | |
| 22 | **Complaints** | |
| 24 | **Coronial Processes** | |

| | | |
|---|---|---|
| | No update this meeting | |
| **25** | **Counter Fraud**<br>No update this meeting | |
| **26** | **Declaration re CURE**<br>No update this meeting | |
| **27** | **Securing Records for Public Inquiry**<br>For noting | |
| **28** | **Urology Timeline for the HSCB**<br>No update this meeting | |
| **Date of Next Meeting** | | |
| **29** | **Via Zoom – 24th February 2021** | |

Southern Health and Social Care Trust

# UROLOGY PATIENT REVIEW FORM

**This form is to be completed for each patient previously under the care of Mr O'Brien reviewed by the Southern Trust Urology team since Mr O'Brien's departure on 17th July 2020. This form is to be retained in the patient notes and copied to Martina Corrigan, Head of Service.**

## Patient Details

| | |
|---|---|
| | |
| | |
| | |

## Appointment Details

| | |
|---|---|
| | |
| | |

**Regarding the patients current care**

| | | |
|---|---|---|
| | | |
| | | |
| | | |

**Based on the information available at the time, please answer the following to the best of your knowledge. If a determination cannot be made please give reasons why.**

| | | |
|---|---|---|
| | | |
| | | |
| | | |

| | | |
|---|---|---|
| **the time?** | | |
| **Was the clinical management approach taken reasonable?** | | |
| **Were there unreasonable delays within the Consultants control with any aspect of care (reviews, prescribing, diagnostics, dictation etc)** | | |
| **On balance, did the patient suffer any harm or detriment as a result?** | | |

## Clinical Professional Reviewing Care

| | |
|---|---|
| **Name** | |
| **Title** | |
| **Date of Appointment** | |

Southern Health and Social Care Trust

*Quality Care - for you, with you*

# Strictly Confidential

# 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<br>(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<br>• Liaise with Human Resources |
| • Staff Backfill | • Complete recruitment |

| Risk Identified | Mitigation Measure |
|---|---|
| | documentation as soon as possible<br>• 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<br>• Extending the operational hours to receive calls<br>• 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<br>• Monitoring clinics and virtual clinics<br>• 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<br>• Utilise independent resources<br>• 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

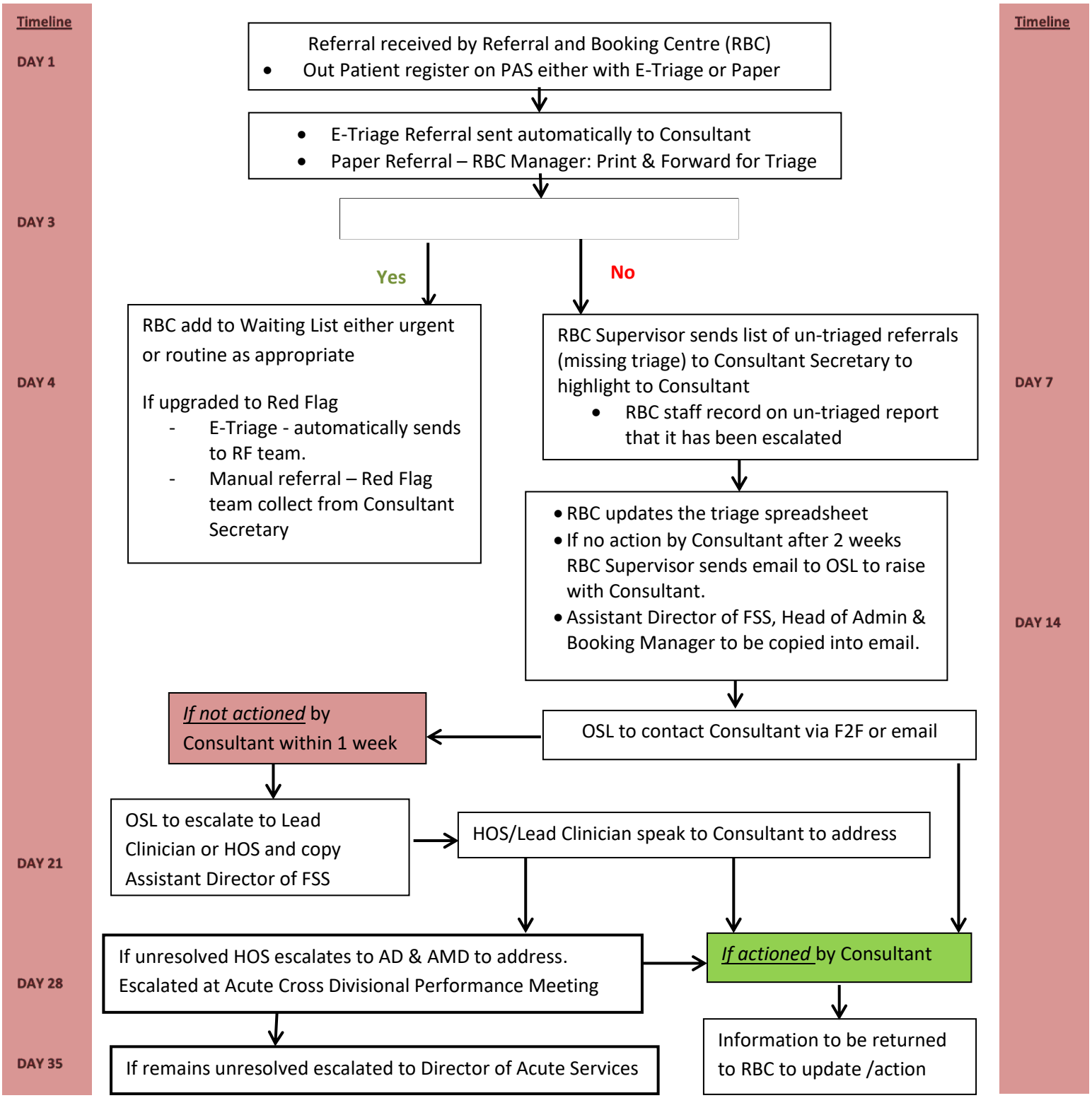
Monitoring and reporting will continue throughout the investigation period and will be provided on a weekly basis. Meetings are scheduled on a weekly basis.

# TRIAGE PROCESS

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

## PURPOSE OF TRIAGE

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




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

| Services not using e-triage | |
|---|---|
| ORTHOPAEDIC GERIATRICS | Planned e-triage commencement Jan/Feb 2021 |
| HAEMATOLOGY | Planned implementation postpone due to service pressures |
| NEPHROLOGY | Currently taking a break from e-triage, will relook at recommencing early 2021 |
| GENERAL MEDICINE | Minimal referrals to this service but working with service looking towards implementation early 2021 |
| BREAST SURGERY | Consultants not currently keen on e-triage – reengaged with service |
| GERIATRIC MEDICINE | Currently engaging with service |

## Action Plan Urology Personal Information redacted by

| Reference number | Recommendations | Designated responsible person | Action required | Date for completion / timescale | Date recommendation completed with evidence |
|---|---|---|---|---|---|
| | | | | | |
| 1 | HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory. | HSCB | See recommendation 5 | | |
| 2 | HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices | HSCB | | | |
| 3 | HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients. | HSCB | | | |
| 4 | GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields. | HSCB | | | |

| | | | | | |
|---|---|---|---|---|---|
| 5 | **TRUST**<br>Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm. | AD surgical/ AMD Primary Care | The urology service hold the view that to enable the referral process to be efficient and effective, the CCG form requires to have mandatory fields which require it to be completed prior to referral from Primary Care. | | NiCan pathway.<br>  <br>Bladder Cancer Pathway March 2020<br>  <br>Revised Prostate Diagnostic Pathway D<br>  <br>Female Lower Urinary Tract Sympto<br>  <br>Female Urinary Tract Infection.docx<br>  <br>Male Lower Urinary Tract Symptoms.docx<br>  <br>male urinary tract infections.docx |
| 6 | The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW. | AD Surgery/ AMD Surgery | Time needs to be made available in consultant job plans to undertake the task of triaging referral letters. Discussions are ongoing with MD and AD | Jan 2021 | |

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|---|---|---|---|---|---|
| 7 | The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner. | AD surgery | Currently the IEAP protocol is followed<br><br>The current regional protocol is being updated. | Jan 2021 |  Integrated Elective Access Protocol - Apr<br>  Integrated Elective Access Protocol Draft<br>  FW IEAP referral.msg<br>  Booking Centre SOP manual.doc<br>  TRIAGE PROCESS 2. lmca.docx |
| 8 | The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list. | AD Surgery | | Nov 2020 | |
| 9 | Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10. | AD surgery | Reports will be sent to AD and AMD/ CD | Nov 2020 | |
| 10 | The Trust must set in place a robust system within its medical management hierarchy for highlighting | MD | | | |

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| | and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence. | | | | |
| 11 | Consultant 1<br><br>needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner. | MD | | | |
| 12 | Consultant 1<br><br>needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6. | MD | | | |

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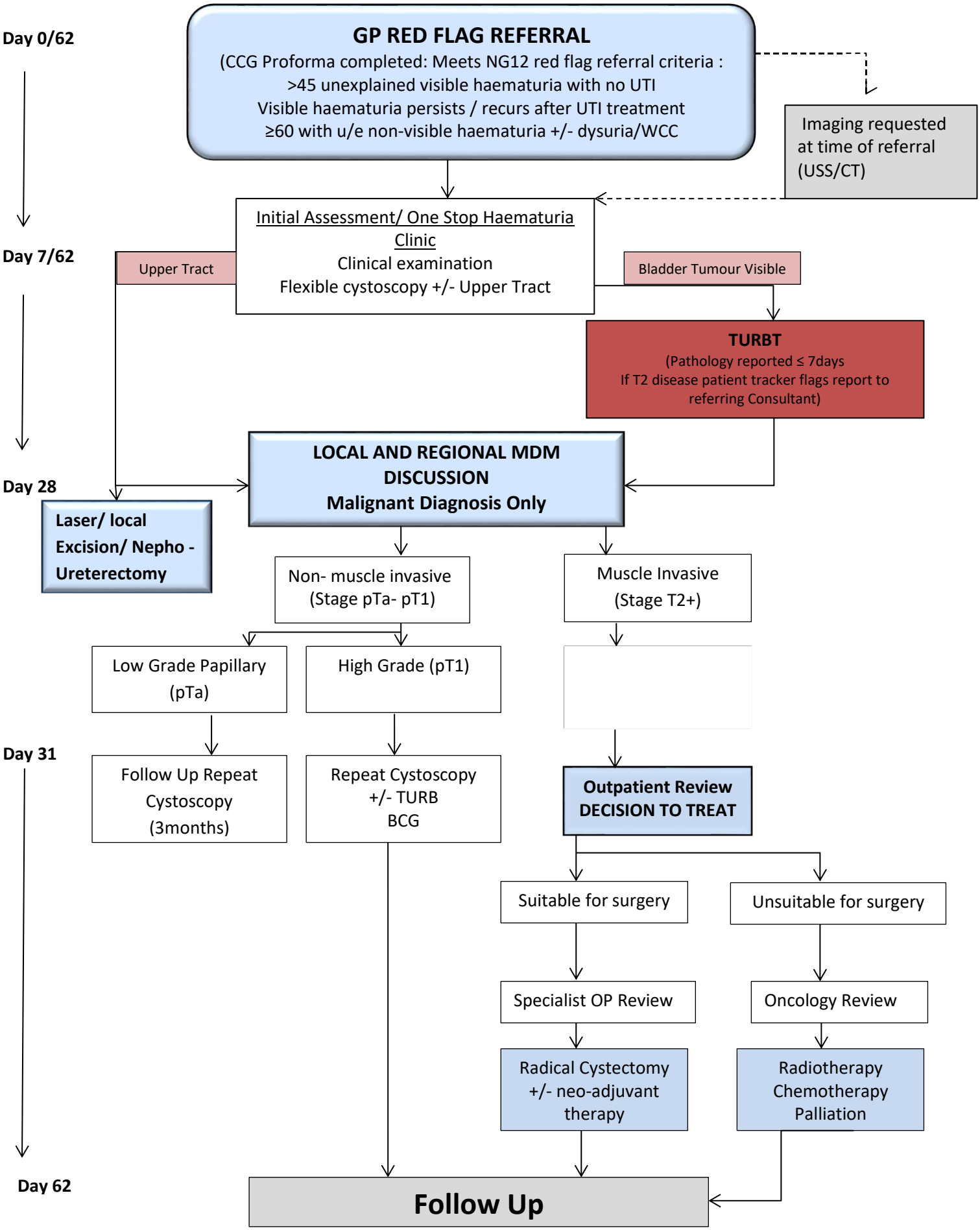
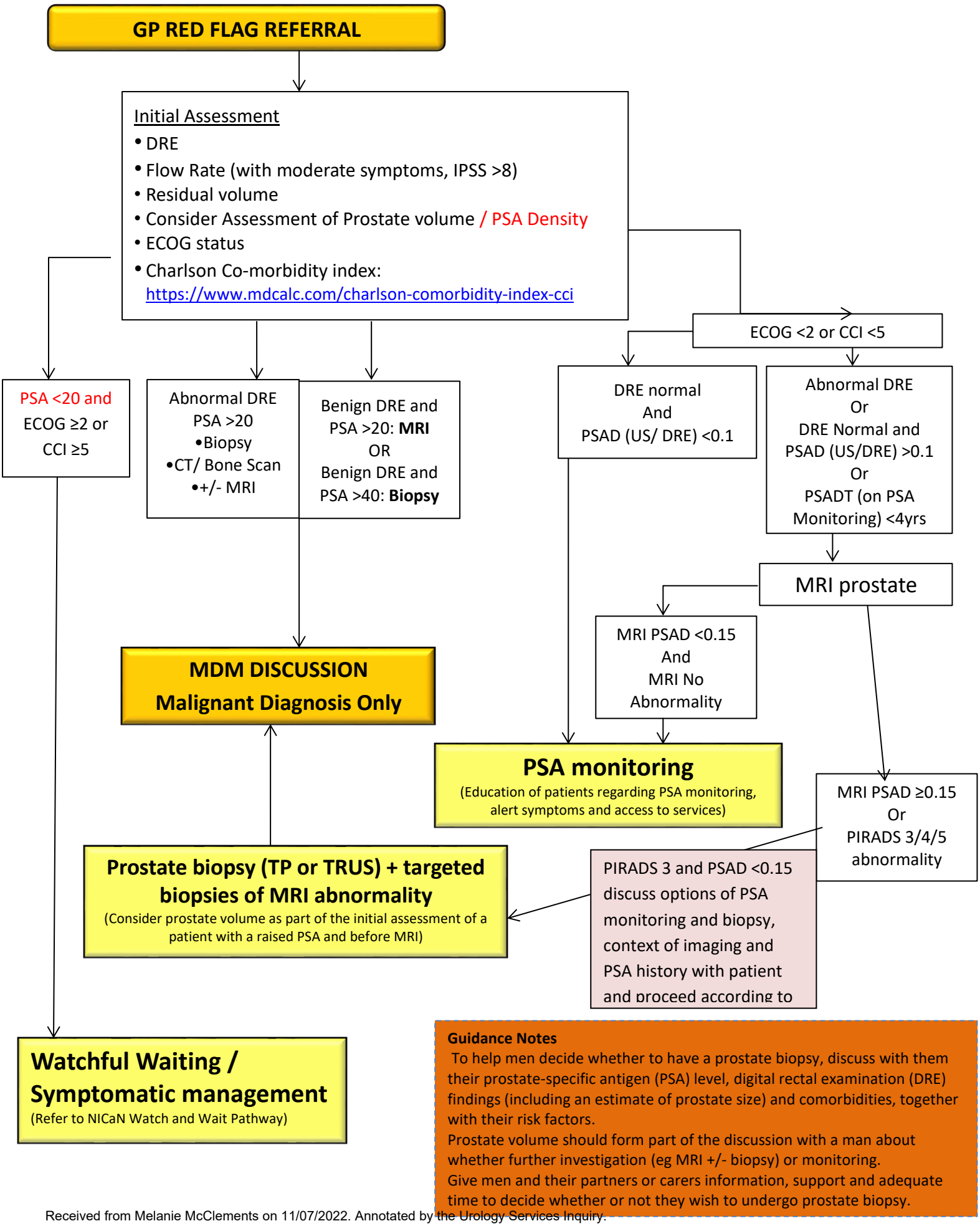
# NICaN SUSPECT BLADDER CANCER REFERRAL AND DIAGNOSTIC PATHWAY



Final Proposed Prostate Diagnostic Pathway December 2019

# NICaN SUSPECT PROSTATE CANCER DIAGNOSTIC PATHWAY




**Guidance Notes**

To help men decide whether to have a prostate biopsy, discuss with them their prostate-specific antigen (PSA) level, digital rectal examination (DRE) findings (including an estimate of prostate size) and comorbidities, together with their risk factors.

Prostate volume should form part of the discussion with a man about whether further investigation (eg MRI +/- biopsy) or monitoring.

Give men and their partners or carers information, support and adequate time to decide whether or not they wish to undergo prostate biopsy.

Southern Health and Social Care Trust

**Incident Oversight Group Minutes**
**8th March 2021 at 8.30am via Zoom Meeting**

| Attendance | Apologies |
|---|---|
| Patricia Kingsnorth<br>Dr Maria O'Kane<br>Dr Damian Gormley<br>Martina Corrigan<br>Ronan Carroll<br>Stephen Wallace<br>Vivienne Toal<br>Jane McKimm<br>Siobhan Hynds<br>Mark Haynes<br>Suzanne Barr | None noted |

| Agenda Item | Discussion | Actions |
|---|---|---|
| 1. Review of previous meeting minutes and actions | Minutes reviewed and agreed | Actions updated accordingly throughout the main body of the Minute |
| **Management of Patient Reviews** | | |
| 2. Private Practice Audit | Martina advised that there was one private patient identified as having only waited 2 weeks for their procedure when other patients have waited up to 91 weeks. Martina advised that IA had completed the first part of the Audit (outpatients/inpatient and Day cases), and that they had moved on to diagnostics (300 queries), and scripts that had been presented to pharmacy. Melanie noted that there is not just a capacity issue, but | Terms of Reference for the Internal Audit have been shared with Dr O'Kane. |

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| | that there will be a lot of support needed to get this work completed. Martina advised that there is a meeting with her and Internal Audit this afternoon to start on these queries, to gage the timescales to complete the work.<br>Martina advised that Mr Haynes had started on Saturday 6th March to look chronologically at the review backlog – from those he has reviewed there was 1 private patient and 1 potential private patient from 2015<br><br>Dr O'Kane advised that there is a Private Practice policy – Clinicians referring in, to ensure that there are handovers and updated information. | Martina to keep the group posted on time taken to complete work and support required.<br><br>Martina to send information of two private patients to Dr O'Kane and ask Mark to look at these clinically to give clinical surety as there may be a probity issue.<br><br>Specific parts of private patient policy to be sent to ensure that correct processes are being followed when referring in. |
| 3. Update on Radiology and MDM Review | no further update from 01/03/2021 | |
| 4. IPT for Review Process<br>Urology Inquiry IPT - draft 8 15.12.2020.c | Maria and Vivienne advised that there is a level of legal input into this, 2 consultancy solicitors required. | Further review and discussions needed before being finalized |
| 5. Additional Subject Matter Expertise<br>- British Association of Urological Surgeons<br><br>- British Association of Urological Nurses | Stephen updated the group that a Consultant Urologist has been secured and will be able to assist with the stage of record review.<br><br>Patient review form was signed off on last Thursday, so can start being used. Mark used on Saturday and advised that it can take a lot of time to complete. Mark advised that as the form is | Stephen to provide name of Consultant |

| | | |
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| UROLOGY PATIENT REVIEW FORM v6.do | based on each episode then if the patient has multiple episodes it can take significant amount of time. He has been completing as part of out-patient clinics – adds at least 5/10 mins per consultation time. Martina and Mark have agreed to book 10 patients per clinic as some patient consultations take quite a bit of time.<br>Mark stated that the form gives structure to justifying of the raising of concerns. Martina advised that Mr Glackin is going to do chart review on these backlog patients to see how the form works for doing the reviews with this method. | Time to complete Review Form to continue to be monitored. |
| 6. Royal College of Surgeons Engagement<br>- Selection of Records<br>- Costing | Martina advised that she had requested the first 18 charts and these will be delivered to the AMD office for Medical input on identifying which notes need scanned. The remainder of the patients are being identified through a piece of work being done by a member of admin staff and Martina thanked Vivienne for his release to assist with this. | Once ready to send to Stephen for randomized selection of the remaining patients |
| 7. Bicalutamide Patient Review | No further updates for this meeting | |
| 8. Engagement of ISP to undertake waiting list work | Paused, work being currently conducted internally. Group to discuss further standardisation of patient assessments | Mark to consider standardisation of patient assessment protocols |
| 9. Telephone Support Service / Patient Triage Update | No further call or emails to Information line/email | |
| 10. MDM Processes | Dr O'Kane reviewed this further over the weekend, there remains a lot of work still to be completed. | Stephen and Dr O'Kane to meet later to discuss further |
| **Professional Governance** | | |
| 11. GMC Discussions – | The Trust continues to gather information to send them. | Stephen to ring Kate Watkins in GMC |
| 12. Litigation / DLS Update | Work remains ongoing | Stephen to link in with Lynne Hainey in Litigation |

| | | |
|---|---|---|
| 13. Grievance Process- | Vivienne advised that Michael O'Brien responded to Zoe Parks re: 3 dates for appeal hearing. The reply back from him made some reference to original grievance and that it was felt it was not a fair process. It is his father's position that he will put through a public inquiry. He outlined that there is no objection to appeal panel and his father will not be attending any further meeting.<br>Correspondence outlined some issues and stated that they believed Mr A O'Brien would be met with hostility and this would cause further trauma to him. This has been forwarded to June.<br>Siobhan advised that within the letter from Mr O'Brien it said that we have all the information, therefore the Trust is considering if they ask the panel not to hear appeal but review the original decision/ case, if panel need to clarify anything they do not have the benefit to get information from Mr A O'Brien. So, rather than appeal, with clear TOR, the Trust would ask the panel to review the previous grievance instead.<br>There are 2 panel members. | Update from previous mins: Vivienne explained the Trust had tried to get in contact with AOB to progress grievance appeal however no further response to date. On this basis, the Trust had moved to offer a range of dates to Mr O'Brien's representative for the appeal hearing with a request for response by 4th March 2021.<br><br>Consideration to be given to the best way forward regarding the grievance. |
| 14. Administration Review Update –<br>  <br>Admin Review Process V10 18 Feb 2 | Martina has linked in with Siobhan and advised that the focus of this work has been the need to look at processes and share with GMC, the majority of this review was only in relation to AOB, therefore it is felt there is a need for 2 reports – 1 GMC and 1 Trust assurance, therefore a more generalized report.<br>Siobhan noted that she felt some of the context was missing, as the report reads as if there was a wide scale problem as there was no preamble | Further work to be completed to the report, specifically into providing appropriate context to completing the review. |

| | | |
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| | contained and rationale as to why being looked at. How we close the gap and assurance to stop in the future. Problem not across the board. She highlighted that other clinicians looking at the document, may think it was including them. Further work required to complete this – 1 detailed and 1 overarching. (GMC and Trust assurance) Ronan stated that AOB was able to do these things as system not there to track and monitor. The Trust needs to recognize the shortcomings and have an action plan at the start of report where the Trust sets context out that there was a need to put processes right from the learnings found. | |
| Serious Adverse Incidents (SAIs) Review | | |
| 15. Update on Current SAI Progress<br>- Screening<br>- Initial Feedback on outcomes from Dr Hughes | At the UAG meeting was held last week – the Trust had advised that SAI reports would be shared with the families and the Urology Clinical Teams today (Monday 8 March), however, due to correspondence from Mr O'Brien's solicitors over the weekend the release of these reports have been paused on the recommendation of the Trust's legal team.<br><br>Patricia advised that the families were aware that the reports would be released over the next number of weeks but had not been given a set date. However, as the name of the Chair of the Inquiry was most likely being announced today it was agreed that Patricia would contact the families once she was aware of the Chair and would advise them that they would be updated on the reports as soon as we can in order to avoid giving a set | Timetable to be agreed today<br><br>Patricia to link in with families re: delay<br><br>Martina to email Urology Team advising of delay in disclosing report. Reason for delay should not be disclosed at this stage. |

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| | timeframe which could change.<br>Martina agreed to email the Urology Clinical Team that there had been a delay in the reports being issued and that she would be in touch once she had a new date of issue. | |
| 16. Initial SAI Recommendations<br>  <br>Action plan [Personal information].docx | This Action plan relates to the previous SAI's and Stephen advised the rationale for the Action Plan was to keep track of the ongoing work and focus all in one action plan.<br>Martina informed the group that there are 2 outstanding areas – there has been discussion around job plans, Michael and Mark to give time to triage however, further consideration for Clinical Nurses to support triage to be given.<br>Sharing pathways with GPs – Martina is currently liaising with Rose McCullough and one of the Consultants is linking with GP meetings. Rest are closed<br>All actions relating to Acute have been implemented bar 2. | |
| 17. Structured Judgement Review Process – (SJR)<br>   <br>DRAFT Structured Clinical Record Review DRAFT - PROPOSAL FOR STRUCTURED CI | Stephen informed the group that the Board has seen SJR and are happy with it. There is a meeting with Royal Collage of Physicians on Thursday which will hopefully have the form signed off and ready to use as of next week and start.<br>He explained that all patients will be reviewed using SJR and any anomalies noted, there will be an SAI. | Stephen to give update re: RCP Thursday 11th March 2021 meeting re: SJR |
| 18. Family Liaison Role | Fiona ready to support and linking in with some | |

| | | |
|---|---|---|
| | families | |
| Communications | | |
| **19.** Media / Assembly Questions – | Jane advised that it is anticipated the chair will be announced today, not on Assembly business agenda but it is her understanding the announcement will happen today. There have been no other queries. She informed that there is no expectation that the Trust will notify families of this, however, she will link in with David to gage if this is correct.<br>Jane commented that there remains a level of uncertainty around the SAIs and Public Inquiry as the latter is the overarching legal process, whereas the information from the SAI's supports it. The group agreed that it was unclear how the dual pathways would work alongside one another. Dr O'Kane explained that the appointment of a Chair to the Public Inquiry would assist in this clarity as there becomes a focus point.<br>Jane stated that once she receives information from David re: announcement and appropriateness of telling families she would notify Melanie and Patricia in order to progress if needed. | |
| Any other Business | | |
| 20. Overarching report | Section 5 summary timeline to be amended as it was felt that there were patient identifiers included. Main body of report remains.<br><br>Melanie clarified that the draft reports should only be shared with the Urology team, the families and the Cancer and Clinical Services. And only a summary should be provided to Clinical | |

| | | |
|---|---|---|
| | Governance at this stage. Dr O'Kane noted that GMC were to be made aware of its availability should they want it. Patricia will be overseeing the sharing of the document. | |
| 21. MDM Assurance Meeting | Dr O'Kane and Stephen meeting with NHS England at 12pm today re: MDMs and possible assurance benchmarks. | Update to be provided at next meeting |
| Date of next meeting: 15th March 2021, 8.30am via zoom | | |

Southern Health and Social Care Trust

*Quality Care - for you, with you*

# Strictly Confidential

# 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.

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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<br>(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<br>• Liaise with Human Resources |
| • Staff Backfill | • Complete recruitment |

| Risk Identified | Mitigation Measure |
|---|---|
| | documentation as soon as possible<br>• 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<br>• Extending the operational hours to receive calls<br>• 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<br>• Monitoring clinics and virtual clinics<br>• 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<br>• Utilise independent resources<br>• 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.

Southern Health and Social Care Trust

# UROLOGY PATIENT REVIEW FORM

**This form is to be completed for each patient previously under the care of Mr O'Brien reviewed by the Southern Trust Urology team since Mr O'Brien's departure on 17th July 2020. This form is to be retained in the patient notes and copied to Martina Corrigan, Head of Service.**

## Patient Details

| | |
|---|---|
| **Name** | |
| **H&C Number** | |
| **Date of Birth** | |

## ~~Appointment~~ Patient Details~~Details~~

| | |
|---|---|
| **Presenting Condition(s)** | |
| ~~Summary of Appointment~~Patient Summary | |

**Regarding the patients current care**

| | Question | Y / N / Unable to Determine | Details |
|---|---|---|---|
| 1 | **Is the present diagnosis / diagnoses reasonable?** *('Reasonable' to consider if diagnosis / diagnoses is consistent with investigations and examinations carried out to date, is there a requirement for further investigations / examinations to confirm diagnosis / diagnoses?)* | | |
| 2 | **Are the current medications prescribed appropriate?** *('Appropriate' to consider if prescribing is consistent with current best evidence based practice, are any deviations from guidance recorded and rationale fully noted?)* | | |
| 3 | **Is a secure clinical management plan currently in place?** *('Secure Clinical Management Plan' to consider if the current* | | |

Commented [GL1]: Does this information relate to the review appointment? Is the review appointment as part of a recall or is it any of the review appointments that pt's may have been called to/had already?
If it's any of the review appointments that pt's may have been called to/had already – now sure previous review apts have been captured?

Commented [GL2]: Will the pts have a presenting condition – are they not likely to have one or more diagnoses, based on their previous care and treatment from the Consultant?

Commented [GL3]: As above- is this a summary of the planned review/recall appointment?
Are you content to leave to free text only?

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Commented [GL4]: Could be more than one diagnosis, neurology recall found % os pts had more that one diagnosis. Need to define what is meant by 'reasonable'?

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Commented [GL5]: Need to define what mean by 'appropriate' in this context.

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Southern Health and Social Care Trust

| | | | |
|---|---|---|---|
| | *patient treatment pathway is optimal and in line with current best evidence based practice and guidance)* | | |
| 4 | **If there is not a secure clinical management plan in place please document immediate actions required to be taken** | | |

**Based on the information available at the time of previous reviews, please answer the following to the best of your knowledge. If a determination cannot be made please give reasons why.**

| No. | Question | Y / N / Unable to Determine | Details |
|---|---|---|---|
| 4 | **Were appropriate and complete investigations carried out for all relevant conditions?** *('Appropriate' to consider if investigations consistent with current best evidence based practice at the time of review, are deviations from guidance recorded and rationale fully noted?)* | | |
| 5 | **Were the medications prescribed ~~reasonable~~appropriate?** *('Appropriate' to consider if prescribing was consistent with current best evidence based practice at the time of previous review, are deviations from guidance recorded and rationale fully noted?)* | | |
| 6 | **~~Was~~ Were the diagnosis / diagnoses reasonable? ~~at the time?~~** *('Reasonable' to consider if diagnosis / diagnoses is consistent with investigations and examinations carried at the time of review, was there a requirement for further investigations / examinations to* | | |

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Commented [GL7]: What does 'at the time' mean here?
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Commented [GL8]: Need to define 'appropriate', also need to take account of possibility of more than one diagnosis
Formatted: Justified
Formatted: Justified
Commented [GL9]: Need to take account of possibility of more than one diagnosis, and that there potentially is likely to be an investigative and diagnostic pathway relevant to each diagnosis
Commented [GL10]: Need to define what 'at the time' means/relates to
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Southern Health and Social Care Trust

| | | | |
|---|---|---|---|
| | *confirm diagnosis / diagnoses?)* | | |
| 7 | **Was the clinical management approach taken reasonable?** *('Reasonable' to consider if clinical management plan if the patient treatment pathway at the time was optimal and in line with best evidence based practice and guidance available at that time.)* | | |
| 8 | **Were there unreasonable delays within the Consultants control with any aspect of care (reviews, prescribing, diagnostics, dictation etc)** *('Unreasonable Delays' to consider if diagnosis required more urgent treatment / intervention that was received based on best evidence based practice and guidance available at that time. The Southern Health and Social Care Trust will consider any delays in treatment highlighted to assess if these were within the Consultants control or due to systematic issues e.g. length of waiting lists)* | | |
| 9 | **On balance, did the patient suffer any harm or detriment as a result of any of the above questions (4-9) ?** | | |

Commented [GL11]: See above comments
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Is 'delay' the only parameter of interest?
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If relates to 'delay' only, are you content this is sufficient?

## Clinical Professional Reviewing Care

| | |
|---|---|
| **Name** | |
| **Title** | |
| **Date of Appointment** | |

Southern Health and Social Care Trust

# Admin Review Processes

| Issues Identified | Description of issue | Gaps that led to the problems | Policies or processes in place | Ongoing Risks/Flaws | Action Required | Owner of Action and date for completion |
|---|---|---|---|---|---|---|
| **1. Triage** | Pre 2014<br>Due to the delayed triage of referrals, the decision was taken to add to the OP waiting list the referral at the clinical priority that the GP had assigned.<br><br>. | 2014-2017<br>For routine and Urgent GP referrals, non-adherence and non-enforcement of the IEAP, resulted in referrals not being returned within the appropriate timeframe, which then resulted in a lost opportunity to either upgrade or downgrade urgent/routine referrals | 2017-current<br>The introduction of e-Triage on 27/3/17 enabled referrals to be monitored with respect to the triage process.<br><br>The revised triage process (draft) detailed in the word document below is based on the current IEAP also addresses these issues of timely and appropriate triaging<br><br>TRIAGE PROCESS DEC 20 (1).docx | Current<br>Consultant-to-Consultant referrals (including outside of Trust) are not currently manged through e-Triage so there is still a risk that these could be delayed.<br><br>Remaining specialties that still do not use e-Triage are being addressed<br><br>Services not using eTriage.docx | Consultant to Consultant referrals to be added to e-Triage and the PDF SOP to be updated<br><br>Consultant to Consultant Referrals.<br><br>Remaining specialties to be added to e-Triage<br><br>The triage process continues to be monitored weekly and needs to be complied to and enforced where necessary | AD for FSS<br><br>Transformational Lead to work with Service Leads for specialties still not on e-Triage and to implement same.<br><br>**June 2021**<br><br>AD FSS and divisional AD's<br><br>**Ongoing** |

| Issues Identified | Description of issue | Gaps that led to the problems | Policies or processes in place | Ongoing Risks/Flaws | Action Required | Owner of Action and date for completion |
|---|---|---|---|---|---|---|
| **2. Undictated Clinics** | Some patients not having a letter dictated following an outpatient consultation resulting in no outcome recorded on PAS. | There is no system or process that provides assurance that each outpatient consultation generates an outpatient outcome letter | All Medical staff must understand that a letter is required for every outpatient attendance. | A limitation with the G2 system is that it simply records speech and generates a letter. However G2 is unable to correlate the letter dictated against the outpatient attendance. | The Trust has been working on the G2/PAS interface. This major piece of work required integration with the help of BSO. It is now in 'live' mode and is being piloted by one consultant with positive feedback. This will provide the Trust with more assurance around the dictation of outpatient clinics.<br><br>Update typing SOP to highlight that when a letters is not dictated for a patient that the secretary raises with the consultant and line manager in the first instance. Secretaries to stipulate on their backlog reports if they know of any undictated clinics/letters | The Referral and Booking Centre Manager.<br><br>**June 2021**<br><br>The Referral and Booking Centre Manager.<br><br>**Ongoing**<br><br>Heads of Services with their Clinical Teams at Induction/ Changeover |

| Issues Identified | Description of issue | Gaps that led to the problems | Policies or processes in place | Ongoing Risks/Flaws | Action Required | Owner of Action and date for completion |
|---|---|---|---|---|---|---|
| | | | | | Monthly typing reports require to be produced and shared throughout all divisions<br><br>At Junior doctor changeover inductions, the importance of timely and accurate dictating of all outpatients they have reviewed must be highlighted to them. | IT Team with BSO and the clinical teams<br><br>**June 2021** |
| **3. Hospital Notes** | Patient's hospital records electronically casenote tracked to a consultant and a location. | When patients hospital records were required same not in the tracked location | Current tracking system is a function on Patient Administrative System (PAS)<br><br>Missing Charts are investigated and an IR1 form is completed if not found | There is currently no system which identifies that a chart is not where it is tracked to other than manual searches.<br><br>Need to establish whether or not as part of the induction and training there is a SOP governing the tracking of patient hospital records? | Any missing notes need to have an IR1 raised to highlight the problem. These should be reported to the respective areas.<br><br>All staff managing patient notes should be reminded of the need for accuracy on PAS when tracking notes and patient records should be returned to file as soon as possible. | Acute Director<br><br>**April 2021** |

| Issues Identified | Description of issue | Gaps that led to the problems | Policies or processes in place | Ongoing Risks/Flaws | Action Required | Owner of Action and date for completion |
|---|---|---|---|---|---|---|
| | | | | | We also need to remind consultants that all charts are tracked in their name and that it is their responsibility to ensure the notes are kept in the location that the notes are tracked to.<br><br>Service Administrators to do spot-checks of offices and highlight any issues of charts being stored beyond a reasonable time period.<br><br>Business Case for IFit which is an electronic tracking system using barcode technology (as used in other Trusts in NI) to be considered for funding until the NI Electronic Patient Record replaces paper records under the Encompass Project This had been previously submitted and approved but no funding identified. | Assistant Director – Functional Support to resubmit to Trust's SMT in new financial year.<br><br>**April 2021** |

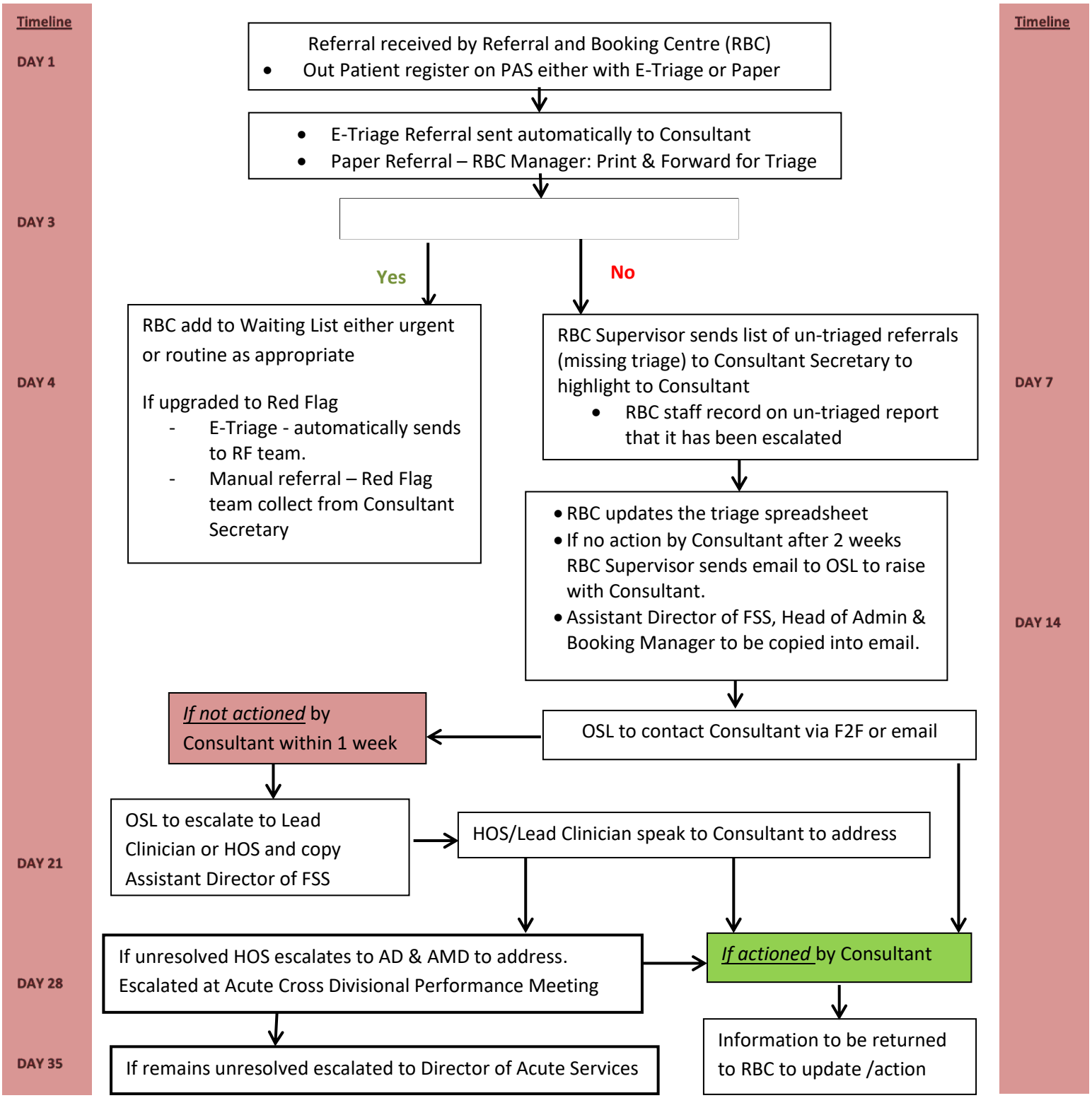
| Issues Identified | Description of issue | Gaps that led to the problems | Policies or processes in place | Ongoing Risks/Flaws | Action Required | Owner of Action and date for completion |
|---|---|---|---|---|---|---|
| **4. Private Patients** | Patients who had been initially reviewed privately were added to the waiting list in a non-chronological manner | No monitoring of patients seen privately where they are entered onto the waiting list | This is governed by the Private Patient policy | It relies on the integrity of the consultant to comply with the private patient policy. | Revise the policy for paying patients in the Trust and share with all clinical teams.<br>  <br>Guide-to-Paying-Patients-Southern-Trust-<br><br>Data Quality Release notice for recording of private patient activity on PAS to be shared amongst clinical teams.<br>  <br>0023-18 PAS OP REFERRRAL PRIVATE | Deputy Medical Director and AD for Medical Directorate **April 2021**<br><br>Functional Services to reissue the Data Quality Release notice for the recording of private patient activity on PAS with all teams.<br><br>**November 2020 Complete** |

# TRIAGE PROCESS

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

## PURPOSE OF TRIAGE

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




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

| Services not using e-triage | |
|---|---|
| ORTHOPAEDIC GERIATRICS | Planned e-triage commencement Jan/Feb 2021 |
| HAEMATOLOGY | Planned implementation postpone due to service pressures |
| NEPHROLOGY | Currently taking a break from e-triage, will relook at recommencing early 2021 |
| GENERAL MEDICINE | Minimal referrals to this service but working with service looking towards implementation early 2021 |
| BREAST SURGERY | Consultants not currently keen on e-triage – reengaged with service |
| GERIATRIC MEDICINE | Currently engaging with service |

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# ADMINISTRATIVE & CLERICAL Standard Operating Procedure

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

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

### Introduction

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

### Implementation

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

# Consultant to Consultant Referrals

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

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

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

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

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

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

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

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# A GUIDE TO PAYING PATIENTS

**V.2 [11th February 2016]**

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

# CONTENTS

## 1. INTRODUCTION

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

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

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

- Private Patients
- Fee Paying Services
- Overseas Visitors

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

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

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

## 2. OBJECTIVES

2.1 The purpose of this guideline is to:

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

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

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

## 3. CATEGORIES OF WORK COVERED BY THIS GUIDE

### 3.1 Fee Paying Services

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

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

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

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

### 3.3 Overseas Visitors

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

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

## 4. POLICY STATEMENT

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

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

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

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

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

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

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

## 5. CONSULTANT MEDICAL STAFF RESPONSIBILITIES

### 5.1 Private Practice

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

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

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

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

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

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

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

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

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

### 5.3 Additional Programmed Activities

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

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

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

## 6. RESTRICTIONS ON PRIVATE PRACTICE FOR CONSULTANT MEDICAL STAFF

### 6.1 New Consultants

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

### 6.2 Locum Consultants

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

### 6.3 Non Consultant Grade Medical Staff

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

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

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

## 7. CHANGE OF STATUS BETWEEN PRIVATE AND NHS

### 7.1 Treatment Episode

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

### 7.2 Single Status

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

### 7.3 Outpatient Transfer

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

### 7.4 Waiting List

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

### 7.5 Inpatient Transfer

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

### 7.6 During Procedure

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

### 7.7 Clinical Priority

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

### 7.8 Change of Status Form

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

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

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

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

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

## 9. OPERATIONAL ARRANGEMENTS

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

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

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

9.4 Clinical governance is defined as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

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

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

## 9.7 Record Keeping Systems and Private Patients

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

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

## 9.8 Health Records of Private Patients

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

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

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

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

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

## 9.9 Booking Arrangements for Admissions and Appointments

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

## 9.10 Walk Ins

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

## 9.11 Radiology

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

## 9.12 Private Patient Records

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

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

9.12.3 It should be noted that

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

## 9.13 Tests Investigations or Prescriptions for Private Patients

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

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

### 9.14 Medical Reports

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

## 10. FINANCIAL ARRANGEMENTS - PRIVATE PATIENTS

### 10.1 Charges to Patients

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

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

### 10.2 Charges for Use of Trust Facilities for Outpatients

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

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

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

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

### 10.3 Basis of Pricing

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

### 10.4 Uninsured Patients – Payment Upfront

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

### 10.5 Insured Patients

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

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

### 10.6 Billing and Payment

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

### 10.7 Audit

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

## 11. FINANCIAL ARRANGEMENTS FOR FEE PAYING SERVICES

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

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

### 11.3 Fee Paying Services Policy (Category 2)

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

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

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

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

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

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

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

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

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

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

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

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

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

## 12. RENUNCIATION OF PRIVATE FEES

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

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

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

## 13. OVERSEAS VISITORS - NON UK PATIENTS

*(Republic of Ireland, EEA, Foreign Nationals)*

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

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

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

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

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

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

### 13.6 Emergency Department

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

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

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

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

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

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

### 13.7 Outpatient Appointments

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

### 13.8 Review Appointments

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

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

### 13.9 Elective Admission

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

### 13.10 Referral from other NHS Trusts

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

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

## 14. AMENITY BED PATIENTS

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

## 15. GLOSSARY

**Undertaking to Pay Form**

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

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

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

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

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

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

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

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

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

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

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

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

   d. work required for life insurance purposes;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

u. delivering lectures;

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

w. attendance as a witness in court;

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

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

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

November 2003

**Recommended Standards of Practice for NHS Consultants**

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

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

**Contents**



## Part I: Introduction

**Scope of Code**

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

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

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

**Key Principles**

1.4 The Code is based on the following key principles:

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

## Part II: Standards of Best Practice

**Disclosure of Information about Private Practice**

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

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

**Scheduling of Work and On-Call Duties**

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

2.4 Consultants should ensure in particular that:

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

- private commitments are rearranged where there is regular disruption of this kind to NHS work; and private commitments do not prevent them from being able to attend a NHS emergency while they are on call for the NHS, including any emergency cover that they agree to provide for NHS colleagues. In particular, private commitments that prevent an immediate response should not be undertaken at these times.

2.5 Effective job planning should minimise the potential for conflicts of interests between different commitments. Regular private commitments should be noted in a consultant's job plan, to ensure that planning is as effective as possible.

2.6 There will be circumstances in which consultants may reasonably provide emergency treatment for private patients during time when they are scheduled to be working or are on call for the NHS. Consultants should make alternative arrangements to provide cover where emergency work of this kind regularly impacts on NHS commitments.

2.7 Where there is a proposed change to the scheduling of NHS work, the employer should allow a reasonable period for consultants to rearrange any private sessions, taking into account any binding commitments entered into (e.g. leases).

**Provision of Private Services alongside NHS Duties**

2.8 In some circumstances NHS employers may at their discretion allow some private practice to be undertaken alongside a consultant's scheduled NHS duties, provided that they are satisfied that there will be no disruption to NHS services. In these circumstances, the consultants should ensure that any private services are provided with the explicit knowledge and agreement of the employer and that there is no detriment to the quality or timeliness of services for NHS patients.

**Information for NHS Patients about Private Treatment**

2.9 In the course of their NHS duties and responsibilities consultants should not initiate discussions about providing private services for NHS patients, nor should they ask other NHS staff to initiate such discussions on their behalf.

2.10 Where a NHS patient seeks information about the availability of, or waiting times for, NHS and/or private services, consultants should ensure that any information provided by them, is accurate and up-to-date and conforms with any local guidelines.

2.11 Except where immediate care is justified on clinical grounds, consultants should not, in the course of their NHS duties and responsibilities, make arrangements to provide private services, nor should they ask any other NHS staff to make such arrangements on their behalf unless the patient is to be treated as a private patient of the NHS facility concerned.

**Referral of Private Patients to NHS Lists**

2.12 Patients who choose to be treated privately are entitled to NHS services on exactly the same basis of clinical need as any other patient.

2.13 Where a patient wishes to change from private to NHS status, consultants should help ensure that the following principles apply:

- a patient cannot be both a private and a NHS patient for the treatment of one condition during a single visit to a NHS organisation;
- any patient seen privately is entitled to subsequently change his or her status and seek treatment as a NHS patient;
- any patient changing their status after having been provided with private services should not be treated on a different basis to other NHS patients as a result of having previously held private status;
- patients referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients; and
- should a patient be admitted to an NHS hospital as a private inpatient, but subsequently decide to change to NHS status before having received treatment, there should be an assessment to determine the patient's priority for NHS care.

**Promoting Improved Patient Access to NHS Care and Increasing NHS Capacity**

2.14 Subject to clinical considerations, consultants should be expected to contribute as fully as possible to maintaining a high quality service to patients, including reducing waiting times and improving access and choice for NHS patients. This should include co-operating to make sure that patients are given the opportunity to be treated by other NHS colleagues or by other providers where this will maintain or improve their quality of care, such as by reducing their waiting time.

2.15 Consultants should make all reasonable efforts to support initiatives to increase NHS capacity, including appointment of additional medical staff.

## Part III – Managing Private Patients in NHS Facilities

3.1 Consultants may only see patients privately within NHS facilities with the explicit agreement of the responsible NHS organisation. It is for NHS organisations to decide to what extent, if any, their facilities, staff and equipment may be used for private patient services and to ensure that any such services do not interfere with the organisation's obligations to NHS patients.

3.2 Consultants who practise privately within NHS facilities must comply with the responsible NHS organisation's policies and procedures for private practice. The NHS organisation should consult with all consultants or their representatives, when adopting or reviewing such policies.

**Use of NHS Facilities**

3.3 NHS consultants may not use NHS facilities for the provision of private services without the agreement of their NHS employer. This applies whether private services are carried out in their own time, in annual or unpaid leave, or – subject to the criteria in paragraph 2.8 - alongside NHS duties.

3.4 Where the employer has agreed that a consultant may use NHS facilities for the provision of private services:

- the employer will determine and make such charges for the use of its services, accommodation or facilities as it considers reasonable;

- any charge will be collected by the employer, either from the patient or a relevant third party; and

- a charge will take full account of any diagnostic procedures used, the cost of any laboratory staff that have been involved and the cost of any NHS equipment that might have been used.

3.5 Except in emergencies, consultants should not initiate private patient services that involve the use of NHS staff or facilities unless an undertaking to pay for those facilities has been obtained from (or on behalf of) the patient, in accordance with the NHS body's procedures.

3.6 In line with the standards in Part II, private patient services should take place at times that do not impact on normal services for NHS patients. Private patients should normally be seen separately from scheduled NHS patients. Only in unforeseen and clinically justified circumstances should an NHS patient's treatment be cancelled as a consequence of, or to enable, the treatment of a private patient.

**Use of NHS Staff**

3.7 NHS consultants may not use NHS staff for the provision of private services without the agreement of their NHS employer.

3.8 The consultant responsible for admitting a private patient to NHS facilities must ensure, in accordance with local procedures, that the responsible manager and any other staff assisting in providing services are aware of the patient's private status.

## 18. APPENDIX 3 - PRIVATE / NOT ORDINARILY RESIDENT IN UK NOTIFICATION AND UNDERTAKING TO PAY FORM

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

**PRIVATE / NOT ORDINARILY RESIDENT IN UK NOTIFICATION AND UNDERTAKING TO PAY FORM**

**Private Patient:** Yes ☐ No ☐ **Non-Ordinarily Resident in UK:** Yes ☐ No ☐

| | | | |
|---|---|---|---|
| **Name of Patient:** | | | |
| **Address:** | | | |
| **Postcode:** | Telephone No: | | |
| **Date of Birth:** | | | |
| **H&C Number:** | | | |
| **Name of Insurer:** | | **Self Funding** | ☐ |
| **Insurer Policy No:** | | | |

I have been seeing this person as a private patient. They are to be admitted / referred to Hospital on _____ as an _____

| | | | | | |
|---|---|---|---|---|---|
| **Inpatient Referral** | ☐ | **Obstetrics** ☐ Estimated Duration of Stay | **Medical** ☐ Estimated Duration of Stay | **Surgical** ☐ Estimated Duration of Stay | **T & O** ☐ Estimated Duration of Stay |
| **Day Case Referral** | ☐ | | | | |
| **Diagnostics** (Inpatient or Outpatient) | ☐ | **Laboratory** ☐ [please detail] | **Radiology** [pleas ☐ detail] | **Other** [e.g. ☐ Pharmacy] | |

| | | | |
|---|---|---|---|
| **Undertaking to Pay Confirmation** To be completed by Consultant | | | |
| **I have advised the patient named above of the estimated hospital charges and of my fees** | | | |
| **Signed Consultant** | | **Date** | |
| **Undertaking to Pay** To be completed by the person who will pay the account | | | |
| **I understand and agreed to pay Southern Health and Social Care Trust all charges[1] associated with this episode of care[2] .Where the Consultant may deem further procedures/investigations necessary which will incur additional charges, I understand that this may result in a different cost from that quoted to me and I undertake to pay the full costs incurred.** | | | |
| **Signed Patient** | | **Date** | |

**RETURN TO PAYING PATIENTS OFFICE CRAIGAVON AREA HOSPIAL/DAISY HILL HOSPITAL** [email:payingpatients@southerntrust.hscni.net]

[1] A list of Tariffs is available from the Private Patients office

[2] Episode of Care – The total treatment of either an inpatient or day case patient from diagnosis through to discharge

Southern Health and Social Care Trust - A Guide to Paying Patients

## 19. APPENDIX 4 APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

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

### APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

| | |
|---|---|
| **Name of Patient:** | |
| **Address:** | |
| **Postcode:** | |
| **Date of Birth:** | |
| **H&C Number:** | |
| **Name of Consultant** | |
| **Date of Last Private Consultation** | |

I have been seeing this person as a private patient. He/she has now been referred to Hospital as an NHS patient.

| | | **Clinical Priority** |
|---|---|---|
| Inpatient Referral | ☐ | |
| Outpatient Referral | ☐ | |
| Day Case Referral | ☐ | |

| | |
|---|---|
| **Signed Consultant** | |
| **Effective Date** | |

Consultants are reminded that in good practice a patient who changes from private to NHS status should receive all subsequent treatment during that episode of care under the NHS as outlined in A Code of Conduct for Private Practice.

**PLEASE FORWARD TO PAYING PATIENTS OFFICE [paying.patients@southerntrust.hscni.net]**

## 20. APPENDIX 5 PRINCIPLES GOVERNING RECEIPT OF ADDITIONAL FEES – SCHEDULE 11

### Principles Governing Receipt of Additional Fees - Schedule 11

1. In the case of the following services, the consultant will not be paid an additional fee, or - if paid a fee - the consultant must remit the fee to the employing organisation:

- any work in relation to the consultant's Contractual and Consequential Services;
- duties which are included in the consultant's Job Plan, including any additional Programmed Activities which have been agreed with the employing organisation;
- fee paying work for other organisations carried out during the consultant's Programmed Activities, unless the work involves minimal disruption and the employing organisation agrees that the work can be done in HPSS time without the employer collecting the fee;
- domiciliary consultations carried out during the consultant's Programmed Activities;
- lectures and teaching delivered during the course of the consultant's clinical duties;
- delivering lectures and teaching that are not part of the consultant's clinical duties, but are undertaken during the consultant's Programmed Activities.
- Consultants may wish to take annual leave [having given the required 6 week notice period] to undertake fee paying work [e.g. court attendance] in this instance the consultant would not be required to remit fees to the Trust.

This list is not exhaustive and as a general principle, work undertaken during Programmed Activities will not attract additional fees.

2. Services for which the consultant can retain any fee that is paid:

- Fee Paying Services carried out in the consultant's own time, or during annual or unpaid leave;
- Fee Paying Services carried out during the consultant's Programmed Activities that involve minimal disruption to HPSS work and which the employing organisation agrees can be done in HPSS time without the employer collecting the fee;
- Domiciliary consultations undertaken in the consultant's own time, though it is expected that such consultations will normally be scheduled as part of Programmed Activities1;
- Private Professional Services undertaken in the employing organisation's facilities and with the employing organisation's agreement during the consultant's own time or during annual or unpaid leave;
- Private Professional Services undertaken in other facilities during the consultant's own time, or during annual or unpaid leave;
- Lectures and teaching that are not part of the consultant's clinical duties and are undertaken in the consultant's own time or during annual or unpaid leave;

- Preparation of lectures or teaching undertaken during the consultant's own time irrespective of when the lecture or teaching is delivered.

This list is not exhaustive but as a general principle the consultant is entitled to the fees for work done in his or her own time, or during annual or unpaid leave.

*And only for a visit to the patient's home at the request of a general practitioner and normally in his or her company to advise on the diagnosis or treatment of a patient who on medical grounds cannot attend hospital.*

## 21. APPENDIX 6 - UNDERTAKING TO PAY CHARGES FOR AN AMENITY BED

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

### UNDERTAKING TO PAY CHARGES FOR AN AMENITY BED

| | |
|---|---|
| Name of Patient: | |
| Address: | |
| Postcode: | |
| Date of Birth: | |
| Hospital Number: | |

**Site:** Craigavon ☐ Daisy Hill ☐

**I was allocated an amenity bed on (date):** _____ **(time)**

**Ward:** _____ **Consultant:** _____

**I undertake to pay the Southern Health Social Care Trust £39 per night for an amenity bed, which has been provided for me at my request.**

**Number of days Amenity Bed required:** _____

**I understand that if I am required to stay in hospital more days than anticipated, the midwifery staff will ask me if I wish to continue and pay for the amenity bed, or if I wish to be transferred to the open ward.**

**Patient's Signature:** _____ **Date:** _____

**Midwife's Signature:** _____ **Date:** _____

**To be completed by WARD CLERK OR MIDWIFE when patient is being transferred /discharged from an amenity bed.**

**Date transferred / discharged from amenity bed** _____

**Signed by midwife / ward clerk when transferred / discharged** _____

## 22. APPENDIX 7 – AGREEMENT FOR THE VOLUNTARY ADVANCE RENUNCIATION OF EARNINGS FROM FEE PAYING ACTIVITIES

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

### AGREEMENT FOR THE VOLUNTARY ADVANCE RENUNCIATION OF EARNINGS FROM FEE PAYING ACTIVITIES

**I *(name)*** _____

**Request that any monies due to me from patients in relation to fees from**
*(description of activity)*

_____

_____

_____

_____

_____

_____

_____

**Shall be transferred to *(Charity title and reference)*** _____

**For its sole use in the advancement of its aims in accordance with the Trust Deed until directed otherwise by me in writing.**

**This request is to take effect from (date*):*** _____

**Signed, sealed and delivered by:** _____
***(Full name in BLOCK CAPITALS)***

**Date:** _____

**In the presence of:** _____

**Date:** _____

**Address::** _____

_____

_____

_____ **Postcode:** _____

_____

## 23. APPENDIX 8 - PROVISIONS GOVERNING THE RELATIONSHIP BETWEEN HPSS WORK AND PRIVATE PRACTICE - SCHEDULE 9

1. This Schedule should be read in conjunction with the 'Code of Conduct for Private Practice', which sets out standards of best practice governing the relationship between HPSS work and private practice.

2. The consultant is responsible for ensuring that their provision of Private Professional Services for other organisations does not:

   - result in detriment to HPSS patients;
   - diminish the public resources that are available for the HPSS.

**Disclosure of information about Private Commitments**

3. The consultant will inform his or her clinical manager of any regular commitments in respect of Private Professional Services or Fee Paying Services. This information will include the planned location, timing and broad type of work involved.

4. The consultant will disclose this information at least annually as part of the Job Plan Review. The consultant will provide information in advance about any significant changes to this information.

**Scheduling of Work and Job Planning**

5. Where a conflict of interest arises or is liable to arise, HPSS commitments must take precedence over private work. Subject to paragraphs 10 and 11below, the consultant is responsible for ensuring that private commitments do not conflict with Programmed Activities.

6. Regular private commitments must be noted in the Job Plan.

7. Circumstances may also arise in which a consultant needs to provide emergency treatment for private patients during time when he or she is scheduled to be undertaking Programmed Activities. The consultant will make alternative arrangements to provide cover if emergency work of this kind regularly impacts on the delivery of Programmed Activities.

8. The consultant should ensure that there are arrangements in place, such that there can be no significant risk of private commitments disrupting HPSS commitments, e.g. by causing HPSS activities to begin late or to be cancelled. In particular where a consultant is providing private services that are likely to result in the occurrence of emergency work, he or she should ensure that there is sufficient time before the scheduled start of Programmed Activities for such emergency work to be carried out.

9. Where the employing authority has proposed a change to the scheduling of a consultant's HPSS work, it will allow the consultant a reasonable period in line with Schedule 6, paragraph 2 to rearrange any private commitments. The employing organisation will take into account any binding commitments that the consultant may have entered into (e.g. leases). Should a consultant wish to reschedule private commitments to a time that would conflict with Programmed Activities, he or she should raise the matter with the clinical manager at the earliest opportunity.

**Scheduling Private Commitments Whilst On-Call**

10. The consultant will comply with the provisions in Schedule 8, paragraph 5 of these Terms and Conditions. In addition, where a consultant is asked to provide emergency cover for a colleague at short notice and the consultant has previously arranged private commitments at the same time, the consultant should only agree to provide such emergency cover if those private commitments would not prevent him Or her returning to the relevant HPSS site at short notice to attend an emergency. If the consultant is unable to provide cover at short notice it will be the employing organisation's responsibility to make alternative arrangements and the consultant will suffer no detriment in terms of pay progression as a result.

**Use of HPSS Facilities and Staff**

11. Where a consultant wishes to provide Private Professional Services at an HPSS facility he or she must obtain the employing organisation's prior agreement, before using either HPSS facilities or staff.

12. The employing organisation has discretion to allow the use of its facilities and will make it clear which facilities a consultant is permitted to use for private purposes and to what extent.

13. Should a consultant, with the employing organisation's permission, undertake Private Professional Services in any of the employing organisation's facilities, the consultant should observe the relevant provisions in the 'Code of Conduct for Private Practice'.

14. Where a patient pays privately for a procedure that takes place in the employing organisation's facilities, such procedures should occur only where the patient has given a signed undertaking to pay any charges (or an undertaking has been given on the patient's behalf) in accordance with the employing organisation's procedures.

15. Private patients should normally be seen separately from scheduled HPSS patients. Only in unforeseen and clinically justified circumstances should a consultant cancel or delay an HPSS patient's treatment to make way for his or her private patient.

16. Where the employing organisation agrees that HPSS staff may assist a consultant in providing Private Professional Services, or provide private services on the consultant's behalf, it is the consultant's responsibility to ensure that these staff are aware that the patient has private status.

17. The consultant has an obligation to ensure, in accordance with the employing organisation's procedures, that any patient whom the consultant admits to the employing organisation's facilities is identified as private and that the responsible manager is aware of that patient's status.

18. The consultant will comply with the employing organisation's policies and procedures for private practice

**Patient Enquiries about Private Treatment**

19. Where, in the course of his or her duties, a consultant is approached by a patient and asked about the provision of Private Professional Services, the consultant may provide only such standard advice as has been agreed between the employing organisation and appropriate local consultant representatives for such circumstances.

20. The consultant will not during the course of his or her Programmed Activities make arrangements to provide Private Professional Services, nor ask any other member of staff to make such arrangements on his or her behalf, unless the patient is to be treated as a private patient of the employing organisation.

21. In the course of his/her Programmed Activities, a consultant should not initiate discussions about providing Private Professional Services for HPSS patients, nor should the consultant ask other staff to initiate such discussions on his or her behalf.

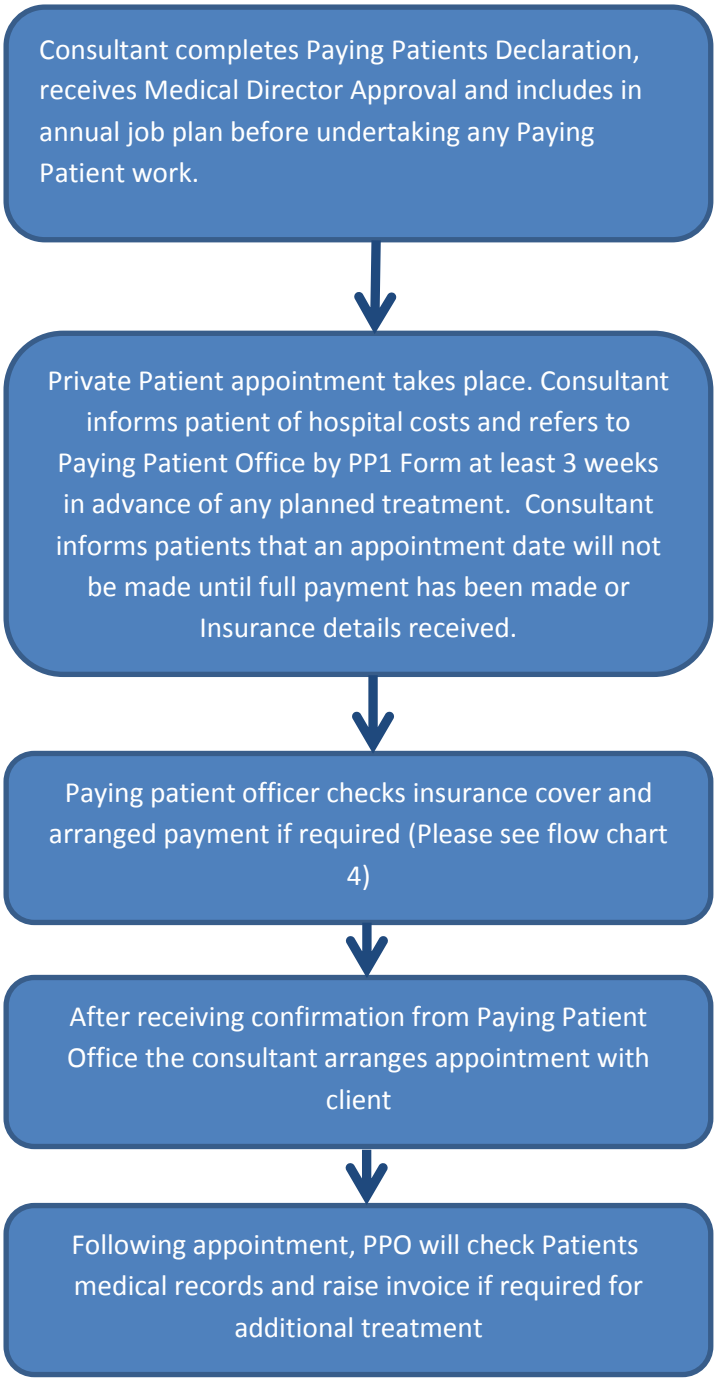
22. Where an HPSS patient seeks information about the availability of, or waiting times for, HPSS services and/or Private Professional Services, the consultant is responsible for ensuring that any information he or she provides, or arranges for other staff to provide on his or her behalf, is accurate and up-to-date.

**Promoting Improved Patient Access to HPSS Care**

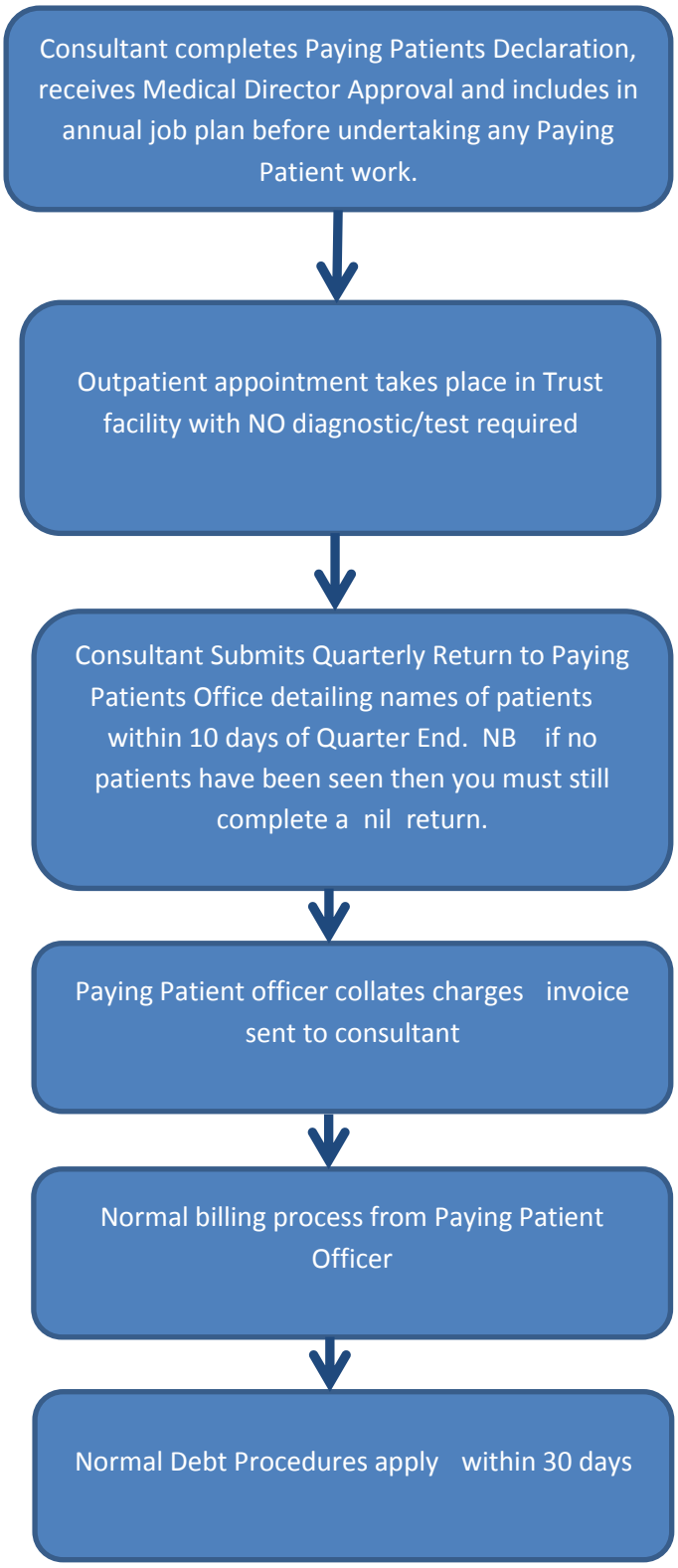
23. Subject to clinical considerations, the consultant is expected to contribute as fully as possible to reducing waiting times and improving access and choice for HPSS patients. This should include ensuring that, as far as is practicable, patients are given the opportunity to be treated by other HPSS colleagues or by other providers where this will reduce their waiting time and facilitate the transfer of such patients.

24. The consultant will make all reasonable efforts to support initiatives to increase HPSS capacity, including appointment of additional medical staff and changes to ways of working.

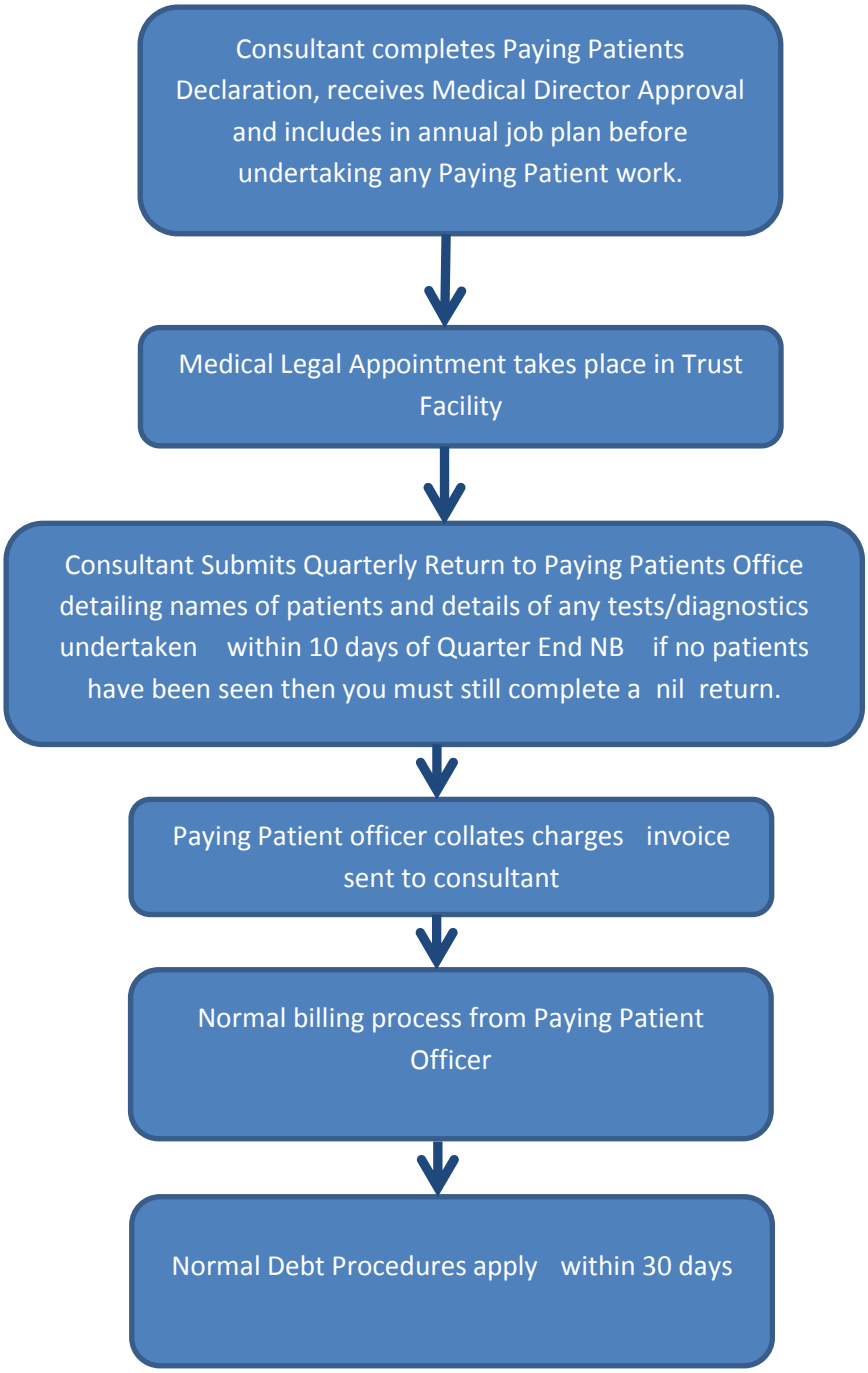
## 24. FLOW CHART 1 - PAYING PATIENTS [Inpatients]



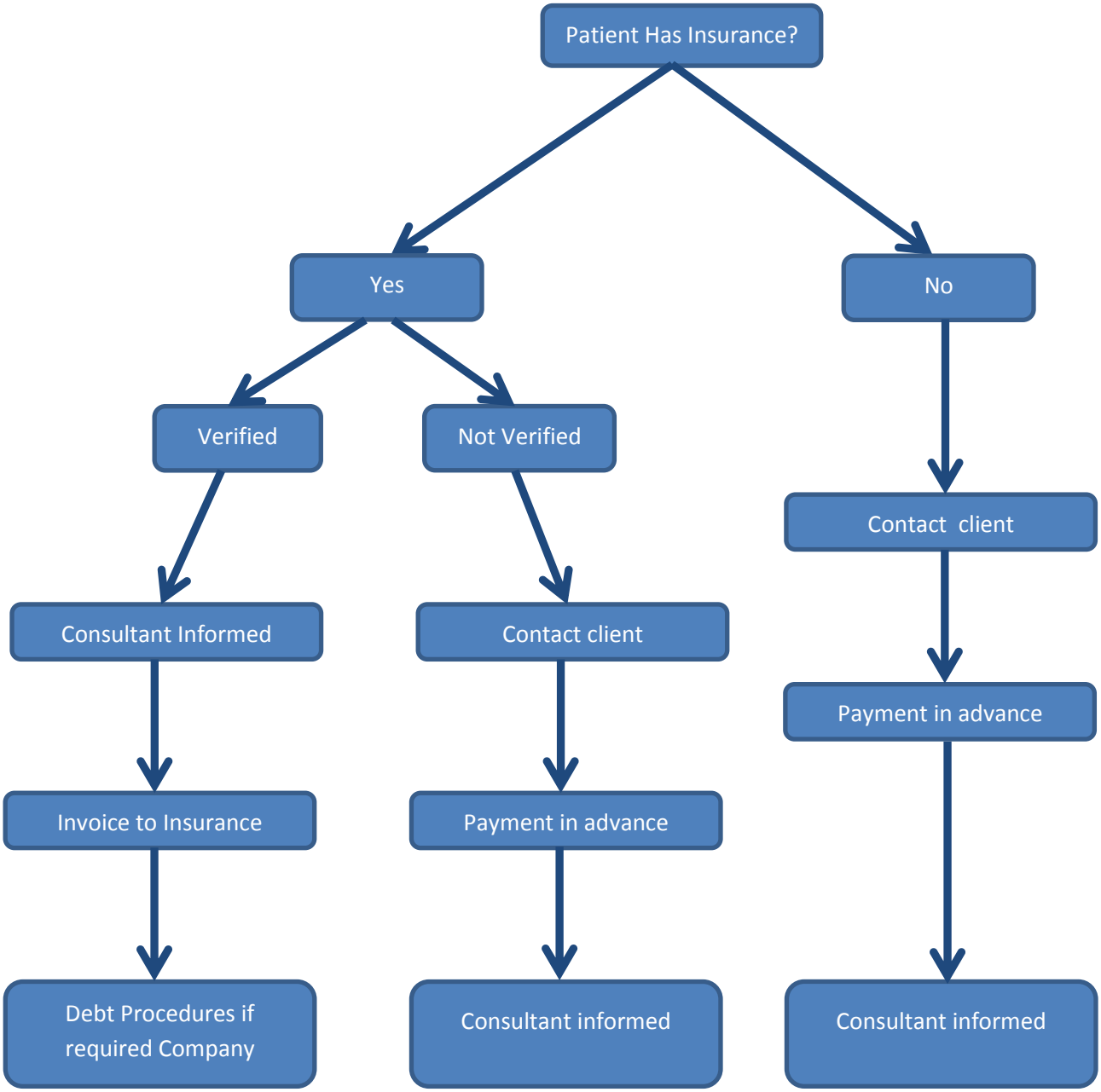
## 25. FLOW CHART 2 - PAYING PATIENTS [Outpatients]



## 26. FLOW CHART 3 - PAYING PATIENTS [Fee Paying Services]



## 27. FLOW CHART 4 – PATIENT INSURANCE



Health and Social Care Board

0023/18

# Query Request Form

**Requires Immediate Response:** Yes

**Reason for Immediate Response:** Required as an action following Internal Audit review of management of private patients

| | | | |
|---|---|---|---|
| ☐ | **Data Definition** | ☒ | **Recording Issue** |
| ☒ | **Technical Guidance** | ☐ | **Other** |

**Name:** Roberta Gibney **Date:** 8th August 2018

**Organisation:** BHSCT **Contact Number:** Personal Information redacted by the USI

**Subject Heading:** PAS OP Referral Source Code – Private to NHS

**a) Issue:** ***Please provide as much detail as possible in order for the query to be considered and resolved as quickly as possible. This query form will be published on SharePoint when resolved.***

Belfast Trust requests a Referral Source Code on PAS for outpatients who change status from Private to NHS. Currently there is no guidance for identifying such patients.

Patient who attends Trust as a private patient has category recorded as PPG. When treatment completed OP registration should be closed with Discharge Reason – Treatment Completed, however if during their treatment the patient decides to change status to NHS the OP registration should be closed with Discharge Reason – Transfer to NHS and a new OP registration opened:
PAS with referral source PTN (Private to NHS) (suggested code), mapped to Internal Value (2) and CMDS Value (11) on Referral Source Masterfile and category as NHS.

This will ensure that the original category of PPG is not overwritten to NHS and the information recorded as per the Draft Technical Guidance on Private and Overseas Patients is not lost.

Belfast Trust request that the above is adopted as regional PAS Technical Guidance.

**b) Response:**

When a patient transfers from Private to NHS during their treatment period the OP registration should be closed using:

Discharge Reason code: TNHS – Transfer from Private to NHS

A new OP registration should be opened using:

Referral Source code: PTN – Private to NHS

**Approved by:** Acute Hospital Information Group

**Date:** 11/09/2018 **Response Published:** Yes / ~~No~~

***Email:*** Personal Information redacted by the USI
***HSC Data Standards Helpdesk:*** Personal Information redacted by the USI

***These forms are available on the Information Standards & Data Quality SharePoint Site at*** *http://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Helpdesk.aspx*

## Action Plan Urology Personal Information redacted by

| Reference number | Recommendations | Designated responsible person | Action required | Date for completion / timescale | Date recommendation completed with evidence |
|---|---|---|---|---|---|
| | | | | | |
| 1 | HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory. | HSCB | See recommendation 5 | | |
| 2 | HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices | HSCB | | | |
| 3 | HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients. | HSCB | | | |
| 4 | GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields. | HSCB | | | |

| | | | | | |
|---|---|---|---|---|---|
| 5 | **TRUST**<br>Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm. | AD surgical/ AMD Primary Care | The urology service hold the view that to enable the referral process to be efficient and effective, the CCG form requires to have mandatory fields which require it to be completed prior to referral from Primary Care. | | NiCan pathway.<br>  <br>Bladder Cancer Pathway March 2020<br>  <br>Revised Prostate Diagnostic Pathway D<br>  <br>Female Lower Urinary Tract Sympto<br>  <br>Female Urinary Tract Infection.docx<br>  <br>Male Lower Urinary Tract Symptoms.docx<br>  <br>male urinary tract infections.docx |
| 6 | The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW. | AD Surgery/ AMD Surgery | Time needs to be made available in consultant job plans to undertake the task of triaging referral letters. Discussions are ongoing with MD and AD | Jan 2021 | |

| | | | | | |
|---|---|---|---|---|---|
| 7 | The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner. | AD surgery | Currently the IEAP protocol is followed<br><br>The current regional protocol is being updated. | Jan 2021 | Integrated Elective Access Protocol - Apr<br><br>Integrated Elective Access Protocol Draft<br><br>FW IEAP referral.msg<br><br>Booking Centre SOP manual.doc<br><br>TRIAGE PROCESS 2. lmca.docx |
| 8 | The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list. | AD Surgery | | Nov 2020 | |
| 9 | Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10. | AD surgery | Reports will be sent to AD and AMD/ CD | Nov 2020 | |
| 10 | The Trust must set in place a robust system within its medical management hierarchy for highlighting | MD | | | |

| | | | | | |
|---|---|---|---|---|---|
| | and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence. | | | | |
| 11 | Consultant 1<br><br>needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner. | MD | | | |
| 12 | Consultant 1<br><br>needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6. | MD | | | |

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Southern Health and Social Care Trust

**Incident Oversight Group Minutes**
**15th March 2021 at 8.30am via Zoom Meeting**

| Attendance | Apologies |
|---|---|
| Patricia Kingsnorth<br>Dr Maria O'Kane<br>Dr Damian Gormley<br>Martina Corrigan<br>Stephen Wallace<br>Jane McKimm<br>Siobhan Hynds<br>Ronan Carroll<br>Suzanne Barr | Melanie McClements<br>Mark Haynes<br>Vivienne Toal |

| Agenda Item | Discussion | Actions |
|---|---|---|
| 1. Review of previous meeting minutes and actions | Minutes reviewed and agreed | Actions updated accordingly throughout the main body of the Minute |
| **Management of Patient Reviews** | | |
| 2. Private Practice Audit | Dr O'Kane explained that management of private patients focuses very much on how patients come from private health care to NHS care. It would be expected that the Consultant gives a clinical handover, although it is unclear if this happens. Private Patient Policy needs revamped with clear clinical responsibilities and appraisal, reviews etc, she confirmed that there is a need for tighter controls as there appears to be a lot of detail about the processes, and we would need to add more to the content around patient safety practices. Dr O'Kane also highlighted that this is a regional issue and not just unique to the Southern Trust. | Ongoing work is needed to review the current policy, |
| 3. Update on Radiology and MDM Review | Martina advised that Professor Sethia has started reviewing the past MDM patients and that he had shared the forms for 7 patients. He has advised her that some cases will be straightforward but it will take a bit of time to work through others and that it would seem that he will need at least 3-4 weeks | Stephen to link in with the Royal College of Surgeons re: sourcing additional assistance |

| | | |
|---|---|---|
| | to get them all done (187 patients) and therefore it would appear that Professor Sethia will need assistance. Dr O'Kane stressed the need to ensure anyone involved is indemnified.<br><br>Stephen that he and Dr O'Kane had met with NICAN on 9 March 2021 to try and understand the role of MDM regionally and if the Southern Trust were any different to others in the region; it was determined that some Trusts have a more robust MDM's where patients are reviewed for reoccurrence and not just when they have had their first definitive treatment. He explained peer review does not look at patient level as this was done through individual audit. NICAN are doing a scoping exercise with rest of Trusts beyond peer review. NICAN are identifying UK mainland documents and identifying organisations for the Southern Trust MDM process – Stephen noted it will be a while before resolution from NICAN. The PHA has shared a document, from 2010 and Stephen has created a baseline questionnaire to assist with structures. It is hoped to get a baseline internally to help with fundamentals across all MDMs so we understand what we do.<br>Dr O'Kane advised that the documents are very process driven but less about patient care, possibly as the documents are so old. There are assumptions that MDM has oversight and expectations for patient care.<br>Patricia advised that the Board want to know can we share report with NICAN, Dr O'Kane answered that this would be a decision for the SAI Chair at finalised point. It was acknowledged that wider circulation will be needed for example RQIA once the reports were finalised. | with patient reviews – query Hugh Gilbert/ Dermot Hughes?<br><br>Patricia to check with SAI Chair, Dermot, the appropriateness of sharing the finalised report with NICAN and RQIA. |
| 4. IPT for Review Process<br>  Urology Inquiry IPT - draft 8 15.12.2020.d<br>  Band 8B_Service Manager for Public In | Stephen outlined the job description for a post advertised in Belfast Trust and indicated that appears to include the function of collating witness statements and managing the process of public inquiries, duties etc and seems to be wide ranging. He highlighted that there are elements the Trust have not considered. | Siobhan agreed to have a look at the Job Description |
| 5. Additional Subject Matter | Stephen informed that the Urology Consultant Edward Tudor for SJR Contact | |

| | | |
|---|---|---|
| Expertise<br>- British Association of Urological Surgeons<br><br>- British Association of Urological Nurses | | |
| 6. Royal College of Surgeons Engagement<br>- Selection of Records<br>- Costing | Martina and Stephen met with Jessica from RCS on 11 March 2021 and acknowledged that there will be ongoing communication re: record transfer. The patient hospital numbers are now ready for randomisation selection. Martina informed some of the cohorts are short in numbers, for example, Andrology was to have a sample of 10 patients however there were only 5 patients referred in for Andrology in 2015 so it was agreed by the group that we would take from other groups to make up 100 patients.<br>Stephen advised that costing is to be finalised as it will need a direct award. | |
| 7. Bicalutamide Patient Review | No further updates for this meeting | |
| 8. Engagement of ISP to undertake waiting list work | No update for this meeting | Mark to update at next meeting |
| 9. Telephone Support Service / Patient Triage Update | Martina updated that there have been no further calls/emails – one patient has contacted the Information line a second time to reiterate how full of praise he had for Mr O'Brien and to check who his care had been transferred to. The patient appears to have been discharged by Mr O'Brien in 2014 and seems to have been a private patient of his, Martina has agreed to make contact with him to discuss and if needed Mark has agreed to take over his care.<br>Mark and Martina have agreed to leave time at the end of his Saturday clinic to respond to any clinical queries that may have been raised during the week | |
| 10. MDM Processes | Update as noted in agenda item 3 | |
| **Professional Governance** | | |

| | | |
|---|---|---|
| 11. GMC Discussions – | Stephen advised there is a three way meeting between the Trust, GMC and Department of Health at 11.30 on Tuesday 16th March. | Update to be given following meeting on 16th March 2021 |
| 12. Litigation / DLS Update | Work remains ongoing – given the earlier discussion around reports being shared with one patient's solicitor it would suggest it could be going to litigation. | |
| 13. Grievance Process- | Siobhan advised that a draft letter had been sent to DLS for review before responding to Mr O'Brien and they were just waiting to hear back from DLS., She advised that he has indicated in his reply that he is not participating through the appeal process, he will just go through Public Inquiry –although is not withdrawing appeal. The Trust has asked the panel to look at it from a review perspective, so they can engage with him and will update him. The plan is to reply as soon as DLS comes back with confirmation to do so. | |
| 14. Administration Review Update –<br>Admin Review Process V10 18 Feb 2 | No further update | |
| Serious Adverse Incidents (SAIs) Review | | |
| 15. Update on Current SAI Progress<br>- Screening<br>- Initial Feedback on outcomes from Dr Hughes | Dr O'Kane advised that the plan is to share the reports on Tuesday (16th) and DLS were to speak to Senior counsel today, but the Trust are still awaiting to hear. Martina queried could the | Egress to be used with 'guest' permissions to restrict sharing. |

| | | |
|---|---|---|
| | reports go electronically to the Urology and Cancer teams so as to ensure they all had access at the same time. It was agreed that the reports should be uploaded to Egress 'guest' permissions and Martina would share with the Teams.<br>Patricia advised that the reports would be going to families also, with one patient who has a solicitor and wants it to go to them. These would be sent when permission had been obtained from DLS | Dr O'Kane and Stephen to link in with DLS so that there is clear direction on the sharing of the reports. On receiving this, to update Martina. |
| 16. Initial SAI Recommendations<br>  <br>Action plan [Personal Information].docx | Dr O'Kane advised that there is a need for an oversight group to be established to start to implement these actions. | Oversight Group to be established |
| 17. Structured Judgement Review Process – (SJR)<br>   <br>DRAFT Structured Clinical Record Review DRAFT - PROPOSAL FOR STRUCTURED CI | Training on 18th and 25th March 2021 | |
| 18. Family Liaison Role | Fiona linking in with families, she will phone them in advance to let them know reports will be out. Spoke to them regarding announcement of the Chair of the Inquiry and advised them that the reports would be shared within the next few weeks | |
| Communications | | |
| **19.** Media / Assembly Questions – | Jane advised that there has been nothing last week, and remarked that there had been minimal media coverage about the Chair being appointed – She updated that there had been a general | |

| | | |
|---|---|---|
| | meeting with MLAs and whilst the topic of Mr O'Brien had been raised this had been all positive towards him | |
| Any other Business | | |
| 20. Complaints | No further complaints | |
| 21. Coronial Processes | Damian advised that he had received a document (Interface Paper) from the Medical Advisor which confirmed that no response was needed from coroner as the public inquiry takes precedence. He explained that if the public inquiry feels an individual case needs reviewed, it would go ahead. This is a Parliamentary document which was published in 1959 in NI. | |
| 22. Counter Fraud | This will be ongoing as cases are identified. | |
| 23. Declaration re CURE | One return outstanding | Stephen to link in with Mark to try and resolve |
| 24. Public Inquiry Update<br>Chair Appointed<br>Securing Records for Public Inquiry | Christine Smith QC has been appointed as Chair of the Inquiry.<br>Stephen advised that he has linked in with Catherine Weaver re: Destruction of Records within the Trust has ceased to support the Inquiry work. | |
| Date of next meeting: 22nd March 2021, 8.30am via zoom | | |

Southern Health and Social Care Trust

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# Strictly Confidential

# 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.

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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<br>(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<br>• Liaise with Human Resources |
| • Staff Backfill | • Complete recruitment |

| Risk Identified | Mitigation Measure |
|---|---|
| | documentation as soon as possible<br>• 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<br>• Extending the operational hours to receive calls<br>• 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<br>• Monitoring clinics and virtual clinics<br>• 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<br>• Utilise independent resources<br>• 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.

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# JOB DESCRIPTION

**POST:** Service Manager Public Inquiry and Trust Liaison

**LOCATION:** Muckamore Abbey Hospital AND Royal Victoria Hospital with travel between Trust sites required

**BAND:** 8B

**REPORTS TO:** Interim Director, Learning Disability Services

**RESPONSIBLE TO:** Chief Executive

## Job Summary / Main Purpose

In the first instance, the post holder will be responsible through the Director for Learning Disability Services, and working closely with the Co-Director Risk and Governance, for ensuring that the Trust meets the legal requirements of the Inquiries Act 2005 in respect of the Muckamore Abbey Hospital Public Inquiry. The post holder will also act as the Trust's Liaison Officer for the Inquiry Panel, the Directorate of Legal Services and other external stakeholders, for example, the Department of Health.

This is a permanent post and as such it is recognised that while the focus will in the first phase be on the Muckamore Abbey Hospital Public Inquiry, there will be future requirements for such a role following the completion of this particular Inquiry.

## Main Duties / Responsibilities

For each of the following, the postholder will;

- Provide administrative support to the Public Inquiry Oversight Steering Group and any Task and Finish Groups which may arise. This will include the organisation of agendas, the co-ordination of papers and reports and completion of accurate and concise minutes to record key issues and decision-making.
- Be responsible for preparation of briefing notes to the Oversight Steering Group, the Executive Team and Trust Board, and the preparation of other ad hoc briefings as required.
- Oversee the collation, cataloguing, storage and maintenance of evidence anticipated to be required for the Public Inquiry, and evidence subsequently submitted to the Inquiry.
- Ensure that there is a safe, secure and retrievable system for storage of evidence anticipated to be required for the Inquiry, and for storage of evidence that is subsequently submitted to the Inquiry.
- Be responsible for briefing and supporting staff who are required to participate in the Inquiry and for providing guidance on best practice throughout the Inquiry process.
- Respond to any queries of the Inquiry Panel and the Director of Legal Services and to ensure the timely provision of witness evidence, and other evidence, as stipulated by the Inquiry Panel.

- Be responsible for developing and maintaining governance processes associated with implementation of agreed recommendations, actions and learning from the findings of the Public Inquiry.

**Setting Direction and Service Delivery**

- Provide effective leadership in the co-ordination of the Trust's response to the Muckamore Abbey Hospital Public Inquiry ensuring that the Trust meets its statutory duties.
- Oversee the co-ordination, collation and provision of evidence, including witness evidence, as required by the Inquiry Panel and/or Directorate of Legal Services, in line with Trust Policy and Regional Guidance on the Provision of Witness Statements.
- Ensure that there is a safe, secure and retrievable system for storage of evidence anticipated to be required for the Inquiry, and for storage of evidence that is subsequently submitted to the Inquiry.
- Ensure that there are systems and processes in place to optimise the timeliness and responsiveness to the Inquiry Panel requests.
- Provide timely information to employees in the requesting of reports and statements required by the Inquiry Panel.
- Ensure that the relevant line manager is aware that a member of staff is being asked to attend the Inquiry.
- Ensure that staff who are required to participate in the Public Inquiry receive adequate support throughout the entire Inquiry process, keeping the team informed of developments in the case and dates and times of any consultations. This will include supporting the relevant directorate management team to guide them through the process and ensure their preparedness to enable them to support staff.
- Escalate any concerns in relation to potential delays in the provision of information to the Inquiry Panel through the Trust's assurance/accountability framework to the Executive Team.
- Provide administrative support to the Public Inquiry Oversight Steering Group and any Task and Finish Groups which may arise. This will include the organisation of agendas, the co-ordination of papers and reports and completion of accurate and concise minutes to record key issues and decision-making.
- Be responsible for preparation of briefing notes to the Oversight Steering Group, the Executive Team and Trust Board, and the preparation of other ad hoc briefings as required.

**Corporate Management**

- Contribute to the Trust's overall corporate governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability.

**Collaborative Working and Communication**

- Establish collaborative relationships and networks with internal and external stakeholders.
- Engage with stakeholders across the organisation including the Risk and Governance Team and the Medical Directors Office to ensure the provision of accurate and timely information to the Inquiry Panel.
- Work collaboratively with external stakeholders including the Directorate of Legal Services and the PSNI.
- Responsible for developing and maintaining sound internal and external communications systems.

- Represent the Trust, as appropriate, on external groups and/or representing Director where appropriate and as required in respect of the Trust's approach to the Public Inquiry.

**Financial and Resource Management**

- Responsible for the management of any financial allocation/budget associated with the Trust's preparation and involvement in the Public Inquiry, in conjunction with financial management colleagues.

**People Management and Development**

- Be responsible for the line management of the Assurance Co-ordinator.
- Promote the corporate values and culture of the organisation through the development and implementation of relevant policies and procedures, and appropriate personal behaviour.
- Be responsible for ensuring that the Health and Social Care Records service complies with employment law and is consistent in their application of the Trust's policies.
- Be responsible for ensuring that staff are appraised at least annually and Knowledge and Skills framework is in place.
- Be responsible for his/her own performance and take action to address identified personal development areas.
- Manage recruitment processes, to ensure staff are recruited in a timely and professional manner and vacancies are filled appropriately.

## General Responsibilities

Employees of the Trust are required to promote and support the mission and vision of the service for which they are responsible and:

- At all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- Demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- Comply with the Trust's Smoke Free Policy.
- Carry out their duties and responsibilities in compliance with the Health and Safety Policies and Statutory Regulations.
- Adhere to Equality and Good Relations duties throughout the course of their employment.
- Ensure the ongoing confidence of the public in-service provision.
- Maintain high standards of personal accountability.
- Comply with the HPSS Code of Conduct.
- The post holder will promote and support effective team working, fostering a culture of openness and transparency. The post holder will ensure that they take all concerns raised with them seriously and act in accordance with Belfast Trust's Whistleblowing Policy and their professional code of conduct, where applicable.
- The post holder will, in the event of a concern being raised with them, ensure it is managed correctly under the Belfast Trust's Whistleblowing Policy, and ensure that feedback/learning is communicated at individual, team and organisational level regarding the concerns raised, and how they were resolved.

## Information Governance

All employees of Belfast Health & Social Care Trust are legally responsible for all records held, created or used as part of their business within the Belfast Health and

Social Care Trust, including patient/client, corporate and administrative records whether paper based or electronic and also including e-mails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000, the Environment Regulations 2004, the General Data Protection Regulation (GDPR) and the Data Protection Act 2018. Employees are required to be conversant and to comply with the Belfast Health and Social Care Trust policies on Information Governance including for example the ICT Security Policy, Data Protection Policy and Records Management Policy and to seek advice if in doubt.

**For further information on how we use your personal data within HR, please refer to the Privacy Notice available on the HUB or Your HR**

## Environmental Cleaning Strategy

The Trusts Environmental Cleaning Strategy recognises the key principle that "Cleanliness matters is everyone's responsibility, not just the cleaners" Whilst there are staff employed who are responsible for cleaning services, all Trust staff have a responsibility to ensure a clean, comfortable, safe environment for patients, clients, residents, visitors, staff and members of the general public.

## Infection Prevention and Control

The Belfast Trust is committed to reducing Healthcare associated infections (HCAIs) and all staff have a part to play in making this happen. Staff must comply with all policies in relation to Infection Prevention and Control and with ongoing reduction strategies. Standard Infection Prevention and Control Precautions must be used at all times to ensure the safety of patients and staff.
This includes:-

- Cleaning hands either with soap and water or a hand sanitiser at the appropriate times (WHO '5 moments');
- Using the correct '7 step' hand hygiene technique;
- Being 'bare below the elbows' when in a clinical environment;
- Following Trust policies and the Regional Infection Control Manual (found on intranet);
- Wearing the correct Personal Protective Equipment (PPE);
- Ensuring correct handling and disposal of waste (including sharps) and laundry;
- Ensuring all medical devices (equipment) are decontaminated appropriately i.e. cleaned, disinfected and/or sterilised;
- Ensuring compliance with High Impact Interventions.

## Personal Public Involvement

Staff members are expected to involve patients, clients, carers and the wider community were relevant, in developing, planning and delivering our services in a meaningful and effective way, as part of the Trust's ongoing commitment to Personal Public Involvement (PPI).

Please use the link below to access the PPI standards leaflet for further information.

http://www.publichealth.hscni.net/sites/default/files/PPI_leaflet.pdf

***Clause:*** ***This job description is not meant to be definitive and may be amended to meet the changing needs of the Belfast Health and Social Care Trust.***

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# PERSONNEL SPECIFICATION

**JOB TITLE / BAND:** Service Manager, Public Inquiry and Trust Liaison / Band 8B

**DEPT / DIRECTORATE:** Muckamore Abbey Hospital AND Royal Victoria Hospital with travel between Trust sites required / Adult Social & Primary Care

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**Notes to applicants:**

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

## ESSENTIAL CRITERIA

The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage.

You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.

| Factor | Criteria | Method of Assessment |
|---|---|---|
| **Experience Qualifications Registration** | • Have a university degree or relevant professional qualification at graduate or diploma level **AND** worked for at least 2 years in a *senior management role in a complex organisation<br>**OR**<br>Have worked for at least 3 years in a *senior management role in a major complex organisation.<br>***Note *senior management role will be considered to be at Band 8A or equivalent or above.*** | Shortlisting by Application Form |
| **Other (e.g. Driving etc.)** | • Full UK Driving Licence and access to a car.<br>*'Where disability prohibits driving, this criteria will be waived if the applicant is able to organise suitable alternative arrangements.'* | Shortlisting by Application Form |

| | | |
|---|---|---|
| **Knowledge**<br>**Skills**<br>**Abilities** | • Delivered against challenging performance management programmes for a minimum of 2 years meeting a full range of key targets and making significant improvements.<br>• Have worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes for a minimum of 2 years.<br>• Successfully demonstrate high level people management, leadership and organisational skills for a minimum of 2 years.<br>• Have good communication skills (written, oral, presentational and interpersonal) with the ability to communicate effectively with all levels of staff within the Trust, and outside the organisation.<br>• Have the ability to collate and critically analyse statistical and qualitative information and the ability to make and take decisions after analysis of options and implications.<br>• Ability to multi-task and continue to function to a high standard when under pressure.<br>• Determination, drive to succeed, perseverance, and resilience.<br>• IT literacy -proficient in MS Word, Excel, PowerPoint, etc. | Shortlisting by Application Form<br>**And / Or**<br>Interview |

## DESIRABLE CRITERIA

Desirable criteria will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these. Failure to do so may result in you not being shortlisted.

| Factor | Criteria | Method of Assessment |
|---|---|---|
| **Experience**<br>**Qualifications**<br>**Registration** | • Experience of working with legal services and/or working on legal processes. | Shortlisting by Application Form |

**NOTE:**

Where educational/professional qualifications form part of the criteria you will be required, if shortlisted for interview, to produce original certificates *and* one photocopy of same issued by the appropriate authority. Only those certificates relevant to the shortlisting criteria should be produced. If educational certificates are not available an original letter *and* photocopy of same detailing examination results from your school or college will be accepted as an alternative.

If successful you will be required to produce documentary evidence that you are legally entitled to live and work in the United Kingdom. This documentation can be a P45, Payslip, National Insurance Card or a Birth Certificate confirming birth in the United Kingdom or the Republic of Ireland. *Failure to produce evidence will result in a non-appointment*.

Where a post involves working in regulated activity with vulnerable groups, post holders will be required to register with the Independent Safeguarding Authority.

## Healthcare Leadership Competencies

Candidates who are shortlisted for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role.

The competencies concerned are set out in the NHS Healthcare Leadership Model, details of which can be found at:

http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model.

Particular attention will be given to the following:

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

# HSC Values

Whilst employees will be expected to portray all the values, particular attention is drawn to the following values for this role

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

Southern Health and Social Care Trust

# Admin Review Processes

| Issues Identified | Description of issue | Gaps that led to the problems | Policies or processes in place | Ongoing Risks/Flaws | Action Required | Owner of Action and date for completion |
|---|---|---|---|---|---|---|
| **1. Triage** | Pre 2014<br>Due to the delayed triage of referrals, the decision was taken to add to the OP waiting list the referral at the clinical priority that the GP had assigned.<br><br>. | 2014-2017<br>For routine and Urgent GP referrals, non-adherence and non-enforcement of the IEAP, resulted in referrals not being returned within the appropriate timeframe, which then resulted in a lost opportunity to either upgrade or downgrade urgent/routine referrals | 2017-current<br>The introduction of e-Triage on 27/3/17 enabled referrals to be monitored with respect to the triage process.<br><br>The revised triage process (draft) detailed in the word document below is based on the current IEAP also addresses these issues of timely and appropriate triaging<br><br>TRIAGE PROCESS DEC 20 (1).docx | Current<br>Consultant-to-Consultant referrals (including outside of Trust) are not currently manged through e-Triage so there is still a risk that these could be delayed.<br><br>Remaining specialties that still do not use e-Triage are being addressed<br><br>Services not using eTriage.docx | Consultant to Consultant referrals to be added to e-Triage and the PDF SOP to be updated<br><br>Consultant to Consultant Referrals.<br><br>Remaining specialties to be added to e-Triage<br><br>The triage process continues to be monitored weekly and needs to be complied to and enforced where necessary | AD for FSS<br><br>Transformational Lead to work with Service Leads for specialties still not on e-Triage and to implement same.<br><br>**June 2021**<br><br>AD FSS and divisional AD's<br><br>**Ongoing** |

| Issues Identified | Description of issue | Gaps that led to the problems | Policies or processes in place | Ongoing Risks/Flaws | Action Required | Owner of Action and date for completion |
|---|---|---|---|---|---|---|
| **2. Undictated Clinics** | Some patients not having a letter dictated following an outpatient consultation resulting in no outcome recorded on PAS. | There is no system or process that provides assurance that each outpatient consultation generates an outpatient outcome letter | All Medical staff must understand that a letter is required for every outpatient attendance. | A limitation with the G2 system is that it simply records speech and generates a letter. However G2 is unable to correlate the letter dictated against the outpatient attendance. | The Trust has been working on the G2/PAS interface. This major piece of work required integration with the help of BSO. It is now in 'live' mode and is being piloted by one consultant with positive feedback. This will provide the Trust with more assurance around the dictation of outpatient clinics.<br><br>Update typing SOP to highlight that when a letters is not dictated for a patient that the secretary raises with the consultant and line manager in the first instance. Secretaries to stipulate on their backlog reports if they know of any undictated clinics/letters | The Referral and Booking Centre Manager.<br><br>**June 2021**<br><br>The Referral and Booking Centre Manager.<br><br>**Ongoing**<br><br>Heads of Services with their Clinical Teams at Induction/ Changeover |

| Issues Identified | Description of issue | Gaps that led to the problems | Policies or processes in place | Ongoing Risks/Flaws | Action Required | Owner of Action and date for completion |
|---|---|---|---|---|---|---|
| | | | | | Monthly typing reports require to be produced and shared throughout all divisions<br><br>At Junior doctor changeover inductions, the importance of timely and accurate dictating of all outpatients they have reviewed must be highlighted to them. | IT Team with BSO and the clinical teams<br><br>**June 2021** |
| **3. Hospital Notes** | Patient's hospital records electronically casenote tracked to a consultant and a location. | When patients hospital records were required same not in the tracked location | Current tracking system is a function on Patient Administrative System (PAS)<br><br>Missing Charts are investigated and an IR1 form is completed if not found | There is currently no system which identifies that a chart is not where it is tracked to other than manual searches.<br><br>Need to establish whether or not as part of the induction and training there is a SOP governing the tracking of patient hospital records? | Any missing notes need to have an IR1 raised to highlight the problem. These should be reported to the respective areas.<br><br>All staff managing patient notes should be reminded of the need for accuracy on PAS when tracking notes and patient records should be returned to file as soon as possible. | Acute Director<br><br>**April 2021** |

| Issues Identified | Description of issue | Gaps that led to the problems | Policies or processes in place | Ongoing Risks/Flaws | Action Required | Owner of Action and date for completion |
|---|---|---|---|---|---|---|
| | | | | | We also need to remind consultants that all charts are tracked in their name and that it is their responsibility to ensure the notes are kept in the location that the notes are tracked to.<br><br>Service Administrators to do spot-checks of offices and highlight any issues of charts being stored beyond a reasonable time period.<br><br>Business Case for IFit which is an electronic tracking system using barcode technology (as used in other Trusts in NI) to be considered for funding until the NI Electronic Patient Record replaces paper records under the Encompass Project This had been previously submitted and approved but no funding identified. | Assistant Director – Functional Support to resubmit to Trust's SMT in new financial year.<br><br>**April 2021** |

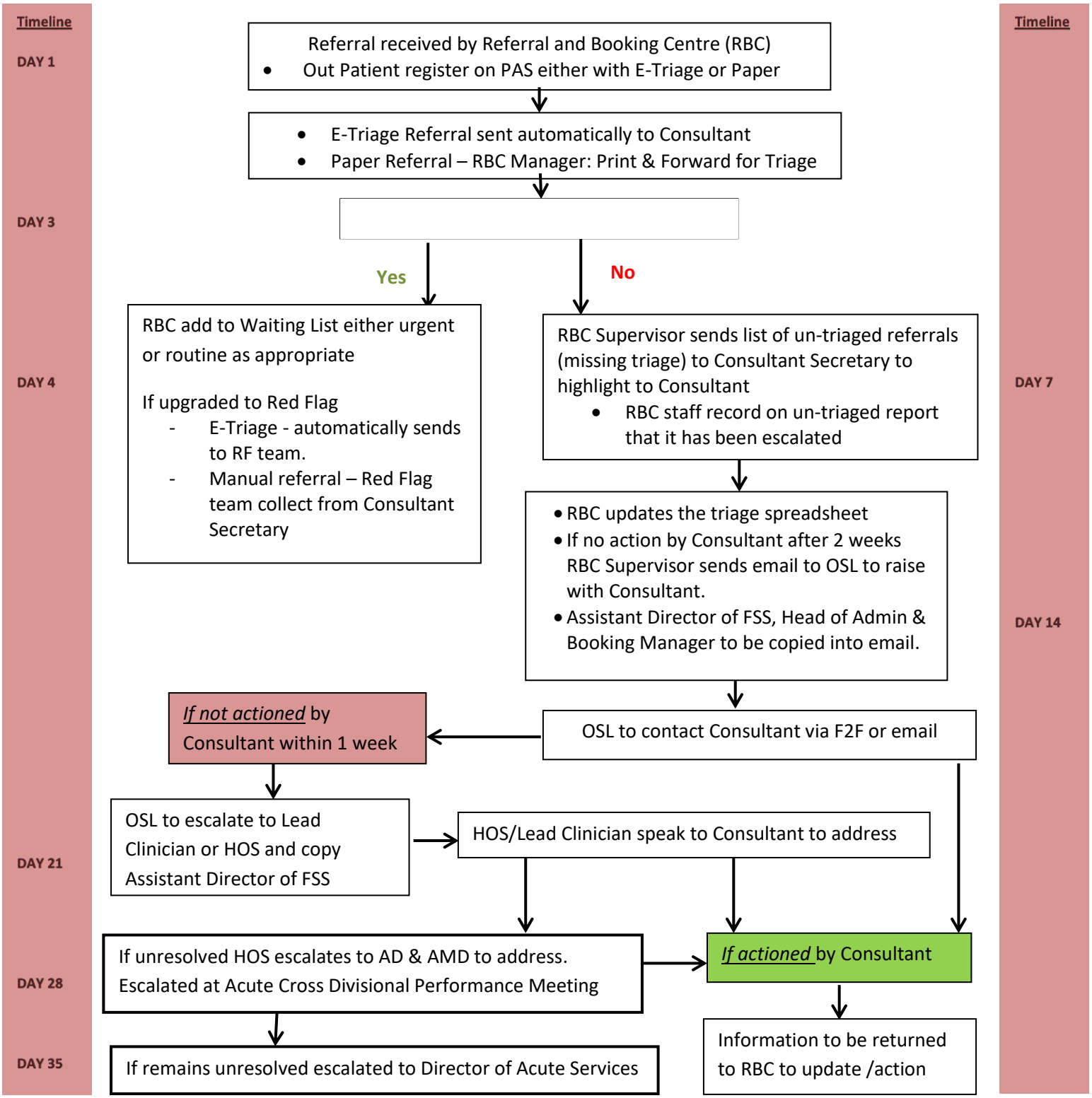
| Issues Identified | Description of issue | Gaps that led to the problems | Policies or processes in place | Ongoing Risks/Flaws | Action Required | Owner of Action and date for completion |
|---|---|---|---|---|---|---|
| **4. Private Patients** | Patients who had been initially reviewed privately were added to the waiting list in a non-chronological manner | No monitoring of patients seen privately where they are entered onto the waiting list | This is governed by the Private Patient policy | It relies on the integrity of the consultant to comply with the private patient policy. | Revise the policy for paying patients in the Trust and share with all clinical teams.<br><br>Guide-to-Paying-Patients-Southern-Trust-<br><br>Data Quality Release notice for recording of private patient activity on PAS to be shared amongst clinical teams.<br><br>0023-18 PAS OP REFERRRAL PRIVATE | Deputy Medical Director and AD for Medical Directorate **April 2021**<br><br>Functional Services to reissue the Data Quality Release notice for the recording of private patient activity on PAS with all teams.<br><br>**November 2020 Complete** |

# TRIAGE PROCESS

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

## PURPOSE OF TRIAGE

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




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

| Services not using e-triage | |
|---|---|
| ORTHOPAEDIC GERIATRICS | Planned e-triage commencement Jan/Feb 2021 |
| HAEMATOLOGY | Planned implementation postpone due to service pressures |
| NEPHROLOGY | Currently taking a break from e-triage, will relook at recommencing early 2021 |
| GENERAL MEDICINE | Minimal referrals to this service but working with service looking towards implementation early 2021 |
| BREAST SURGERY | Consultants not currently keen on e-triage – reengaged with service |
| GERIATRIC MEDICINE | Currently engaging with service |

Southern Health and Social Care Trust

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# ADMINISTRATIVE & CLERICAL Standard Operating Procedure

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

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

### Introduction

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

### Implementation

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

# Consultant to Consultant Referrals

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

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

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

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

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

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

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

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# A GUIDE TO PAYING PATIENTS

**V.2 [11th February 2016]**

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

# CONTENTS

## 1. INTRODUCTION

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

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

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

- Private Patients
- Fee Paying Services
- Overseas Visitors

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

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

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

## 2. OBJECTIVES

2.1 The purpose of this guideline is to:

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

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

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

## 3. CATEGORIES OF WORK COVERED BY THIS GUIDE

### 3.1 Fee Paying Services

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

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

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

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

### 3.3 Overseas Visitors

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

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

## 4. POLICY STATEMENT

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

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

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

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

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

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

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

## 5. CONSULTANT MEDICAL STAFF RESPONSIBILITIES

### 5.1 Private Practice

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

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

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

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

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

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

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

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

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

### 5.3 Additional Programmed Activities

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

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

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

## 6. RESTRICTIONS ON PRIVATE PRACTICE FOR CONSULTANT MEDICAL STAFF

### 6.1 New Consultants

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

### 6.2 Locum Consultants

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

### 6.3 Non Consultant Grade Medical Staff

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

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

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

## 7. CHANGE OF STATUS BETWEEN PRIVATE AND NHS

### 7.1 Treatment Episode

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

### 7.2 Single Status

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

### 7.3 Outpatient Transfer

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

### 7.4 Waiting List

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

### 7.5 Inpatient Transfer

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

### 7.6 During Procedure

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

### 7.7 Clinical Priority

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

### 7.8 Change of Status Form

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

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

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

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

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

## 9. OPERATIONAL ARRANGEMENTS

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

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

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

9.4 Clinical governance is defined as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.

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

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

## 9.7 Record Keeping Systems and Private Patients

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

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

## 9.8 Health Records of Private Patients

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

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

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

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

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

## 9.9 Booking Arrangements for Admissions and Appointments

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

## 9.10 Walk Ins

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

## 9.11 Radiology

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

## 9.12 Private Patient Records

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

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

9.12.3 It should be noted that

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

## 9.13 Tests Investigations or Prescriptions for Private Patients

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

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

### 9.14 Medical Reports

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

## 10. FINANCIAL ARRANGEMENTS - PRIVATE PATIENTS

### 10.1 Charges to Patients

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

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

### 10.2 Charges for Use of Trust Facilities for Outpatients

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

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

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

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

### 10.3 Basis of Pricing

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

### 10.4 Uninsured Patients – Payment Upfront

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

### 10.5 Insured Patients

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

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

### 10.6 Billing and Payment

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

### 10.7 Audit

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

## 11. FINANCIAL ARRANGEMENTS FOR FEE PAYING SERVICES

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

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

### 11.3 Fee Paying Services Policy (Category 2)

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

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

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

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

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

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

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

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

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

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

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

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

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

## 12. RENUNCIATION OF PRIVATE FEES

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

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

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

## 13. OVERSEAS VISITORS - NON UK PATIENTS

*(Republic of Ireland, EEA, Foreign Nationals)*

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

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

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

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

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

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

## 13.6 Emergency Department

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

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

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

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

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

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

## 13.7 Outpatient Appointments

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

### 13.8 Review Appointments

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

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

### 13.9 Elective Admission

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

### 13.10 Referral from other NHS Trusts

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

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

## 14. AMENITY BED PATIENTS

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

## 15. GLOSSARY

**Undertaking to Pay Form**

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

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

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

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

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

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

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

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

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

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

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

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

   d. work required for life insurance purposes;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

u. delivering lectures;

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

w. attendance as a witness in court;

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

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

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

November 2003

**Recommended Standards of Practice for NHS Consultants**

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

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

**Contents**



## Part I: Introduction

**Scope of Code**

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

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

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

**Key Principles**

1.4 The Code is based on the following key principles:

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

## Part II: Standards of Best Practice

**Disclosure of Information about Private Practice**

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

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

**Scheduling of Work and On-Call Duties**

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

2.4 Consultants should ensure in particular that:

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

- private commitments are rearranged where there is regular disruption of this kind to NHS work; and private commitments do not prevent them from being able to attend a NHS emergency while they are on call for the NHS, including any emergency cover that they agree to provide for NHS colleagues. In particular, private commitments that prevent an immediate response should not be undertaken at these times.

2.5 Effective job planning should minimise the potential for conflicts of interests between different commitments. Regular private commitments should be noted in a consultant's job plan, to ensure that planning is as effective as possible.

2.6 There will be circumstances in which consultants may reasonably provide emergency treatment for private patients during time when they are scheduled to be working or are on call for the NHS. Consultants should make alternative arrangements to provide cover where emergency work of this kind regularly impacts on NHS commitments.

2.7 Where there is a proposed change to the scheduling of NHS work, the employer should allow a reasonable period for consultants to rearrange any private sessions, taking into account any binding commitments entered into (e.g. leases).

**Provision of Private Services alongside NHS Duties**

2.8 In some circumstances NHS employers may at their discretion allow some private practice to be undertaken alongside a consultant's scheduled NHS duties, provided that they are satisfied that there will be no disruption to NHS services. In these circumstances, the consultants should ensure that any private services are provided with the explicit knowledge and agreement of the employer and that there is no detriment to the quality or timeliness of services for NHS patients.

**Information for NHS Patients about Private Treatment**

2.9 In the course of their NHS duties and responsibilities consultants should not initiate discussions about providing private services for NHS patients, nor should they ask other NHS staff to initiate such discussions on their behalf.

2.10 Where a NHS patient seeks information about the availability of, or waiting times for, NHS and/or private services, consultants should ensure that any information provided by them, is accurate and up-to-date and conforms with any local guidelines.

2.11 Except where immediate care is justified on clinical grounds, consultants should not, in the course of their NHS duties and responsibilities, make arrangements to provide private services, nor should they ask any other NHS staff to make such arrangements on their behalf unless the patient is to be treated as a private patient of the NHS facility concerned.

**Referral of Private Patients to NHS Lists**

2.12 Patients who choose to be treated privately are entitled to NHS services on exactly the same basis of clinical need as any other patient.

2.13 Where a patient wishes to change from private to NHS status, consultants should help ensure that the following principles apply:

- a patient cannot be both a private and a NHS patient for the treatment of one condition during a single visit to a NHS organisation;
- any patient seen privately is entitled to subsequently change his or her status and seek treatment as a NHS patient;
- any patient changing their status after having been provided with private services should not be treated on a different basis to other NHS patients as a result of having previously held private status;
- patients referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients; and
- should a patient be admitted to an NHS hospital as a private inpatient, but subsequently decide to change to NHS status before having received treatment, there should be an assessment to determine the patient's priority for NHS care.

**Promoting Improved Patient Access to NHS Care and Increasing NHS Capacity**

2.14 Subject to clinical considerations, consultants should be expected to contribute as fully as possible to maintaining a high quality service to patients, including reducing waiting times and improving access and choice for NHS patients. This should include co-operating to make sure that patients are given the opportunity to be treated by other NHS colleagues or by other providers where this will maintain or improve their quality of care, such as by reducing their waiting time.

2.15 Consultants should make all reasonable efforts to support initiatives to increase NHS capacity, including appointment of additional medical staff.

## Part III – Managing Private Patients in NHS Facilities

3.1 Consultants may only see patients privately within NHS facilities with the explicit agreement of the responsible NHS organisation. It is for NHS organisations to decide to what extent, if any, their facilities, staff and equipment may be used for private patient services and to ensure that any such services do not interfere with the organisation's obligations to NHS patients.

3.2 Consultants who practise privately within NHS facilities must comply with the responsible NHS organisation's policies and procedures for private practice. The NHS organisation should consult with all consultants or their representatives, when adopting or reviewing such policies.

**Use of NHS Facilities**

3.3 NHS consultants may not use NHS facilities for the provision of private services without the agreement of their NHS employer. This applies whether private services are carried out in their own time, in annual or unpaid leave, or – subject to the criteria in paragraph 2.8 - alongside NHS duties.

3.4 Where the employer has agreed that a consultant may use NHS facilities for the provision of private services:

- the employer will determine and make such charges for the use of its services, accommodation or facilities as it considers reasonable;

- any charge will be collected by the employer, either from the patient or a relevant third party; and

- a charge will take full account of any diagnostic procedures used, the cost of any laboratory staff that have been involved and the cost of any NHS equipment that might have been used.

3.5 Except in emergencies, consultants should not initiate private patient services that involve the use of NHS staff or facilities unless an undertaking to pay for those facilities has been obtained from (or on behalf of) the patient, in accordance with the NHS body's procedures.

3.6 In line with the standards in Part II, private patient services should take place at times that do not impact on normal services for NHS patients. Private patients should normally be seen separately from scheduled NHS patients. Only in unforeseen and clinically justified circumstances should an NHS patient's treatment be cancelled as a consequence of, or to enable, the treatment of a private patient.

**Use of NHS Staff**

3.7 NHS consultants may not use NHS staff for the provision of private services without the agreement of their NHS employer.

3.8 The consultant responsible for admitting a private patient to NHS facilities must ensure, in accordance with local procedures, that the responsible manager and any other staff assisting in providing services are aware of the patient's private status.

## 18. APPENDIX 3 - PRIVATE / NOT ORDINARILY RESIDENT IN UK NOTIFICATION AND UNDERTAKING TO PAY FORM

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

### PRIVATE / NOT ORDINARILY RESIDENT IN UK NOTIFICATION AND UNDERTAKING TO PAY FORM

**Private Patient:** Yes ☐ No ☐ **Non-Ordinarily Resident in UK:** Yes ☐ No ☐

| | | | |
|---|---|---|---|
| **Name of Patient:** | | | |
| **Address:** | | | |
| **Postcode:** | Telephone No: | | |
| **Date of Birth:** | | | |
| **H&C Number:** | | | |
| **Name of Insurer:** | | **Self Funding** | ☐ |
| **Insurer Policy No:** | | | |

I have been seeing this person as a private patient. They are to be admitted / referred to Hospital on _____ as an _____

| | | | | | |
|---|---|---|---|---|---|
| **Inpatient Referral** | ☐ | **Obstetrics** ☐ Estimated Duration of Stay | **Medical** ☐ Estimated Duration of Stay | **Surgical** ☐ Estimated Duration of Stay | **T & O** ☐ Estimated Duration of Stay |
| | | | | | |
| **Day Case Referral** | ☐ | | | | |
| **Diagnostics** (Inpatient or Outpatient) | ☐ | **Laboratory** ☐ [please detail] | **Radiology** [pleas ☐ detail] | **Other** [e.g. ☐ Pharmacy] | |
| | | | | | |

| | | | |
|---|---|---|---|
| **Undertaking to Pay Confirmation** To be completed by Consultant | | | |
| **I have advised the patient named above of the estimated hospital charges and of my fees** | | | |
| **Signed Consultant** | | **Date** | |
| **Undertaking to Pay** To be completed by the person who will pay the account | | | |
| **I understand and agreed to pay Southern Health and Social Care Trust all charges[1] associated with this episode of care[2] .Where the Consultant may deem further procedures/investigations necessary which will incur additional charges, I understand that this may result in a different cost from that quoted to me and I undertake to pay the full costs incurred.** | | | |
| **Signed Patient** | | **Date** | |

**RETURN TO PAYING PATIENTS OFFICE CRAIGAVON AREA HOSPIAL/DAISY HILL HOSPITAL** [redacted] Personal Information redacted by the USI

[1] A list of Tariffs is available from the Private Patients office

[2] Episode of Care – The total treatment of either an inpatient or day case patient from diagnosis through to discharge

Southern Health and Social Care Trust - A Guide to Paying Patients

## 19. APPENDIX 4 APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

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

### APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

| | |
|---|---|
| **Name of Patient:** | |
| **Address:** | |
| **Postcode:** | |
| **Date of Birth:** | |
| **H&C Number:** | |
| **Name of Consultant** | |
| **Date of Last Private Consultation** | |

I have been seeing this person as a private patient. He/she has now been referred to Hospital as an NHS patient.

| | | **Clinical Priority** |
|---|---|---|
| Inpatient Referral | ☐ | |
| Outpatient Referral | ☐ | |
| Day Case Referral | ☐ | |

| | |
|---|---|
| **Signed Consultant** | |
| **Effective Date** | |

Consultants are reminded that in good practice a patient who changes from private to NHS status should receive all subsequent treatment during that episode of care under the NHS as outlined in A Code of Conduct for Private Practice.

**PLEASE FORWARD TO PAYING PATIENTS OFFICE** [redacted] Personal Information redacted by the USI

## 20. APPENDIX 5 PRINCIPLES GOVERNING RECEIPT OF ADDITIONAL FEES – SCHEDULE 11

### Principles Governing Receipt of Additional Fees - Schedule 11

1. In the case of the following services, the consultant will not be paid an additional fee, or - if paid a fee - the consultant must remit the fee to the employing organisation:

- any work in relation to the consultant's Contractual and Consequential Services;
- duties which are included in the consultant's Job Plan, including any additional Programmed Activities which have been agreed with the employing organisation;
- fee paying work for other organisations carried out during the consultant's Programmed Activities, unless the work involves minimal disruption and the employing organisation agrees that the work can be done in HPSS time without the employer collecting the fee;
- domiciliary consultations carried out during the consultant's Programmed Activities;
- lectures and teaching delivered during the course of the consultant's clinical duties;
- delivering lectures and teaching that are not part of the consultant's clinical duties, but are undertaken during the consultant's Programmed Activities.
- Consultants may wish to take annual leave [having given the required 6 week notice period] to undertake fee paying work [e.g. court attendance] in this instance the consultant would not be required to remit fees to the Trust.

This list is not exhaustive and as a general principle, work undertaken during Programmed Activities will not attract additional fees.

2. Services for which the consultant can retain any fee that is paid:

- Fee Paying Services carried out in the consultant's own time, or during annual or unpaid leave;
- Fee Paying Services carried out during the consultant's Programmed Activities that involve minimal disruption to HPSS work and which the employing organisation agrees can be done in HPSS time without the employer collecting the fee;
- Domiciliary consultations undertaken in the consultant's own time, though it is expected that such consultations will normally be scheduled as part of Programmed Activities1;
- Private Professional Services undertaken in the employing organisation's facilities and with the employing organisation's agreement during the consultant's own time or during annual or unpaid leave;
- Private Professional Services undertaken in other facilities during the consultant's own time, or during annual or unpaid leave;
- Lectures and teaching that are not part of the consultant's clinical duties and are undertaken in the consultant's own time or during annual or unpaid leave;

- Preparation of lectures or teaching undertaken during the consultant's own time irrespective of when the lecture or teaching is delivered.

This list is not exhaustive but as a general principle the consultant is entitled to the fees for work done in his or her own time, or during annual or unpaid leave.

*And only for a visit to the patient's home at the request of a general practitioner and normally in his or her company to advise on the diagnosis or treatment of a patient who on medical grounds cannot attend hospital.*

## 21. APPENDIX 6 - UNDERTAKING TO PAY CHARGES FOR AN AMENITY BED

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

### UNDERTAKING TO PAY CHARGES FOR AN AMENITY BED

| | |
|---|---|
| Name of Patient: | |
| Address: | |
| Postcode: | |
| Date of Birth: | |
| Hospital Number: | |

Site: Craigavon ☐ Daisy Hill ☐

I was allocated an amenity bed on (date): _____ (time)

Ward: _____ Consultant: _____

I undertake to pay the Southern Health Social Care Trust £39 per night for an amenity bed, which has been provided for me at my request.

Number of days Amenity Bed required: _____

I understand that if I am required to stay in hospital more days than anticipated, the midwifery staff will ask me if I wish to continue and pay for the amenity bed, or if I wish to be transferred to the open ward.

Patient's Signature: _____ Date: _____

Midwife's Signature: _____ Date: _____

To be completed by WARD CLERK OR MIDWIFE when patient is being transferred /discharged from an amenity bed.

Date transferred / discharged from amenity bed _____

Signed by midwife / ward clerk when transferred / discharged _____

## 22. APPENDIX 7 – AGREEMENT FOR THE VOLUNTARY ADVANCE RENUNCIATION OF EARNINGS FROM FEE PAYING ACTIVITIES

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

### AGREEMENT FOR THE VOLUNTARY ADVANCE RENUNCIATION OF EARNINGS FROM FEE PAYING ACTIVITIES

**I *(name)*** _____

**Request that any monies due to me from patients in relation to fees from**
*(description of activity)*

_____

_____

_____

_____

_____

_____

_____

**Shall be transferred to *(Charity title and reference)*** _____

**For its sole use in the advancement of its aims in accordance with the Trust Deed until directed otherwise by me in writing.**

**This request is to take effect from (date*):*** _____

**Signed, sealed and delivered by:** _____
***(Full name in BLOCK CAPITALS)***

**Date:** _____

**In the presence of:** _____

**Date:** _____

**Address::** _____

_____

_____

_____ **Postcode:** _____

_____

## 23. APPENDIX 8 - PROVISIONS GOVERNING THE RELATIONSHIP BETWEEN HPSS WORK AND PRIVATE PRACTICE - SCHEDULE 9

1. This Schedule should be read in conjunction with the 'Code of Conduct for Private Practice', which sets out standards of best practice governing the relationship between HPSS work and private practice.

2. The consultant is responsible for ensuring that their provision of Private Professional Services for other organisations does not:

   - result in detriment to HPSS patients;
   - diminish the public resources that are available for the HPSS.

**Disclosure of information about Private Commitments**

3. The consultant will inform his or her clinical manager of any regular commitments in respect of Private Professional Services or Fee Paying Services. This information will include the planned location, timing and broad type of work involved.

4. The consultant will disclose this information at least annually as part of the Job Plan Review. The consultant will provide information in advance about any significant changes to this information.

**Scheduling of Work and Job Planning**

5. Where a conflict of interest arises or is liable to arise, HPSS commitments must take precedence over private work. Subject to paragraphs 10 and 11below, the consultant is responsible for ensuring that private commitments do not conflict with Programmed Activities.

6. Regular private commitments must be noted in the Job Plan.

7. Circumstances may also arise in which a consultant needs to provide emergency treatment for private patients during time when he or she is scheduled to be undertaking Programmed Activities. The consultant will make alternative arrangements to provide cover if emergency work of this kind regularly impacts on the delivery of Programmed Activities.

8. The consultant should ensure that there are arrangements in place, such that there can be no significant risk of private commitments disrupting HPSS commitments, e.g. by causing HPSS activities to begin late or to be cancelled. In particular where a consultant is providing private services that are likely to result in the occurrence of emergency work, he or she should ensure that there is sufficient time before the scheduled start of Programmed Activities for such emergency work to be carried out.

9. Where the employing authority has proposed a change to the scheduling of a consultant's HPSS work, it will allow the consultant a reasonable period in line with Schedule 6, paragraph 2 to rearrange any private commitments. The employing organisation will take into account any binding commitments that the consultant may have entered into (e.g. leases). Should a consultant wish to reschedule private commitments to a time that would conflict with Programmed Activities, he or she should raise the matter with the clinical manager at the earliest opportunity.

**Scheduling Private Commitments Whilst On-Call**

10. The consultant will comply with the provisions in Schedule 8, paragraph 5 of these Terms and Conditions. In addition, where a consultant is asked to provide emergency cover for a colleague at short notice and the consultant has previously arranged private commitments at the same time, the consultant should only agree to provide such emergency cover if those private commitments would not prevent him Or her returning to the relevant HPSS site at short notice to attend an emergency. If the consultant is unable to provide cover at short notice it will be the employing organisation's responsibility to make alternative arrangements and the consultant will suffer no detriment in terms of pay progression as a result.

**Use of HPSS Facilities and Staff**

11. Where a consultant wishes to provide Private Professional Services at an HPSS facility he or she must obtain the employing organisation's prior agreement, before using either HPSS facilities or staff.

12. The employing organisation has discretion to allow the use of its facilities and will make it clear which facilities a consultant is permitted to use for private purposes and to what extent.

13. Should a consultant, with the employing organisation's permission, undertake Private Professional Services in any of the employing organisation's facilities, the consultant should observe the relevant provisions in the 'Code of Conduct for Private Practice'.

14. Where a patient pays privately for a procedure that takes place in the employing organisation's facilities, such procedures should occur only where the patient has given a signed undertaking to pay any charges (or an undertaking has been given on the patient's behalf) in accordance with the employing organisation's procedures.

15. Private patients should normally be seen separately from scheduled HPSS patients. Only in unforeseen and clinically justified circumstances should a consultant cancel or delay an HPSS patient's treatment to make way for his or her private patient.

16. Where the employing organisation agrees that HPSS staff may assist a consultant in providing Private Professional Services, or provide private services on the consultant's behalf, it is the consultant's responsibility to ensure that these staff are aware that the patient has private status.

17. The consultant has an obligation to ensure, in accordance with the employing organisation's procedures, that any patient whom the consultant admits to the employing organisation's facilities is identified as private and that the responsible manager is aware of that patient's status.

18. The consultant will comply with the employing organisation's policies and procedures for private practice

**Patient Enquiries about Private Treatment**

19. Where, in the course of his or her duties, a consultant is approached by a patient and asked about the provision of Private Professional Services, the consultant may provide only such standard advice as has been agreed between the employing organisation and appropriate local consultant representatives for such circumstances.

20. The consultant will not during the course of his or her Programmed Activities make arrangements to provide Private Professional Services, nor ask any other member of staff to make such arrangements on his or her behalf, unless the patient is to be treated as a private patient of the employing organisation.

21. In the course of his/her Programmed Activities, a consultant should not initiate discussions about providing Private Professional Services for HPSS patients, nor should the consultant ask other staff to initiate such discussions on his or her behalf.

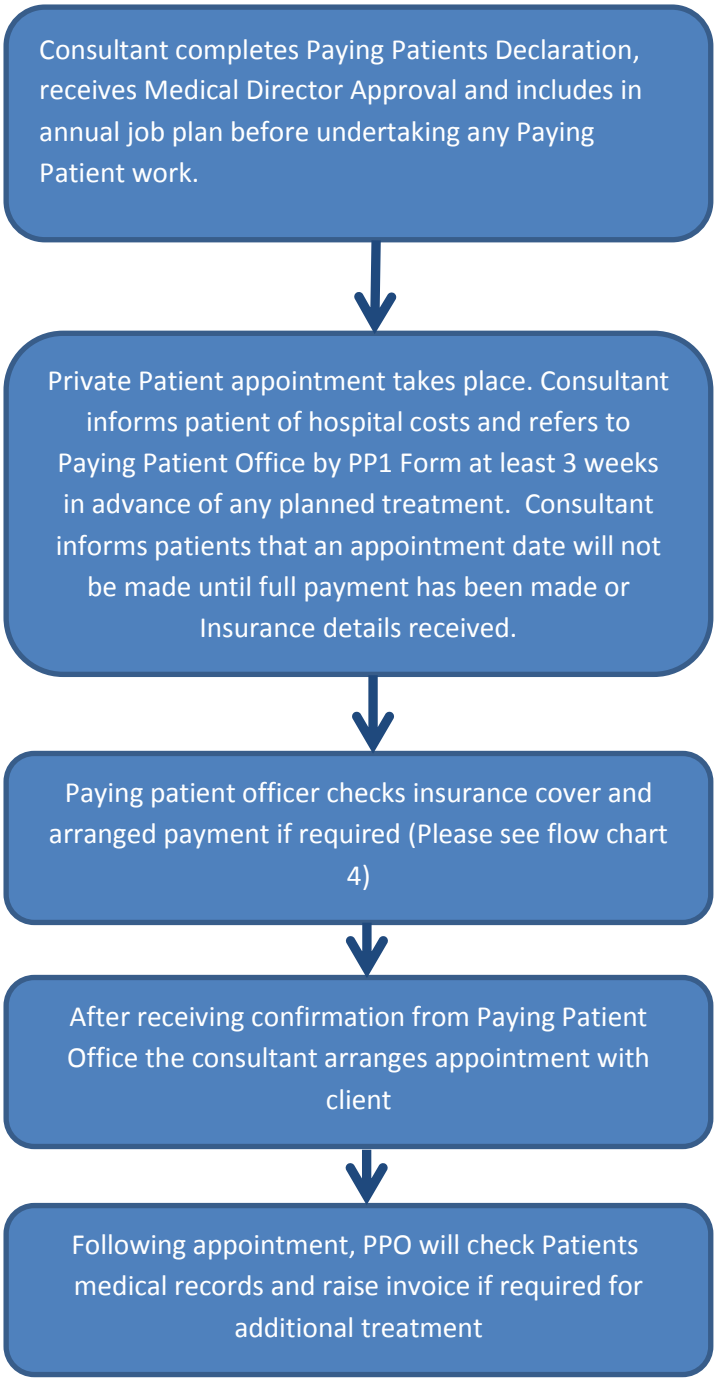
22. Where an HPSS patient seeks information about the availability of, or waiting times for, HPSS services and/or Private Professional Services, the consultant is responsible for ensuring that any information he or she provides, or arranges for other staff to provide on his or her behalf, is accurate and up-to-date.

**Promoting Improved Patient Access to HPSS Care**

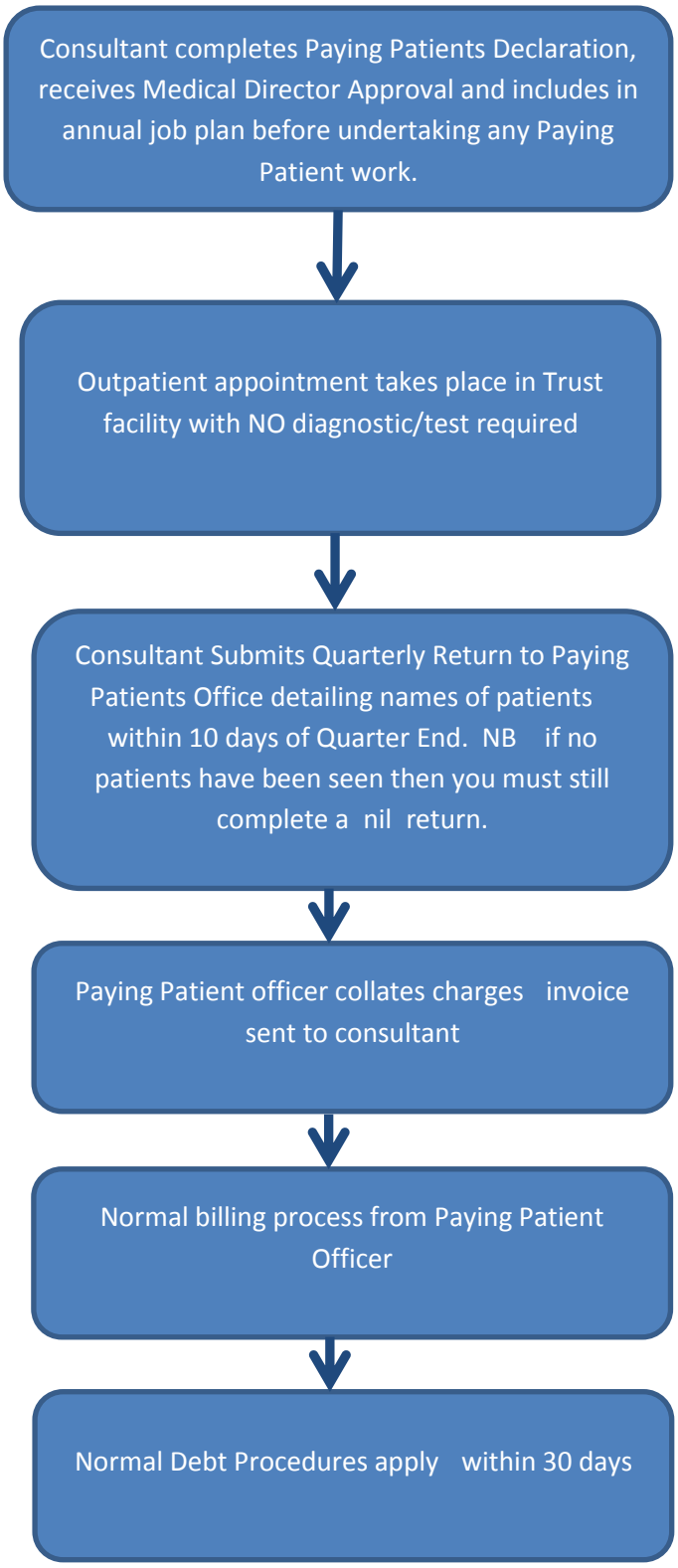
23. Subject to clinical considerations, the consultant is expected to contribute as fully as possible to reducing waiting times and improving access and choice for HPSS patients. This should include ensuring that, as far as is practicable, patients are given the opportunity to be treated by other HPSS colleagues or by other providers where this will reduce their waiting time and facilitate the transfer of such patients.

24. The consultant will make all reasonable efforts to support initiatives to increase HPSS capacity, including appointment of additional medical staff and changes to ways of working.

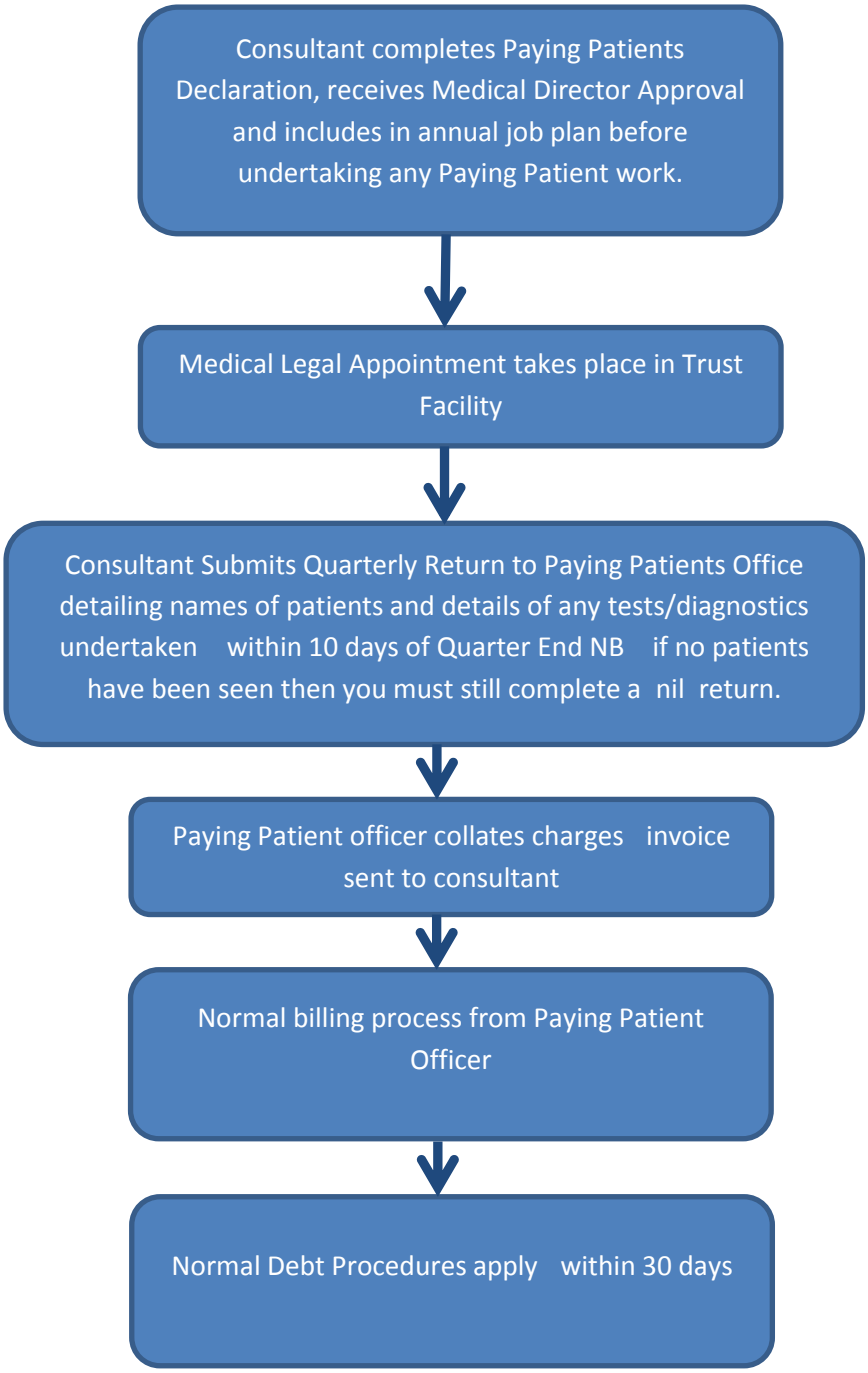
## 24. FLOW CHART 1 - PAYING PATIENTS [Inpatients]



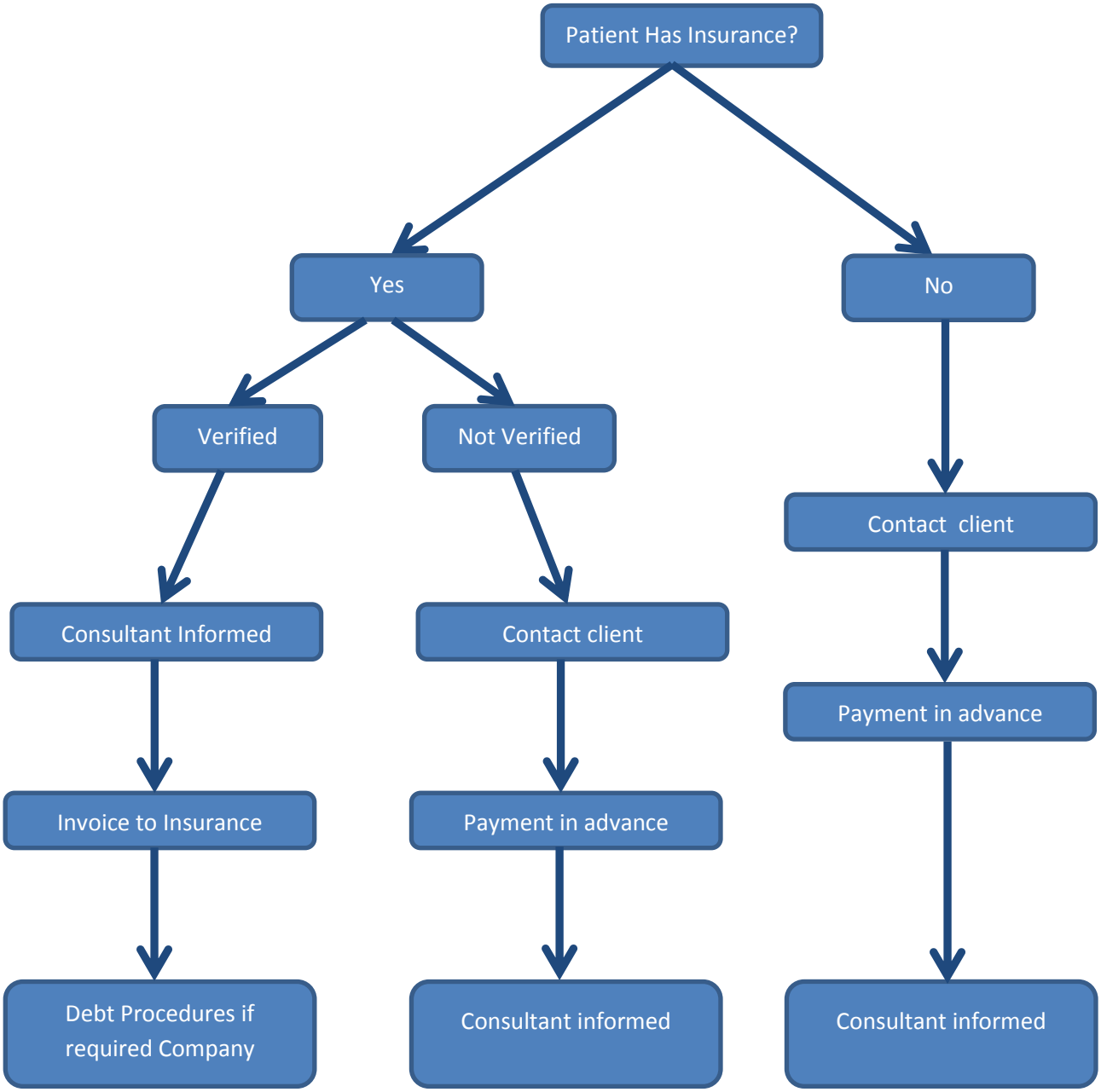
## 25. FLOW CHART 2 - PAYING PATIENTS [Outpatients]



## 26. FLOW CHART 3 - PAYING PATIENTS [Fee Paying Services]



## 27. FLOW CHART 4 – PATIENT INSURANCE



Health and Social Care Board

0023/18

# Query Request Form

**Requires Immediate Response:** Yes

**Reason for Immediate Response:** Required as an action following Internal Audit review of management of private patients

| | | | |
|---|---|---|---|
| ☐ | **Data Definition** | ☒ | **Recording Issue** |
| ☒ | **Technical Guidance** | ☐ | **Other** |

**Name:** Roberta Gibney **Date:** 8th August 2018

**Organisation:** BHSCT **Contact Number:** Personal Information redacted by the USI

**Subject Heading:** PAS OP Referral Source Code – Private to NHS

**a) Issue:** ***Please provide as much detail as possible in order for the query to be considered and resolved as quickly as possible. This query form will be published on SharePoint when resolved.***

Belfast Trust requests a Referral Source Code on PAS for outpatients who change status from Private to NHS. Currently there is no guidance for identifying such patients.

Patient who attends Trust as a private patient has category recorded as PPG. When treatment completed OP registration should be closed with Discharge Reason – Treatment Completed, however if during their treatment the patient decides to change status to NHS the OP registration should be closed with Discharge Reason – Transfer to NHS and a new OP registration opened:
PAS with referral source PTN (Private to NHS) (suggested code), mapped to Internal Value (2) and CMDS Value (11) on Referral Source Masterfile and category as NHS.

This will ensure that the original category of PPG is not overwritten to NHS and the information recorded as per the Draft Technical Guidance on Private and Overseas Patients is not lost.

Belfast Trust request that the above is adopted as regional PAS Technical Guidance.

**b) Response:**

When a patient transfers from Private to NHS during their treatment period the OP registration should be closed using:

Discharge Reason code: TNHS – Transfer from Private to NHS

A new OP registration should be opened using:

Referral Source code: PTN – Private to NHS

**Approved by:** Acute Hospital Information Group

**Date:** 11/09/2018 **Response Published:** Yes / ~~No~~

***Email***: Personal Information redacted by the USI
***HSC Data Standards Helpdesk***: ( Personal Information redacted by the USI

***These forms are available on the Information Standards & Data Quality SharePoint Site at*** *http://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Helpdesk.aspx*

## Action Plan Urology Personal Information redacted by

| Reference number | Recommendations | Designated responsible person | Action required | Date for completion / timescale | Date recommendation completed with evidence |
|---|---|---|---|---|---|
| | | | | | |
| 1 | HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory. | HSCB | See recommendation 5 | | |
| 2 | HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices | HSCB | | | |
| 3 | HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients. | HSCB | | | |
| 4 | GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields. | HSCB | | | |

| | | | | | |
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| 5 | **TRUST**<br>Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm. | AD surgical/ AMD Primary Care | The urology service hold the view that to enable the referral process to be efficient and effective, the CCG form requires to have mandatory fields which require it to be completed prior to referral from Primary Care. | | NiCan pathway.<br>  <br>Bladder Cancer Pathway March 2020<br>  <br>Revised Prostate Diagnostic Pathway D<br>  <br>Female Lower Urinary Tract Sympto<br>  <br>Female Urinary Tract Infection.docx<br>  <br>Male Lower Urinary Tract Symptoms.docx<br>  <br>male urinary tract infections.docx |
| 6 | The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW. | AD Surgery/ AMD Surgery | Time needs to be made available in consultant job plans to undertake the task of triaging referral letters. Discussions are ongoing with MD and AD | Jan 2021 | |

| | | | | | |
|---|---|---|---|---|---|
| 7 | The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner. | AD surgery | Currently the IEAP protocol is followed<br><br>The current regional protocol is being updated. | Jan 2021 |  <br>Integrated Elective Access Protocol - Apr<br>  <br>Integrated Elective Access Protocol Draft<br>  <br>FW IEAP referral.msg<br>  <br>Booking Centre SOP manual.doc<br>  <br>TRIAGE PROCESS 2. lmca.docx |
| 8 | The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list. | AD Surgery | | Nov 2020 | |
| 9 | Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10. | AD surgery | Reports will be sent to AD and AMD/ CD | Nov 2020 | |
| 10 | The Trust must set in place a robust system within its medical management hierarchy for highlighting | MD | | | |

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| | and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence. | | | | |
| 11 | Consultant 1<br><br>needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner. | MD | | | |
| 12 | Consultant 1<br><br>needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6. | MD | | | |

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# Incident Oversight Group

**Monday 12th April 2021, 8:30am**

**Via Zoom**

**Action Notes**

| | Item | Actions |
|---|---|---|
| 1 | Attendees:<br>Stephen Wallace, Martina Corrigan, Melanie McClements, Damian Gormley, Patricia Kingsnorth, Siobhan Hynds, Mark Haynes, Maria O'Kane, Fiona Davidson, Ruth Montgomery | Apologies:<br>Ronan Carroll, Jane McKimm |
| 2 | Minutes | Previous minutes were reviewed and agreed |
| 3 | Urology Oversight Moving Forward | Stephen updated the group on the document – Regional Guidance for Implementing a Lookback Review Process – Final Draft and has included a summary document that had been discussed the previous Thursday. Melanie agreed, along with Dr O'Kane, to speak with Shane to bring him up to speed. Melanie requested that the oversight group all email their comments on progress so far to ensure that all members are involved.<br><br>**Actions** – with regards to Guidance Document Melanie requested that everyone review it and to email their comments to Stephen<br><br>AGENDA 08.04.2021.docx<br>ITEM 3 - Existing Urology Oversight St |
| | **Management of Patient Reviews** | |
| 4 | Private Practice<br>- Private Practice Audit<br>- Letter to Private Patients from SHSCT<br>- Letter to GP Practices from SHSCT | Letter to GPs reminding them to flag up any private patients who may need referred. The phone line on the GP letter comes through to Martina and the 0800 number is the patient advice line.<br>A patient letter has been drawn up and passed to AOB's solicitor and a request made to circulate to his private patients – This request was submitted over a week ago and a deadline for response is this Thursday.<br><br>LtrtoGPPracticesUrology 02.04.2021.pdf<br>Patient Letter.pdf |
| 5 | IPT for Review Process | There as a brief discussion around the recruitment for the Inquiry and included the 8B post previously circulated. |

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| | | It was reiterated that as there was no funding for the Inquiry that this couldn't limit getting posts in place to address the Inquiry issues. So costs would need to be highlighted specifically in respect of the Inquiry.<br>Martina will speak to finance to request a cost centre to be set up for the inquiry to keep all costs together.<br>It was noted that Belfast Trust had spent 8million within 18 months; our IPT has been come in at 2.5million per year so it was agreed that this is potentially underestimated.<br><br>Urology Inquiry IPT - draft 8 15.12.2020.d Band 8B_Service Manager for Public In |
| 6 | Additional Subject Matter Expertise<br>- British Association of Urological Surgeons<br>- British Association of Urological Nurses | Stephen to speak to Royal College today to see if we can get someone remotely to support us. |
| 7 | Royal College of Surgeons Engagement<br>- Selection of Records<br>- Costing | RCS are now in a position to commence this work and Martina has started to get the charts pulled and are in the AMD office; Stephen advised that we have now got a Medical Technician to start on this work. Stephen will brief Fiona following meeting and Martina and Stephen will meet with the Medical Technician to advise them on what needs to be done with the notes.<br>A DAC has been created for the funding and is awaiting approval by Shane<br>**Action** – Stephen to brief Fiona<br>Stephen and Martina to meet with Technicians |
| 8 | Bicalutamide Patient Review | No new updates |
| 9 | Engagement of ISP to undertake waiting list work | ISP Waiting list work<br>Dr O'Kane advised that for the Neurology Inquiry that Belfast had used 352 to get the patients seen and we may need to look into using 352, Kingsbridge etc for patients affected by the Inquiry.<br>Mark advised that for all of Mr O'Brien's patients, that whoever does the review they will need to complete a patient review form, and suggested that training needs to be provided to those completing these forms – Dr O'Kane agreed with this. Independent sector would need to have the same approach for consistency.<br><br>Mark also noted that there's now another group of patients who may need to be reviewed - TURP patients who are on the waiting list will all need to be reassessed. Patients who have already had this surgery as well as those who have been referred and awaiting the procedure and others who may need further assessment. There is a basic assessment which should show evidence of obstruction before referring for this procedure. |

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| | | Mark stated his preference would be independent sector staff who are undertaking the work are employees of the Trust to retain control of the quality of the reviews.<br><br>**Actions** – Capacity with independent sector through Lesley – Martina to investigate. |
| 10 | Telephone Support Service / Patient Triage Update | No new updates on telephone support services.<br>It was agreed that Job planning within Urology needs to be up to date and that this should include Patient triage. |
| 12 | MDM Processes<br>- Audit Document | Stephen discussed a document from the National Cancer action team – the document talks about leadership management and he has developed an audit checklist. It was suggested that peer reviews could be done by the Chair of the MDM to develop an action plan.<br><br>Damian Gormley noted that it looks very comprehensive and a standard that we should be aspiring to.<br><br>It was agreed by the Group that this should be tested on Urology as a starting point.<br><br>**Action** – Martina and Mark to discuss with view to applying it.<br>  <br>Cancer MDM Baseline Audit.docx |
| **Professional Governance** | | |
| 13 | GMC Discussions | No new update |
| 14 | Litigation / DLS Update<br>- Training - Preparation for Legal / Court Engagements | Aisling Diamond has sourced general training for preparation for legal issues/public inquiry. The intention is to go through E&G funds and it was agreed that this is something that would be beneficial for all staff going forward.<br>Siobhan Hynds agreed that there is a need for this for staff to ensure they are prepped for what they will be facing.<br>A package needs to be developed and all aspects considered as staff are indicating concerns with not knowing what they will be facing.<br>**Action** – Siobhan to discuss with Stephen<br>  <br>Costs for Evidence and Expert Witness T |
| 15 | Grievance Process | Siobhan shared the Draft for the TOR for the Grievance Process and has asked for the Group to review and comments back to her so that she can share with the Review Panel.<br>**Action** – All comments to be back with Siobhan today |

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| 16 | Administration Review Update | There is still the issue regarding the escalation of admin concerns and that there is a need for a new process.<br>**Action** -Melanie to discuss with Anita on how to progress this.<br><br>Siobhan noted that a further letter has been sent to Mr O'Brien to return documentation due to data protection and a potential data breech, as he has yet to respond. Siobhan advised that Zoe Parks is corresponding directly with Mr O'Brien's solicitor.<br><br>Admin Review Process V12 26 March |
| | **Serious Adverse Incident (SAI) Reviews** | |
| 17 | Update on Current SAI Progress<br>- Finalisation of SAIs<br>- Screening | Patricia updated that six families have come back with comments, 3 of which wanted a meeting.<br><br>Every family has mentioned that the letter from Mr O'Brien's solicitor was distressing and advised that they felt that there was no requirement for it to be included.<br>Patricia advised that 1 patient has since died; and he was one of the patients with a delayed prostate cancer diagnosis. Patricia said she will send a sympathy card to the family. 1 family had went straight to litigation and 1 patient has expressed that he wants no further contact so Patricia advised that he has been sent the reports and we are aware that there will be no further contact from him. Patricia advised that there was a review meeting with the SAI panel later that morning to discuss comments that had been received to date.<br>Melanie updated that DOH have asked the Trust to contact the families to advise on the process. 3 families are yet to be contacted. Fiona Sloan, patient liaison officer is going to meet with the families.<br>Patricia updated on the meeting that she had attended with the Board and PCC to determine what involvement the PCC could have and following discussion, the PCC don't think they have anything to offer for the 9 patients as they believe they are being well looked after but want to know what they can do to help the other families going forward. They suggested that there are perhaps charities that may be in a position to support patients.<br>The PCC had asked for a copy of the UAG notes but the group agreed that UAG meeting notes can be summarized for the PCC rather than sharing the complete minutes. It was noted that as of this date that there had been no feedback from Mr O'Brien or his solicitor, and as the deadline had been 31 March 2021, |

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| | | it was agreed to proceed with drafts of the SAI's.<br>**Action** - Patricia to type up notes from the PCC meeting last week to send to Melanie.<br><br>Screening of Structured Clinical Record Review:<br>Mark updated on the extra MDM set up to discuss patients that had been highlighted as having concerns. Mark advised that they had planned discussions on 14 patients (2 deferred to 22 April), and out of the 12 cases discussed the panel determined that there were 11 patients who will need Structured clinical record reviews, due to either being referred for radical treatment or not being referred at all. These patients will need to be seen in the first instance for face to face review and Martina has organised for Mark to see them on his Wednesday clinics over the next few weeks. The patients will be reviewed first and then notified if there is a need for their clinical care to be reviewed.<br>Patients will all get a standard consultation letter from Mark Haynes which should then include a letter to introduce the families to support staff (service user liaison).<br>**Action** – Patricia to draft up letter to provide to Mark |
| 18 | SAI Recommendations | Action plan has previous SAI recommendations on it; the majority have now been closed off, Patricia Kingsnorth to update the action plan to forward to the Board for comment.<br>**Action** – Final parts need to be completed and closed off by next Monday.<br>Action plan Personal .docx |
| 19 | Structured Clinical Record Review Process | As above |
| 20 | Family Liaison Role | No updates |
| **Communications** | | |
| 21 | Media / Assembly Questions | No updates |
| **Any Other Business** | | |
| No other business to be discussed. | | |
| **Date of Next Meeting** | | |
| | Via Zoom – 19th April 2021 | 8.30am |

# Urology Assurance Workstreams

**Thursday 8th April 2021, 1:00pm**

**Via Zoom**

## AGENDA

| | | |
|---|---|---|
| 1 | **Apologies** | |
| | | |
| 2 | **Purpose of Meeting**<br>• To stocktake current urology incidents governance structures<br>• To review scope of work ahead<br>- Lookback / Review Processes<br>- Public Inquiry Support<br>- SAI Quality Improvement Work<br>- Professional Governance / Supporting Activities<br>• Decision on management and reporting structures going forward | |
| 3 | **Current Urology Governance Structure** | Existing Urology Oversight Structure.c |
| 4 | **Patient Scoping Exercise to Date** | Patients Records 07.04.2021.pptx |
| 5 | **Draft Regional Lookback Policy and Guidance** | Regional Guidance for Implementing a Lc<br>Policy for Implementing a Lookb |
| 6 | **Draft Terms of Reference – Urology Operational Lookback Group** | Urology Lookback Operational Group.dc |
| 7 | **Draft Terms of Reference – Urology Oversight Group** | Urology Lookback Oversight Group.doc |
| 8 | **Role Descriptions for Individual Group Members** | Urology Assurance Role Description CX.d |
| 9 | **Public Inquiry Lead** | Band 8B_Service Manager for Public In |
| 10 | **Decision on Governance Arrangements Moving Forward** | |

# Regional Guidance for Implementing a Lookback Review Process

# Final Draft

## Contents

# Regional Guidance for the Implementing of a Lookback Review Process

## 1.0 Introduction

A Lookback Review Process is implemented as a matter of urgency where a number of people have been exposed/potentially exposed to a specific hazard in order to identify if any of those exposed have been harmed, and to identify the necessary steps to ameliorate the harm (e.g. repeat diagnostic test/ investigation/ referral to relevant clinical service etc.).[1]

This Regional Guidance, along with the accompanying policy document, has been drafted in order to standardise and update the approach taken to Lookback Reviews by the HSC in Northern Ireland. It replaces HSS (SQSD) 18/2007, issued by the Office of the Chief Medical Officer on 8 March 2007.

A Lookback Review is a process consisting of four stages; immediate action including a preliminary investigation and risk assessment to establish the extent, nature and complexity of the issue(s); the identification of the service user cohort through a service review or audit of records to identify those potentially affected; the recall of affected service users; and finally closing and evaluating the Lookback Review Process and the provision of a report including any recommendations for improvement (see summary diagram of Lookback Review Process (Diagram 1) and Lookback Review Process Checklist Appendix 5).

The triggering event or circumstances under which a Lookback Review would be considered include; faulty or contaminated equipment, missed/delayed/incorrect diagnosis relating to diagnostic services, failure of safety critical services or processes, competence issues with a practitioner(s) or identification of a practitioner with a transmissible infection or underlying health problem that may impact on performance (see also Policy on the Implementation of a Lookback Review Policy Section 1 for a more comprehensive list).[2]

[1] Health Service Executive (HSE) 'Guideline for the implementation of a Look-back Review Process in the HSE'. HSC National Incident Management and Learning Team, 2015. Section 7.1 Page 10.
[2] See also 'Policy for the Implementation of a Lookback Review Process' Section 1 Page 3.

The existence of a hazard exposing a number of people to a risk of harm is not always immediately apparent. The triggering event may have been raised as a concern by a service users and/or their family/carers or it may have been highlighted by a service review/audit or it may have come to light as a result of a concern expressed by a colleague or through a Serious Adverse Incident (SAI) Review or Thematic Review undertaken by the Regulation and Quality Improvement Authority. The triggering event will alert the Health and Social Care (HSC) organisation that a number of people may have been exposed to a hazard and the need to instigate a Lookback Review Process should be immediately considered.

### 1.1 What does a Lookback Review Process involve?

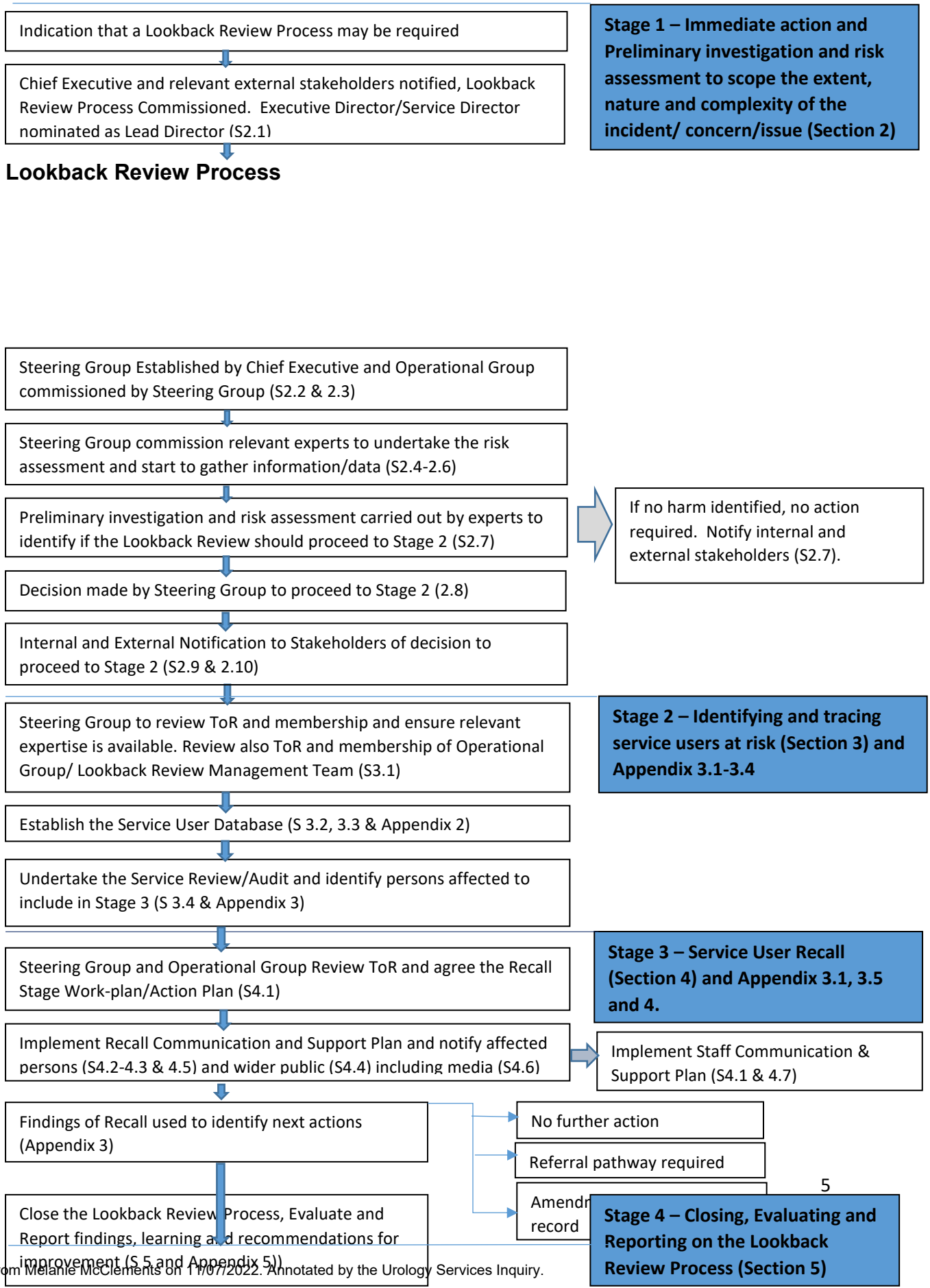
The Lookback Review Process involves:

- Identifying, tracing, communicating, and providing appropriate ongoing advice to, and/or management of, the group of service users who have been exposed or potentially exposed to a hazard and who may have been harmed, or are at risk of future harm or loss;
- Notification internally to Trust Board and to appropriate external stakeholders (see Sections 2.1, 2.9 and 2.10);
- Notification to the wider public as and when required. While openness and candour are guiding principles in a Lookback, it is essential that communication occurs at a time when clear messages can be conveyed whilst ensuring that the 'at risk' population has been identified and communicated with before the wider public is alerted. Relevant healthcare professionals including General Practitioners should also be identified and communicated with in advance of any public statements. This is essential to maintain public confidence and prevent unnecessary anxiety and to ensure that services can be focused on the correct group of people (See Section 4 below).

The following diagram (Diagram 1) provides a summary of each stage of the Lookback Review Process and may be used in conjunction with the Lookback Review Process Checklist (see Appendix 5). The Process, as laid out below is a step by step guide. It is important, however, that the primary focus should remain on harm and risk of harm to service users. Therefore, there will be occasions where it is

clear from the outset that a Lookback Review will be necessary and where the organisation effectively runs more than one of these stages consequently.

**Diagram 1 Flowchart - Summary of Stages in a Lookback Review Process**



### 1.3 Governance Arrangements

The HSC organisation should ensure that the Lookback Review Process is managed in line with extant Governance and Assurance Framework arrangements.[3] The Steering Group (Section 2.2) should be seen as a 'task and finish' group within the HSC organisation's Governance/Assurance Framework structure reporting to Trust Board through the Senior Management Team/ Executive Team of Trust Board. The Steering Group should commission an Operational Group or Lookback Review Management Team to take forward the operational aspects of the Review Process (unless the Lookback Review is anything other than limited in terms of nature, extent and complexity).

When scoping the nature, extent and complexity of the Lookback Review Process (Section 2.6 – 2.7) the Steering Group should evaluate and escalate the risk in line with the organisation's Risk Management Strategy. This will ensure that the risk(s) identified will be included in either the organisation's Board Assurance Framework, Corporate Risk Register or Directorate Risk Register and managed in line with the Risk Management Strategy.

The Lookback Review Process should be outlined in the mid-year Assurance and/or annual Governance Statement as required. The annual Governance Statement is the means by which the Accounting Officer provides a comprehensive explanation on the HSC organisations' approach to governance, risk management and internal control arrangements and how they operate in practice.[4] The Statement provides a medium for the Accounting Officer to highlight significant control issues which have been identified during the reporting period and those previously reported control issues which are continuing within the organisation.

### 1.4 Other Related Incident Management Processes including Investigations

As stated previously, Lookback Reviews are carried out in order to identify if any of those exposed to a hazard have been harmed, and to identify the necessary steps to take care of those harmed. The incident giving rise to the Lookback Review Process or issues identified as a result of the process may require review as a Serious

[3] DoH '*An Assurance Framework: a Practical Guide for Boards of DoH Arm's Length Bodies*.' April 2009.
[4] Department of Finance ' *Managing Public Money NI (MPMNI)*' AS.1

Adverse incident (SAI).[5] This will require a parallel (though interlinked) review which should be undertaken in line with Health and Social Care Board guidance [6] to identify key causal and contributory factors relating to the triggering event (see Sections 2.10 and Section 5). In some circumstances, a Lookback Review Process may have been prompted by a preceding SAI review.

The circumstances leading to a decision to implement a Lookback Review may require the HSC organisation to notify other statutory agencies such as the Coroners Service for Northern Ireland and/or the Police Service for Northern Ireland (PSNI). The reporting of the Lookback Review as an SAI to the Health and Social Care Board (HSCB) will work in conjunction with, and in some circumstances inform, the reporting requirements of other statutory agencies and external bodies. In that regard, all existing local or national reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this Regional Guidance.

A Memorandum of Understanding (MoU) has been agreed between the Department of Health (DoH, on behalf of the Health and Social Care Service (HSCS), the Police Service of Northern Ireland (PSNI), the Northern Ireland Courts and Tribunals Service (Coroners Service for NI) and the Health and Safety Executive for Northern Ireland (HSENI).[7] The MoU applies to people receiving care and treatment from HSC in Northern Ireland. The principles and practices promoted in the MoU apply to other locations, where health and social care is provided e.g. it could be applied when considering an incident in a family doctor or dental practice, or for a person receiving private health or social care provided by the HSCS.

A Lookback Review Process may raise issues of professional competence/conduct. HSC organisations will then be required to instigate performance management, capability and disciplinary reviews or investigations in line with their internal Human Resource policies, procedures and relevant professional regulatory guidance for

[5] Health and Social Services Board (HSCB) 'Procedure for the Reporting and Follow-up of Serious Adverse Incidents'. November 2016 Version 1.1.
[6] *Ibid.*
[7] DoH *'A Memorandum of Understanding' developed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations/reviews are required into a serious incident'.* HSS (MD) 06/2006, February 2006.

example Maintaining High Professional Standards (MHPS).[8] These processes should run as a parallel process to the Lookback Review, although relevant information from one process may inform the other. In such circumstances, confidentiality in respect of the member of staff must be taken into consideration.

[8] DoH 'Maintaining High Professional Standards in the Modern HPSS'. HSS (TC8) 6/2005. November 2005.

## 2.0 Stage 1 – Immediate Action, Preliminary Investigation and Risk Assessment

Immediate action should be taken to ensure the safety and wellbeing of the service users.

### 2.1 Notification of the need to consider a Lookback Review Process

The Director of the service involved should be notified immediately that a hazard or potential hazard has been identified which may require the organisation to consider implementing a Lookback Review Process. The Director will report the issue(s) internally through the Chief Executive to the Board of Directors in line with the organisation's risk escalation processes. The relevant Director will also need to consider if the hazard might affect other HSC Organisations or private/ independent providers.

It is recognised that at this early stage there may be limited information available to the HSC organisation until information and intelligence is gathered and the risk assessment is undertaken (see Sections 2.6 and 2.7), however, in line with extant guidance, the Director should notify the DoH of the emerging issues by way of an Early Alert (see also Section 2.9).[9] The Early Alert should make clear, if the information is available, the details of other organisations/services potentially involved in NI or in other jurisdictions, the timeframe during which the issue may have been relevant and the potential volumes of services users who may be affected. The Director should also consider if the findings, given the potentially limited information could be considered as an SAI at this time (see Section 2.10). [10] If in doubt, the extant SAI guidance provides the opportunity for the organisation to declare the matter as an SAI, which can then be 'de-escalated' later.[11] The HSC Organisation will also have to consider possible notification of the event(s) to the Coroners Service for NI and/or the PSNI (see Section 1.4).

It is also important to advise the organisation's Head of Communications/Communications Manager at an early stage so that a communication plan including media responses can be prepared in advance.

[9]Department of Health 'Early Alert System' HSC (SQSD) 5/19.
[10] HSCB 'Procedure for the Reporting and Follow up of Serious Adverse Incidents. November 2016.
[11] *Ibid.,* Section 7.6 Page 21

### 2.2 Establish Steering Group

A Steering Group should be convened as soon as possible after the disclosure of the issue of concern to develop an action plan and oversee its implementation. Depending on the extent, nature and complexity of the triggering event the Steering Group should be chaired by either the relevant Service Director or in some circumstances it may be chaired by the relevant Executive Director/Professional Lead.

If other investigation processes are in place (e.g. Capability/Performance Management Reviews) these should run as parallel processes, however, information from the other investigative processes, taking into account confidentiality and the information governance requirements that will apply to these parallel processes, may be used to inform the decision making of the Steering Group.

The Steering Group will need to meet on a regular basis to ensure that they receive feedback/ situation reports (SITREPS) from the Operational Group/Lookback Review Management Team and provide a co-ordinated approach to the oversight of the Process. SITREPS should also be shared as required with internal stakeholders (Executive Team/Senior Management Team and Board of Directors) and external stakeholders i.e. HSCB, Public Health Agency (PHA) and DoH.

### 2.3 Composition of the Steering Group

The composition of the Steering Group will be dependent on the service involved and the nature and extent of the Lookback Review Process. The Steering Group should not normally involve personnel who may have been directly involved in the event/hazard that triggered the Lookback Review Process.

Depending again on the extent and nature of the Lookback Review the HSC organisation should consider the following as core members; a Non-Executive Director, the Director of service/speciality concerned, relevant professional Executive Director(s), Risk and Governance representative, Head of Communications, Information Technology manager, Medical Records manager and senior service representatives with expertise (including clinical and/or social care) in the services/ processes which are the subject of the Review Process, a PHA representative and an HSCB representative (in the case where the Lookback Review has been

identified as an SAI, the role on the Steering Group will be clearly identified to ensure that the independence of the PHA/HSCB is not jeopardised).

The organisation may also wish to consider a member of a relevant service user representative/advocacy group is included as a member of the Steering Group.[12] In these instances, a confidentiality agreement must be signed by the service user representative. The representative should not have access to service user identifiable data. Such an agreement should be proportionate and reflect the need of the organisation to protect the information of individuals and to ensure that information disseminated is accurate, proportionate and timely and that support mechanisms are in place for service users and staff.

The Steering Group should also commission an Operational Group or Lookback Review Management team which should report to and support the Steering Group in taking forward the operational aspects of the action plan e.g. establishing the service user database (Section 3.2) and supporting the Recall Stage (Section 4).

### 2.4 Role of the Steering Group

Within 24-48 hours from being established the Steering Group should decide on the immediate response which includes;

- Methodology to determine the size/magnitude, complexity and nature of the risk/harm to service users/carers in order to plan an appropriate Lookback Review Process e.g. risk assessment (see Section 2.7 below);
- Determine if the Lookback Review Process is limited to one HSC organisation or if the process will involve a number of HSC organisations as well as the independent sector and organisations in other jurisdictions;
- Determine the extent of notifications to the DoH, HSCB and PHA that is required, if these notifications have not already been initiated (see Section 2.1 above and Sections 2.9 and 2.10);
- Address and manage notification internally through the Senior Management Team/Executive Team to the Board of Directors;

[12] The Patient and Client Council (PCC) is responsible for delivering and/or providing access to advocacy and support services as specified by the DoH and HSCB guidance in supporting families through a 'hub and spoke' model of service delivery working with providers of advocacy services. Other independent services may be accessed as required through the PCC, including the development of a network of available advisory services.

- Agree on the formation of an expert advisory sub group comprising experts in the area of concern, relevant clinicians, and department or directorate heads to undertake the risk assessment and service review or audit . Consideration should be given as to whether or not that expertise should come from outside the organisation;
- Agree on a service user communications plan. Communication with the service user/family is a priority and the organisation should be proactive in managing the manner and timing in which affected service users receive relevant information (see Section 4.2).
- Agree on a communication plan/liaison plan for other HSC organisations or independent/private providers which might be affected.
- Agree on a media/communications management plan if required, that aims to be proactive in disclosure to the general public and considers responses to media enquiries (see Section 4.6).[13]

### 2.5 Steering Group Terms of Reference and Action Planning

The Steering Group should develop and approve Terms of Reference and establish a Lookback Review Action Plan for Stage 1 of the Process. Both the Terms of Reference and action plan should be reviewed and revised as and when the Process proceeds to the next stages.

The action plan should include as a minimum; the management of immediate safety issues, identify those who may have been exposed to harm, care for those who may have been harmed/affected, actions to prevent further occurrences of harm, a communication plan, contingency planning for business continuity of the service and plans for potential service user follow-up.

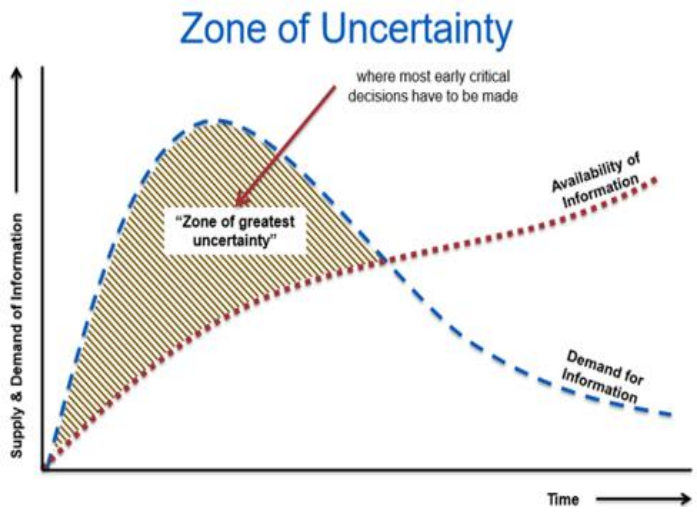
### 2.6 Gathering Information and Intelligence to Scope the Extent, Complexity and Nature of Harm

[13] New South Wales 'Lookback Policy Directive', Clinical Excellence Commission Safety & Quality, System Performance & Service Delivery, September 2007. Section 4 Page 5.

Key decisions have to be made at this early stage of the process when minimal information may be available to the Steering Group. Decision making should be based on a joint understanding of risk (see below) and shared situation awareness.[14] Situation awareness is having a common understanding of the circumstances, immediate consequences and implications of the triggering event along with an appreciation of the available capabilities and the priorities of the response.[15]

It is important that internal and external stakeholders are aware that the Steering Group may be required to make decisions during a time of uncertainty (or zone of uncertainty) about the level of risk or harm to service users (see Figure 1 below).[16] Depending on the extent, nature and complexity of the Lookback Review Process it can be difficult for the Steering Group to predict when it has gathered the optimum level of information to make decisions such as the decision to announce the Service User Recall stage.

**Figure 1 Zone of Uncertainty**




At the early stage, as above when limited information is available upon which the Steering Group will be required to make crucial decisions then a Decision Making Model, widely used amongst the emergency services as a tool, could be considered. Tools to aid decision making include for example the Joint Decision Making (JDM)

[14] Joint Emergency Services Interoperability Principles (JESIP) ' www.jesip.org.uk
[15] *Ibid*.
[16] *Ibid*

Model (Figure 2)[17] which helps bring together the available information, reconcile objectives and make effective decisions.

**Figure 2 Joint –Decision Making Model**


Further information and use of the JDM are available via the Joint Emergency Services Interoperability Principles (JESIP).[18]

All decisions should be recorded/logged, justified, seen to be reasonable and proportionate to the information available at the time. Therefore the Steering Group will require the services of an experienced minute-taker or 'loggist'[19] to ensure an accurate record of actions and decisions is maintained at each stage of the process.

## 2.7 Risk Assessment [20]

[17] Joint-Decision Making Model @ www.jesip.org.uk/joint-descision-model
[18] *Ibid*.
[19] A term used in Major Incident Planning a loggist is the person who is responsible for capturing, through decision logs, the decision making process that might be used in any legal proceedings following an incident ' www.epcresilience.com
[20] HSE. *Op.Cit* Section 7.6 Preliminary Risk Assessment Page 115-16.

As indicated above, the first stage in the process is to undertake a risk assessment to determine whether the scope, size/magnitude, complexity and nature of harm arising from the triggering event should progress to the next stage(s) i.e. a service user lookback and potential service user recall. In order to do this, the Steering Group should commission relevant experts to undertake this risk assessment. As above (Section 2.3), the relevant experts may include but are not exclusive to: people with the clinical or social care expertise in the services/ processes which are the subject of the Lookback Review Process, Risk and Governance Managers, and a Public Health Specialist. This will be determined by the Steering Group on a case by case basis.

A decision to undertake the completed Lookback Review Process has significant implications for service users, providers and resources. The risk assessment, therefore, should provide a thorough assessment of the chance of harm and the seriousness of that potential harm. It must be conducted in a manner that balances the need to identify and address all cases where there might be safety concerns on the one hand, with the need not to cause any unnecessary concern to service users or to the public on the other.[21]

The risk assessment should look at:

- If the Lookback Review Process is limited to one HSC organisation or if the process will involve a number of HSC organisations including the independent sector;
- The potential extent of the issue and the level of exposure to the hazard;
- Evidence of harm that has occurred;
- The likelihood of future harm occurring;
- The potential and actual (if relevant) outcomes of the issue e.g. missed diagnosis/ missed return appointments for follow up etc;
- The potential impact of the issue;
- The potential cohort of service users affected (including service users of other HSC and non-HSC Organisations);
- The potential impact on other service users (not in the 'at risk' cohort) e.g. potential delays in treatment and diagnosis;

[21] *Ibid*. Appendix 1

- The manner in which harm would be ameliorated (e.g. repeat investigation/ onward referral for treatment).

The HSC Regional Risk Matrix and Impact Table may be used as guidance to evaluate the risk.[22] A template for undertaking a preliminary risk assessment is included in Appendix 1 of this Guidance.[23]

The Steering Group will use the information obtained from this assessment to decide if the Process should continue to the Service User Lookback and Recall stages (see Section 2.8). If there is no harm or risk to service users, the Lookback Review Process can be closed. The Steering Group will inform the relevant internal and external stakeholders. It is advised that the Early Alert is updated to indicate that the process has been closed, outlining clear reasons for the decision. The HSC organisation should consider the incident as a 'near miss' and undertake a systems analysis to establish contributory factors, learning and recommendations.

### 2.8 Decision to proceed to Stage 2 Service User Lookback and Stage 3 Service User Recall

The decision to proceed to the Service User Lookback and Recall stages is a difficult and complex one and should not be taken lightly. As above, the decision should only be considered in circumstances where it is indicated following careful risk assessment, which may necessitate external peer review and advice from senior decision-makers and/or others with knowledge and experience in the specialty in which the Process is being considered and with advice from those who have experience in conducting a Lookback Review Process (see Section 2.7 Risk Assessment).[24] The decision should also include consideration of the impact on other service users (i.e. not the 'at risk' cohort) for potential delays in diagnosis and treatment.

Lookback Reviews by their nature are often high-volume, involve high-complexity and high-cost (including opportunity cost which diverts time and resources from ongoing care.) As described above, they involve a number of stages and logistical challenges.

[22] HSCB. *Op.cit*. Appendix 16.
[23] HSE. *Op.cit*. Preliminary Risk Assessment Stage pages 15 to 16 and Appendix 1.
[24] *Loc.cit*.

If a decision is taken to proceed to the Service User Lookback and Recall stages then the Chair of the Steering Group must inform the Chief Executive and Board of Directors and notify the relevant external bodies. The Early Alert should be updated (Section 2.9). If the Process has not already been reported as an SAI then the Steering Group should review the SAI criteria and take appropriate action (see Section 2.10).

The Steering Group should continue to consider any safety concerns that may arise at any stage of the Review Process which may need prompt action. Concerns may include the following:

- Taking preventative action such as the removal of the hazard [25];
- Consideration of the benefits and risks of suspending or transferring the service under review;
- Management of staff member(s)/service whose caseload is under review in line with Professional/Regulatory Guidance/HR/Occupational Health policy and procedure;
- Clinical and social care management of service users/ staff identified by the preliminary review and suspected of being adversely affected;
- Providing support to service users and staff involved.

The Steering Group should ensure that business continuity plans are considered and implemented, where necessary, including providing for additional health and social care demands which may arise as a consequence of the Lookback Review. The HSC organisation is responsible for securing service capacity and for ensuring that the necessary resources are allocated to conduct all the stages of the Review Process and subsequent follow-up processes. If the resources required exceed what is available then this should be escalated to the organisation's Board and if necessary to the Health and Social Care Board.

The Steering Group should be prepared for the fact that when a full Lookback Review Process is being considered this information can often become publicly known at the planning stage and should have a contingency plan in place for notification of affected persons and the wider public if this should occur.

[25] If the hazard is associated with a medical device then the HSC organisation should report this in line with Norther Ireland Adverse Incident Centre (NIAIC) adverse incident reporting – guidance and forms. October 2018 ' www.health-ni.gov.uk.

## 2.9 Early Alert Notification [26]

The established communications protocol between the Department and HSC organisations emphasises the principles of 'no surprises', and an integrated approach to communications. Accordingly, HSC organisations should notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services. Events should meet one or more of the following criteria;

1. *Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;*
2. *The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;*
3. *The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;*
4. *The event may attract media attention;*
5. *The Police Service of Northern Ireland (PSNI) is involved in the investigation of a death or serious harm that has occurred in the HSC Service, where there are*

   *concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does <u>not</u> include any deaths routinely referred to the Coroner, <u>unless</u>:*

   *i. there has been an event which has caused harm to a patient or client and which has given rise to the Coroner's investigation; or*

   *ii. evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or*

   *iii. the Coroner's inquest is likely to attract media interest.*

[26] Department of Health 'Early Alert System' HSC (SQSD) 5/19.

6. *The following should always be notified:*

i. *the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;*

ii. *the death of, or significant harm to, a Looked After Child, a child on the Child Protection Register or a young person in receipt of leaving and after care services;*

iii. *allegations that a child accommodated in a children's home has committed a serious offence; and*

iv. *any serious complaint about a children's home or persons working there.*

7. *There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.*

The next steps will be agreed during the initial contact/telephone call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the updated pro forma attached at Annex C, and forwarded, within 24 hours of notification of the event, to the Department at [redacted] and the HSC Board at [redacted]

The Early Alert must provide a succinct description which clearly outlines the key issues and the circumstances of the event. Information contained within the brief is to include:

- urgency;
- determining who has been affected and how - physical and/or psychological harm, or no known harm;
- process for determining risks;
- need for Department participation/involvement/oversight.

### 2.10 SAI Notification and Investigation

In some circumstances an SAI review may have triggered the Lookback Review Process (Section 1). However, often the Lookback Review will be triggered by a concern that has been raised by a service user or their family/carers or a member of staff. The Steering Group should consider at an early stage if the findings of the Lookback Review meets any of the criteria for reporting the concerns as an SAI (see also Section 7.2.1). The criteria for reporting an SAI are defined within the HSCB