

7. LEARNING, DEVELOPMENT AND SUPPORT

There are systems in place to monitor workforce volumes, highlight issues and to ensure that the Nursing and Midwifery workforce have the appropriate knowledge, skills and support needed to provide high-quality care.

Corporate Induction

The Trust Induction Policy (SHSCT, 2013a) requires all newly appointed staff to attend a Corporate Induction (in addition to a Departmental Induction / orientation). The programme comprises of information of common interest across all staff groups and contributes to building a commonality of understanding amongst the workforce. New employees are required to attend Corporate Induction ideally within three months of commencement but no longer than six months following appointment.

Nurse Induction for New Registrants

A Nurse Induction programme is delivered biannually to all new Nursing registrants. The programme is delivered in a blended approach by Clinical Education Centre, Practice Education Team and in-house SHSCT staff over a period of 3 days. It combines Corporate and Professional Induction, elements of Mandatory Training, a range of e-learning, and preceptorship training. All new registrants are given the option at recruitment phase to undertake a Rotational Programme to facilitate consolidation of knowledge and skills across a range of care settings.

Currently there is work ongoing to develop a Regional Induction Programme for Nursing Assistants.

Specialty / Departmental Induction

The Trust Induction Policy (2013a) requires all new employees to undertake specialty / departmental induction to ensure they have the information they may need to undertake the requirements of the post and to undertake the requirements of the job / professional role.

Preceptorship Programme

The Practice Education Team delivers a Preceptorship Programme to new registrants.

The duration of the programme is six months and runs concurrently with induction and the probationary period. A Preceptorship procedure (SHSCT, 2018) details the requirements for the Preceptorship Programme. The Trust reports annually to the Chief Nursing Officer (CNO) and quarterly to Trust Board regarding compliance with the Preceptorship Framework (DHSSPS, 2013).

Nursing and Midwifery Supervision & Annual Appraisal

The learning and development requirements of the Nursing and Midwifery workforce are identified through the Trust supervision and appraisal systems. The Trust considers the implementation of supervision and KSF processes as a critical priority in valuing staff and supporting their development to help achieve the key objective of safe, high-quality health and social care. The outcome of supervision activities informs the individual's KSF and Personal Development Plans, including identification of training requirements.

Mandatory Training

The Trust Corporate Mandatory Training Policy (Southern Health and Social Care Trust, 2013) details the Corporate Mandatory Training for Nursing and Midwifery staff groups. The policy denotes the mandatory training requirements for nursing, midwifery and nursing assistant staff groups.

Role Specific Training

All clinical areas ensure Nursing and Midwifery staff undertake role specific training to deliver safe and effective care. This is managed locally by the Ward Sister / Charge Nurse / Team Lead and all registrants.

Continuous Professional Development (CPD) Maintenance

All nursing and midwifery registrants have access to educational programmes provided through the Clinical Education Centre Level Agreement and the Education Commissioning Plan which provides them with opportunities to maintain Post Registration Training and Learning and gain recognition for learning.

Clinical Education Centre (CEC) – Service Level Agreement (SLA)

All nursing and midwifery registrants have access to the CEC which provides them with a range of programmes to maintain continuous professional development. Monitoring and uptake is ongoing throughout the financial year through monthly

reports from the CEC. The procedure for the Management of the Nursing and Midwifery SLA with the CEC provides guidance on all courses available and with the CEC (SHSCT, 2016a)

Education Commissioning Cycle – Training Needs Analysis

As part of the Regional Education Commissioning Group chaired by the DoH funds are allocated for education to each HSC Trust. The completion of an annual Training Needs Analysis facilitates Nursing and Midwifery staff to undertake further education including stand-alone modules, short courses and specialist practice to facilitate the development of skills, knowledge and expertise for practitioners. The procedure for the Management of Nursing and Midwifery Post-Registration Education Commissioning provides guidance on all aspects of the Nurse Education Commissioning process (SHSCT, 2016b)

8. WORKFORCE

The Trust recognises that ensuring appropriate nurse staffing is a key element in influencing the quality of care. Given this, a comprehensive Nursing and Midwifery Workforce Action Plan 2019 – 21 has been developed and the action plan is being progressed through 3 work streams. Progress is reported through to SMT and Trust Board.

8.1 Recruitment

Active recruitment of Nursing and Midwifery staff occurs on an ongoing basis via an open advertisement with the Business Services Organisation (BSO). Targeted recruitment via International Nurse Recruitment, UK wide recruitment fairs and local recruitment is managed by the HR Trust's recruitment team and the Corporate Nursing Team in a planned process. Monthly vacancy reports are reviewed by Directorates and escalation processes are in place to address staff shortages.

8.2 Delivering Care Project (Normative Staffing)

The Delivering Care Project continues to be implemented (DHSSPS, 2014). It aims to support the provision of high quality care which is safe and effective in hospital and community settings, through the development of a framework to determine staffing ranges for the Nursing and Midwifery workforce in a range of major specialties. Although funding has only been approved for phase 1, biannual reporting is completed to the HSCB of all agreed phases.

9. REGISTRATION / REVALIDATION

The Trust has developed an infrastructure to support the registration of the Nursing and Midwifery workforce which enhances the professional regulation of the workforce and reinforces the individual's responsibility to provide quality Nursing and Midwifery services.

Monitoring at Operational Level

While the responsibility to maintain registration lies with the registrant, line managers are responsible for ensuring that registered nurses and midwives have a valid registration and are on the NMC Register (SHSCT, 2017c).

HRPTS Oversight & NMC Registration Employer Centralised Oversight

The Trust has a dedicated Revalidation Team which record and monitor Nursing and Midwifery workforce registration and renewal status. The regional HRPTS system is used for central recording and monitoring of workforce registration and renewal status. Monthly reports are issued to managers on registration and renewal status.

Pre-Employment Checks

The Trust Recruitment and Selection Procedure (SHSCT, 2010) stipulates a pre-recruitment phase which involves the development and approval of personnel specifications and a range of checks to be undertaken pre-employment.

NMC Registration and Renewal Processes

The Trust Policy on the Validation and Monitoring of Registration with a Professional Regulatory Body (SHSCT, 2017d) defines the approach for registration and the maintenance of Nursing and Midwifery professional registration.

10. RAISING AND HANDLING CONCERNS

The Trust has a range of mechanisms for raising and handling concerns which are designed to ensure the Nursing and Midwifery workforce achieve and maintain appropriate standards of conduct, performance and behaviour.

Identification of Poor or Variable Performance

Concerns about poor or variable performance are identified through supervision, probationary reviews, incidents, complaints, patient feedback, whistleblowing and managerial engagement with front-line teams. Depending on the severity and potential impact of the issues identified a line manager may seek to resolve locally through identification of further training and development needs, increased supervision or enact the Trust's management of probationary, capability or disciplinary procedures.

Probationary

All Nursing and Midwifery appointments are subject to a probationary period which is normally 6 months duration, during which time progress is monitored. In the event of unsatisfactory progress, despite appropriate support and / or counselling, employment will be terminated with appropriate notice either during or at the end of the probationary period in accordance with the Trust's procedure for probationary periods (SHSCT, no year).

Management of Capability, Conduct or Health Concerns

The Trust Capability Procedure (SHSCT, 2015a) has been designed for use in situations where there is evidence of '*a genuine lack of capability rather than a deliberate failure on the part of the employee to perform to the standards of which he / she is capable*'.

The Trust Disciplinary Procedure (SHSCT, 2015b) is designed to help and encourage all employees to achieve and maintain appropriate standards of conduct, performance and behavior.

Line managers work very closely with the Trust Occupational Health Department and Attendance Management Team to appropriately manage health concerns related to the Nursing and Midwifery workforce.

Management of Fitness to Practice Referrals to NMC and NMC Investigation Process

Trust Procedures for initiating and managing a referral to a Professional Regulatory Body and the Independent Safeguarding Authority and Requesting the DHSSPS to issue an ALERT (SHSCT, 2015c) outline the processes to be followed should this be required. All referrals to NMC for fitness to practice and requested for an alert to be issued should be discussed with and quality assured by the Assistant Director of Nursing (Safety, Quality and Patient Experience) and approved by the EDoN.

The corporate nursing team will support nurses and midwives involved in NMC investigations and hearings.

Nursing and Midwifery Human Resources Interface Forum

The Trust Nursing and Midwifery Human Resource Interface Forum has formalised interfaces between the Assistant Director of Nursing (Safety, Quality and Patient Experience), Assistant Directors of Human Resources (Directorate) and Head of Employee Relations in relation to conduct, capability or fitness to practice of Nursing and Midwifery staff.

11. NURSING QUALITY IN THE INDEPENDENT SECTOR

There are robust processes in place for assuring the quality and safety of services commissioned from third or independent sector providers.

Contracts

Where externally provided services are commissioned by the Trust, the same high levels of compliance with Trust safety and quality standards are required to be implemented by the Provider through adherence to robust, descriptive contracts. The contracts stipulate clear arrangements for monitoring that these standards are met. Advice and guidance can be sought from the Operational Assistant Directors or Assistant Directors of Nursing as required.

If concerns are identified regarding the conduct, capability or fitness to practice of a registrant not employed by the Trust the Trust Procedures for initiating and managing a referral to a Professional Regulatory Body and the Independent Safeguarding Authority and Requesting the DHSSPS to issue an ALERT (SHSCT, 2015c) should be followed.

Contract Management and Monitoring

There are identified contract managers who undertake both formal and informal contract management and monitoring. At a minimum, an Independent / 3rd Party Contractor is subject to an annual formal Contract Management meeting.

The majority of Independent / 3rd Party Contractors engaged with by the Trust are registered with RQIA and subject to their ongoing monitoring and inspection.

12. REFERENCES

Department of Health Social Services and Public Safety and Northern Ireland Practice Education Council (2013) *Preceptorship Framework for Nursing, Midwifery and Specialist Community Public Health Nursing in Northern Ireland*, Belfast: NIPEC.

Department of Health, Social Services and Public Safety (2014) *Delivering Care: Nurse Staffing in Northern Ireland*

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Nursing and Midwifery Council (2015) *The Code for Nurses and Midwives* Retrieved from www.nmc.org.uk/standards/code

Nursing and Midwifery Council (2016) *Revalidation* Retrieved from <http://revalidation.nmc.org.uk/welcome-to-revalidation>

Southern Health and Social Care Trust (no year) *Management Guidance Note: EER 05, Trust's procedure for probationary periods* (SHSCT).

Southern Health and Social Care Trust (2010) *Recruitment and Selection*

Southern Health and Social Care Trust (2013) *Corporate Mandatory Training Policy*

Southern Health and Social Care Trust (2013a) *Trust Induction Policy*

Southern Health and Social Care Trust (2015) *Policy for the Management of Complaints (Working Draft)*

Southern Health and Social Care Trust (2015a) *Capability Procedure*

Southern Health and Social Care Trust (2015b) *Disciplinary Procedure*

Southern Health and Social Care Trust (2015c) *Trust Procedures for initiating and managing a referral to A Professional Regulatory Body and The Independent Safeguarding Authority and Requesting the DHSSPS to issue an ALERT*

Southern Health and Social Care Trust (2016) *Policy for Supporting Nursing & Midwifery Students in Practice*

Southern Health and Social Care Trust (2016a) *Procedure for the Management of the Nursing and Midwifery Service Level Agreement with the Clinical Education Centre*

Southern Health and Social Care Trust (2016b) *Procedure for the Management of Nursing and Midwifery Post-Registration Education Commissioning*

Southern Health and Social Care Trust (2018) *Preceptorship Procedure for Nurses, Midwives and Specialist Community Public Health Nurses*

Southern Health and Social Care Trust (2017) *Board Assurance Framework*

Southern Health and Social Care Trust (2017a) *Procedure on the Identification, Management and Monitoring of Practice Placements for Students who are undertaking NMC approved programmes.*

Southern Health and Social Care Trust (2017b) *Procedure for Maintaining the Trust Register.*

Southern Health and Social Care Trust (2017c) *Policy on the Validation and Monitoring of Registration with a Regulatory Body*

Southern Health and Social Care Trust (2017d) *Professional Registration Policy*

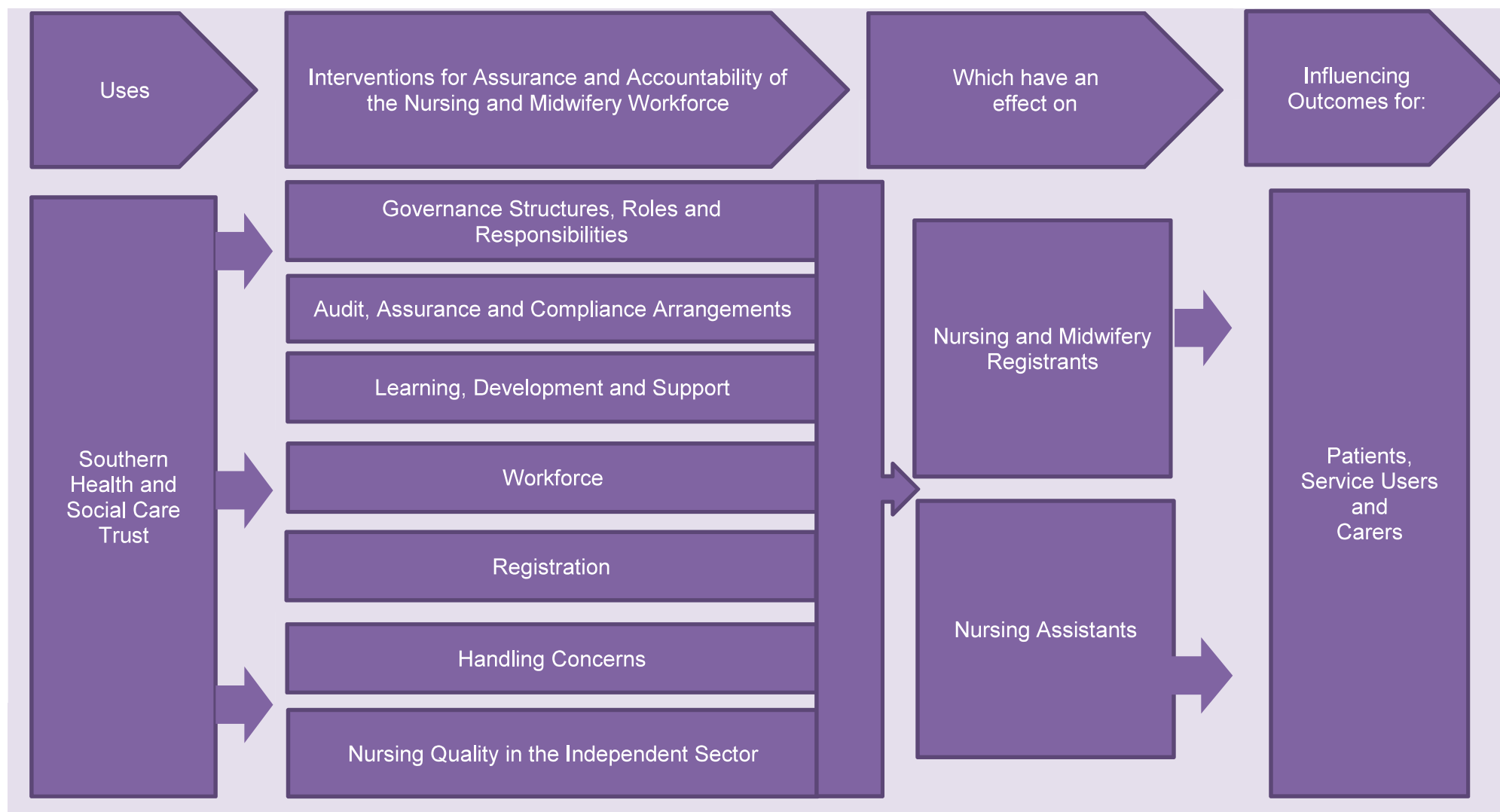
Southern Health and Social Care Trust (2019) *Nursing and Midwifery Workforce Action Plan 2019-21*



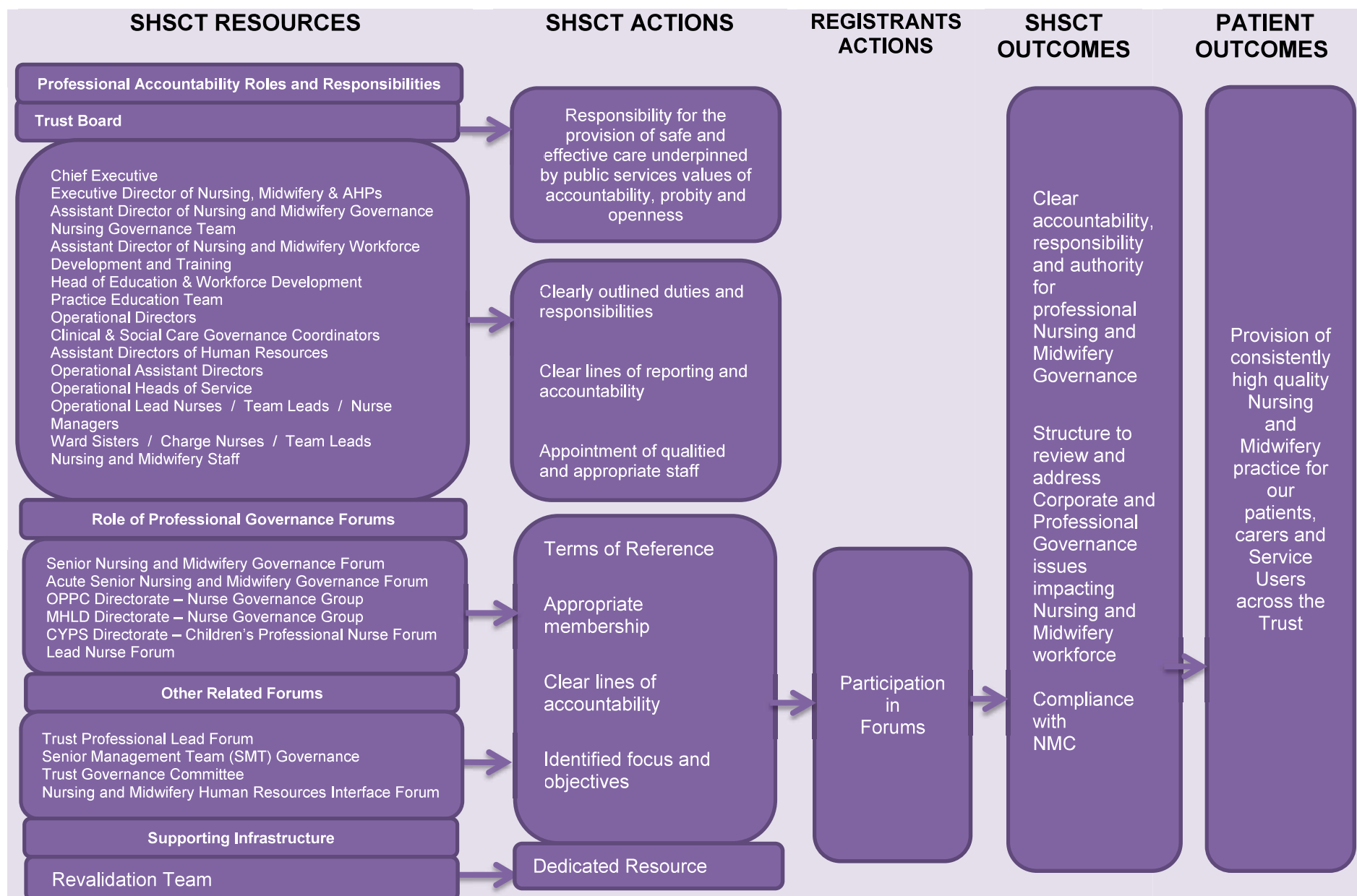
Quality Care - for you, with you

Nursing and Midwifery Accountability and Assurance

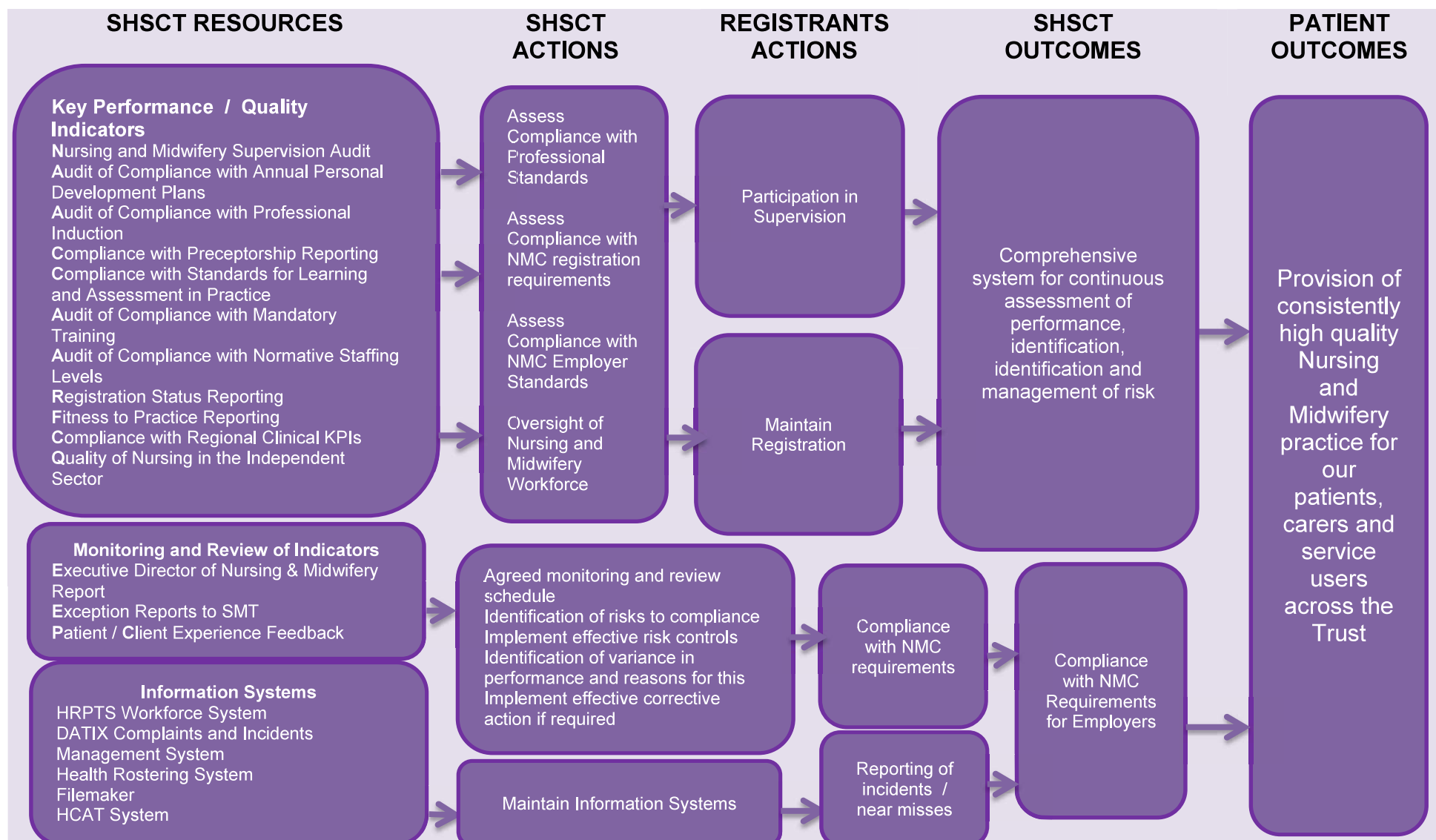
Logic Models



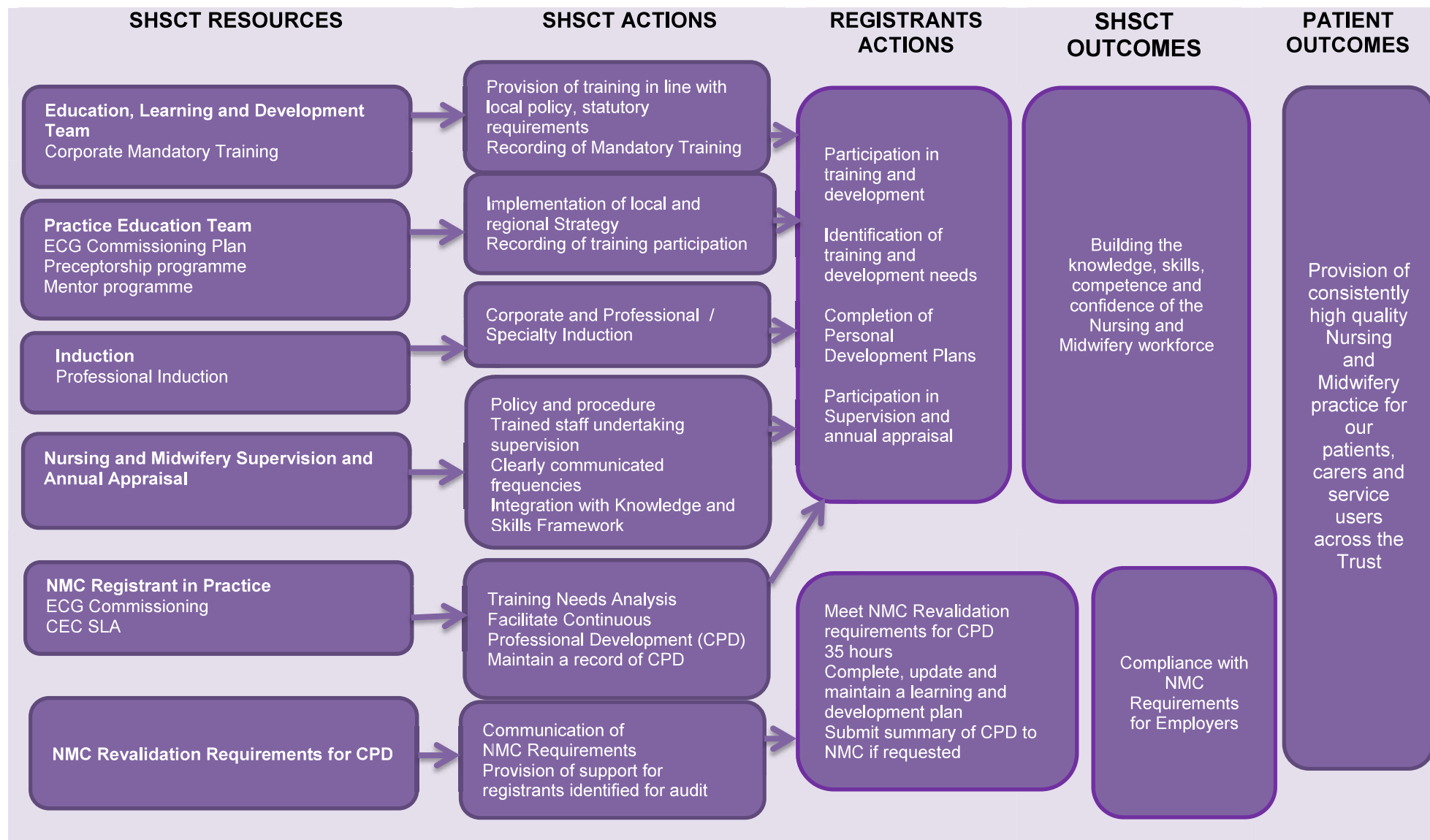
Governance Structures, Roles and Responsibilities



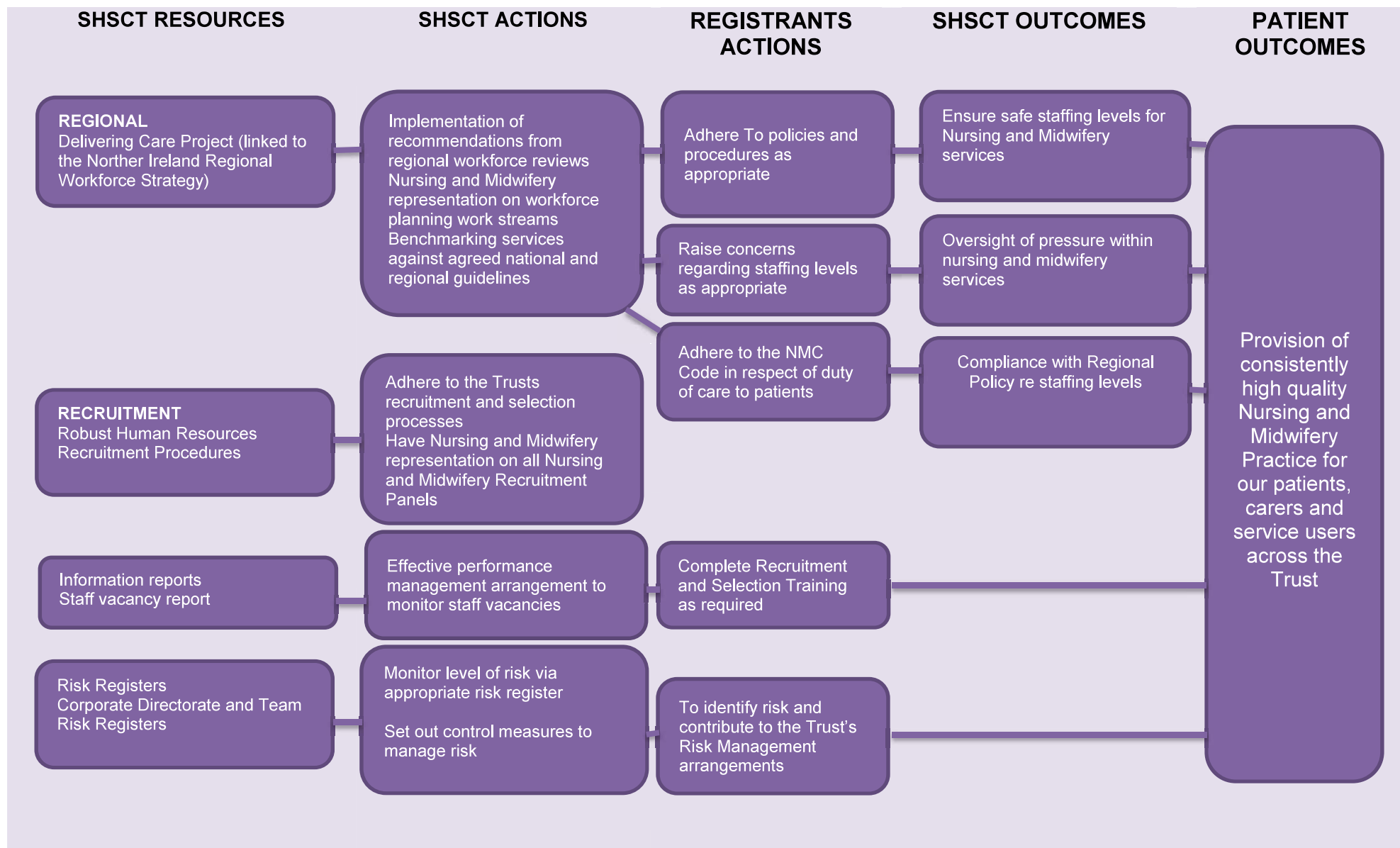
Audit, Assurance and Compliance Arrangements



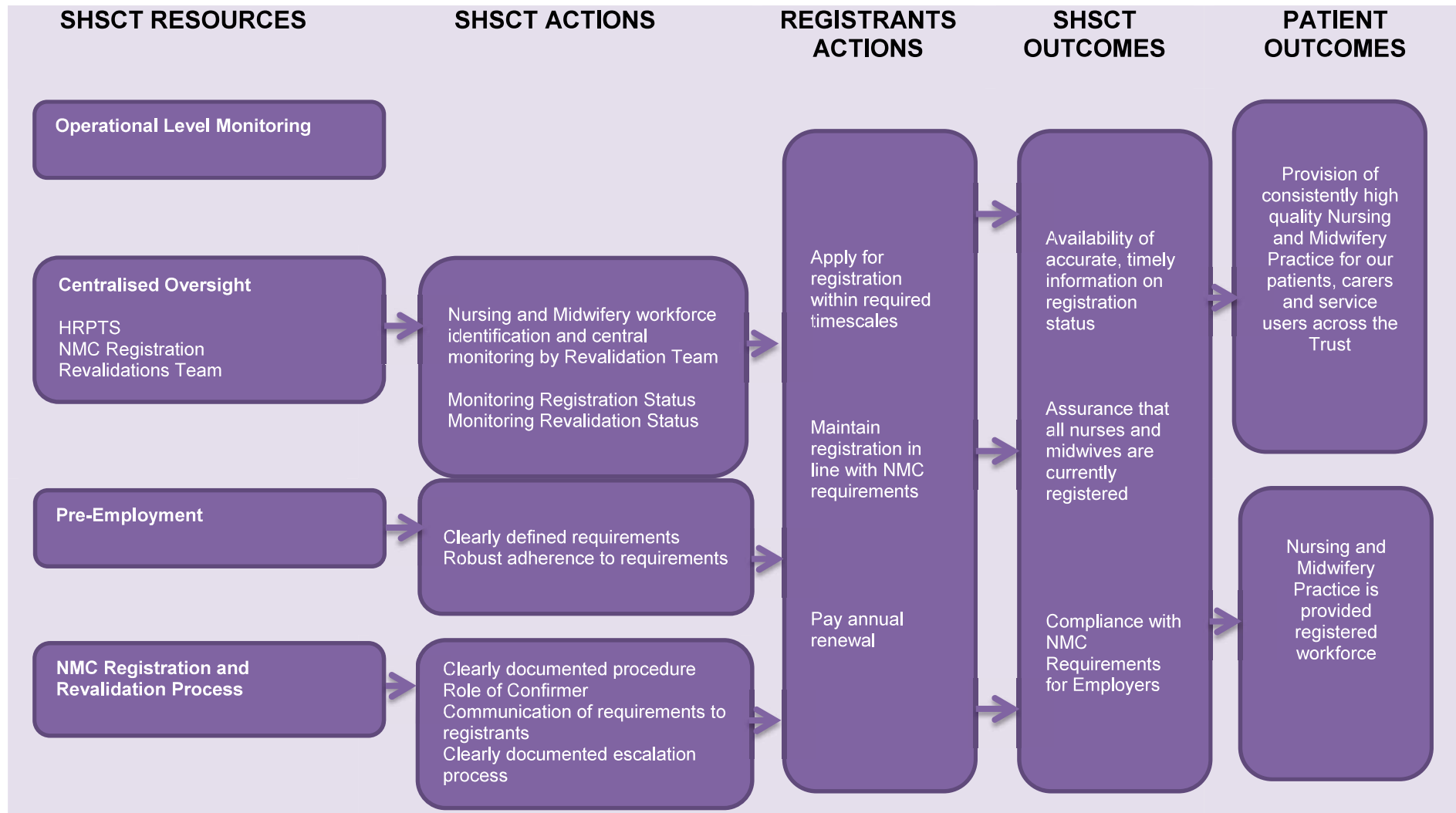
Learning, Development and Support



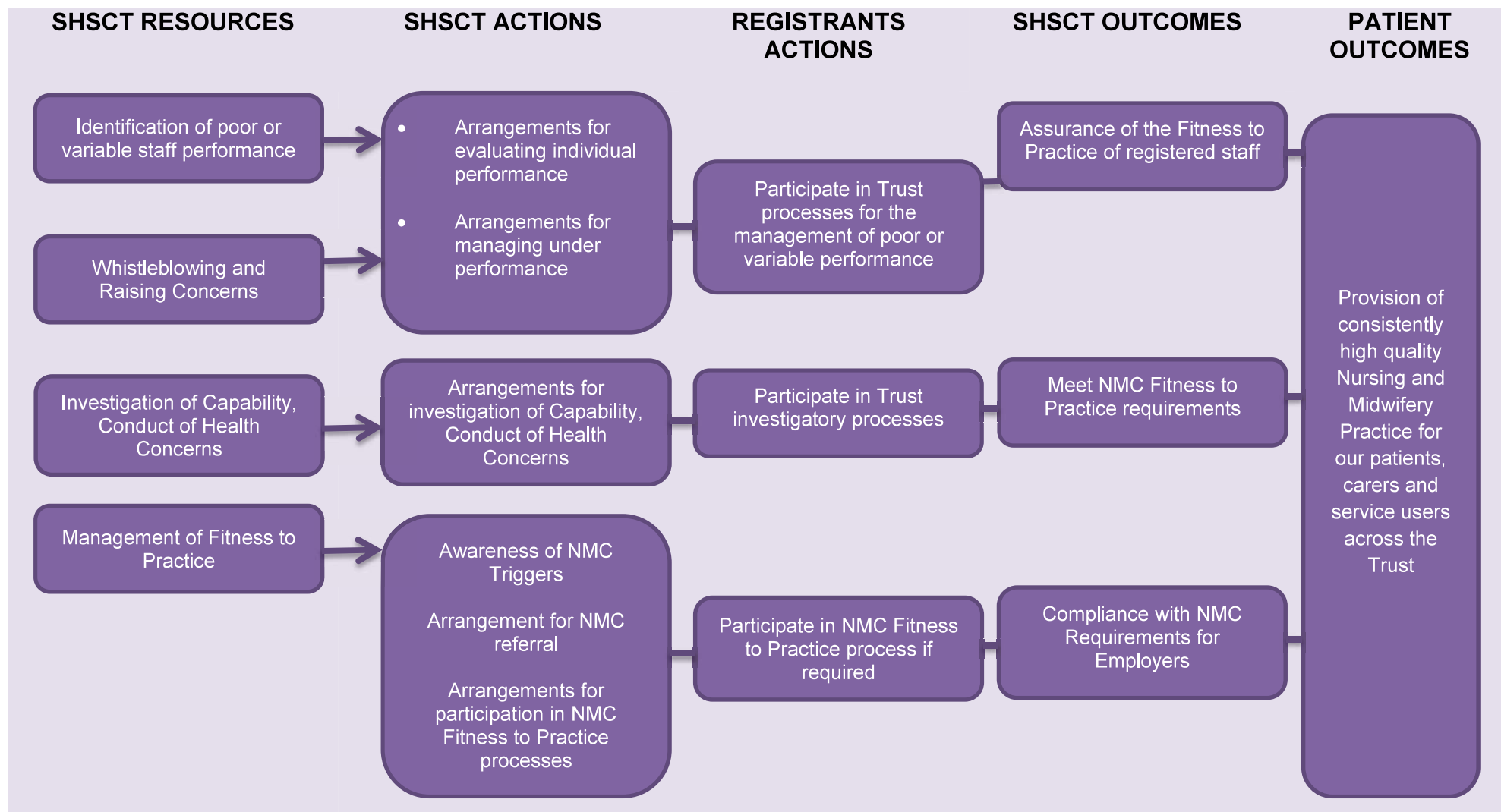
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Registration



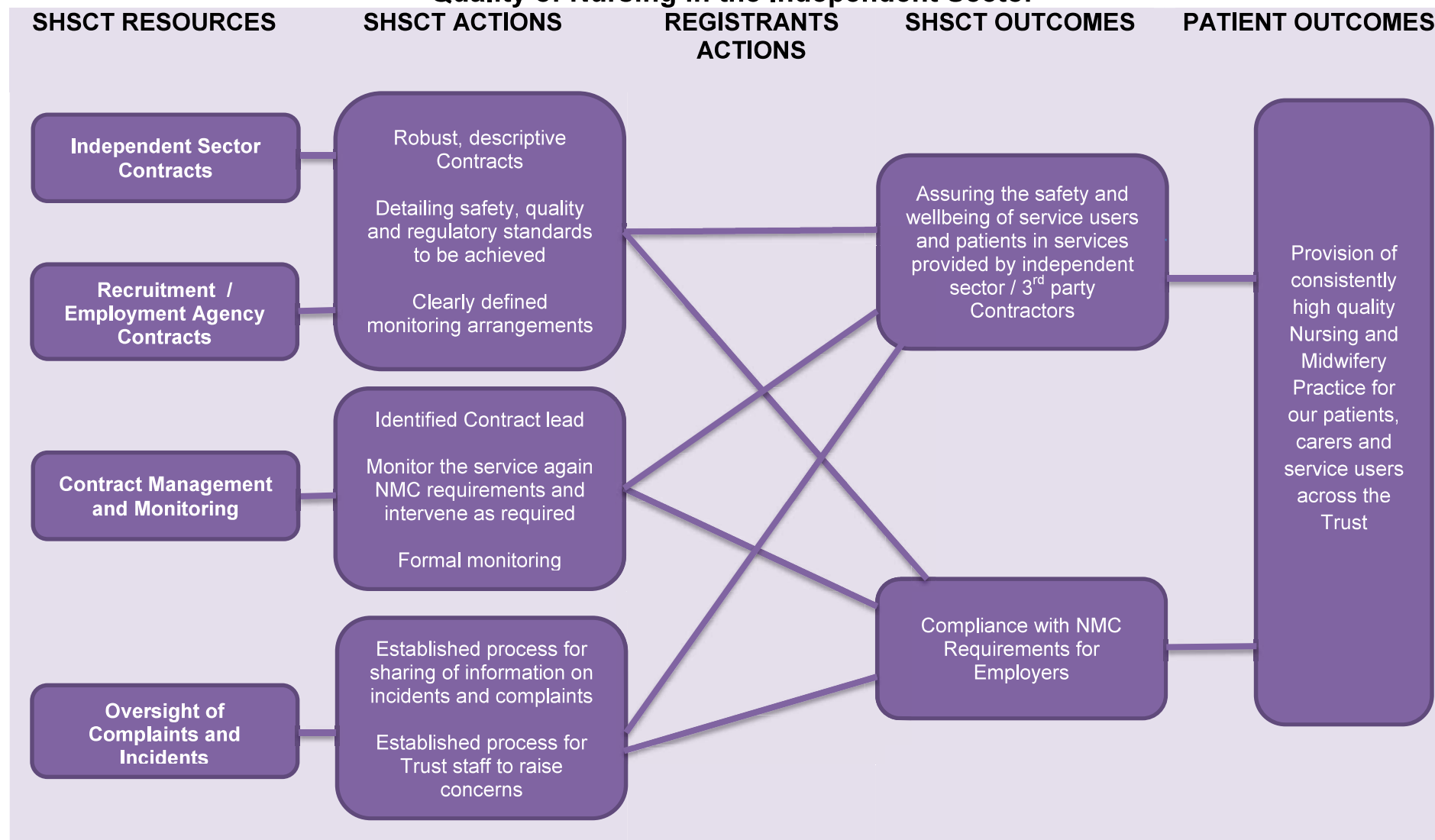
Handling Concerns



Accountability and Assurance Framework

Nursing and Midwifery

Quality of Nursing in the Independent Sector



Appendix 14- Revalidation NMC & GMC guidelines

Nursing Revalidation SharePoint Tile [Nursing & Midwifery Governance - Revalidation](#)



FAQs on NMC
Revalidation.pdf

Medical Revalidation SharePoint Tile [M&M Resources - Home](#)



Medical Induction
& Revalidation.html

NMC – Nursing and Midwifery Council.

CPD – Continuous Professional Development

	FAQs	Information will be updated as arrangements for revalidation are agreed
GENERAL	<i>What is Revalidation?</i>	Revalidation is a legislative requirement of the Nursing and Midwifery (Amendment) Order 2014 which came into force in December 2014. See Appendix 1 for more information. The amended Order allows the NMC to prescribe Fitness to Practise Rules and specific arrangements for revalidation.
	<i>Why do we need it?</i>	- The legislation requires it. Revalidation - - Improves public protection by ensuring that all registrants remain fit to practise throughout their career. - Reinforces individual personal and professional duty to remain fit to practise, incorporating the Code into daily practice. - Builds on existing PREP arrangements by seeking feedback from patients and colleagues, reflecting on the Code and seeking confirmation that requirements have been met. - Enhances employer engagement and awareness of regulatory standards and increases participation in appraisals and professional development.
	<i>Who does it apply to?</i>	To ALL Nurses, Midwives and Specialist Community Public Health Nurse who are registered with the NMC.
	<i>When does it take effect from?</i>	October 2015 – NMC is expected to approve the revalidation arrangements at its meeting in October. The arrangements will take effect immediately but in practice will, in the first instance, apply to those registrants due to revalidate in April 2016. Thereafter all registrant must comply with the new arrangements.
	<i>What do I need to do?</i>	Register to access your personal NMC online account. This is the route for submitting information on compliance with revalidation requirements. Go to http://www.nmc.org.uk/registration/nmc-online/. See information on NMC website.
	<i>How will I know when to revalidate?</i>	Once you have registered to access your personal NMC online account – log out and then log in again using your password and you will be able to access your personal information held by the NMC which includes the date you are due to revalidate.
	<i>Is this date the same as the date for annual payment of fees?</i>	Not necessarily. NB fees are paid annually and usually on the same month each year. Revalidation is every 3 years. You need to check on your personal NMC online account for your revalidation date. The month for annual payment of fees may be different from that of your revalidation.

PRACTICE HOURS	<i>How do I know if I have met the required hours of practice?</i>	<i>You will be required to declare that you have undertaken 450 practice hours over the previous 3 years.</i> The hours of practice can be estimated from your employment contract which specifies the hours/week you are required to work. The minimum is 450 hours over 3 years (150 hours / year or 12.5 hours / month). Those with e.g., 1.0 or 0.5 wte contract will have met these requirements. However, registrants who are 'pure' Bank staff with no fixed hours will need to clearly demonstrate to their confirmer that they have worked for the minimum 450 practice hours over the previous 3 years. Similarly, registrants who have had a career break or a long term sickness period must also evidence that they have practiced for 450 at some point over the previous 3 year period.
	<i>I am a Registered Nurse and a Registered Midwife, how many hours of practice do I need to do?</i>	You will be required to declare that you have met 900 hours of practice over the previous 3 years, 450 in each area. If you are a Registered Nurse and a Registered Specialist Community Public Health Nurse you need only declare that you have met 450 hours of practice over the previous 3 years.
	<i>Does voluntary or unpaid work count?</i>	Yes but only if the role requires you to be a NMC registrant. If you are NOT required to be a registrant you cannot count these as practice hours.
	<i>What happens if I don't have the required practice hours?</i>	You must complete an appropriate NMC-approved Return to Practice programme before the date of your revalidation application
CONTINUING PROFESSIONAL DEVELOPMENT	<i>How will I know if I have the required CPD hours?</i>	<i>You will be required to declare that you have undertaken 40 hours of CPD over the previous 3 years.</i> Keep a note of all course, conference and learning activity undertaken in the past 3 years. For each Identify the part of the Code relevant to the learning activity. In your discussion with your registrant colleague you can agree the learning activity undertaken which supports compliance with the CPD revalidation criteria.
	<i>Does mandatory training count as CPD?</i>	Only if it is relevant to your scope of practice as a nurse or midwife and professional development.
	<i>What does Participatory Learning mean / include?</i>	Participatory Learning includes any learning activity in which you personally interacted with other people.
	<i>How will I evidence the other 20 hours?</i>	The remaining 20 hours does not have to be participatory, i.e., learning with other people, and can include reading journal articles, scoping best practice, project work undertaken as part of a course. As with participatory learning you will need to Identify the part of the Code relevant to the learning activity.
	<i>I am a RN (A) and RN (MH) and have a recordable qualification, do I need to demonstrate that I have met CPD requirements for each?</i>	No. The evidence is to support your overall fitness to practise as a registrant and not specific parts of the register. However, the CPD evidence should reflect activity within your <u>current</u> area of practice.

NMC REVALIDATION - FREQUENTLY ASKED QUESTION

PRACTICE-RELATED FEEDBACK	How will I gather my evidence on practice-related feedback?	You must obtain at least five pieces of practice-related feedback over the previous 3 years. Feedback can be gathered from a variety of sources and can be specifically related to yourself and your individual performance or your team, ward or division/directorate's performance. However, you will need to be clear about the specific impact that the feedback has had on your practice as a registrant. At your registrant discussion you need to say how this feedback has influenced your practice and your application of the Code.
	My role is not patient/client facing so how do I obtain the evidence?	You can obtain feedback from a variety of sources relevant to your role such as from students, service users or colleagues who do not have to be nurses or midwives. You can also obtain feedback through reviewing complaints, team performance reports and serious event reviews. You can also use feedback received at your annual appraisal.
	How do I record this feedback?	The NMC has developed a template to support registrants in recording feedback but this can be amended to suit your own individual feedback requirements.
	Does the person feeding back have to sign to say it is correct?	No, however, you should tell patients or colleagues about how you intend to use their feedback and that it will remain confidential and be careful not to include any information that might identify a specific patient or service user in your portfolio.
REFLECTION & DISCUSSION	How will I gather my evidence of reflective practice?	You must record at least five written reflections on the Code, your CPD and practice-related feedback over the previous 3 years. There are a number of reflective models which can be used to support this activity including the Nurse Supervision model currently in place. You should record all reflections on your CPD and practice including those discussed at supervision.
	How far back can I use examples from?	You can use examples gathered over the past 3 years but it may be useful to more recent reflections to map across to the revised Code.
	How do I record reflective practice?	The NMC has developed a template to support registrants in recording their reflections but this can be amended to suit your own needs. There are other templates that you can use e.g., NIPPEC DPF. You should retain these in your portfolio as a record and provide them to the NMC if requested. You must make sure that the NMC registrant with whom you had your professional development discussion signs a form stating their name, NMC PIN, email, address and postcode and date of the discussion.
	Who will I have my registrant discussion with?	If your line manager is also a registrant, your discussion will most likely be with him/her. However, you can also have the discussion with someone you

NMC REVALIDATION - FREQUENTLY ASKED QUESTION

		frequently work with or e.g., who is in the same learning group.
	What is the purpose of this discussion?	The purpose is to share what you have learned from your CPD activity or feedback with another registrant and discuss specifically how you have changed or improved your work and how this has impacted on your application of the Code.
	I am a lone-worker so can I do this over the phone?	The NMC expect the registrant discussion to be a face-to-face conversation. If for some reason this is not possible, then you could arrange a video conference.
	Who will arrange this?	You are expected to arrange the discussion meeting with your registered colleague.
	Can I have my confirmation meeting at the same time?	While the discussion with another registered colleague can form part of your wider confirmation discussion, it is not the same as obtaining confirmation. If your line manager is also a registrant it is likely that these two processes will take place consecutively and will usually form part of your annual appraisal meeting.
HEALTH & CHARACTER	What does declaring good health and character mean / entail?	You will need to complete the following declarations as part of your revalidation application. - You must provide a health and character declaration and - You must declare if you have been convicted of any criminal offence or issued with a formal caution over the three years prior to the renewal of your registration. Further information can be found at http://www.nmc.org.uk/education/becoming-a-nurse-or-midwife/when-studying-to-be-a-nurse-or-midwife/ http://www.nmc-uk.org/Registration/Staying-on-the-register/Declaring-police-charges-cautions-and-convictions/
	Does having a disability or health condition mean I am not of good health?	No, but the NMC expects that you are able to provide safe and effective practice without supervision, after any reasonable adjustments are made by your employer.
	Do I have to declare the time I have been on sick leave in the past 3 years?	No, unless this adversely affects your ability to practice safe and effectively. You should discuss this with your line manager.
	Do I have to declare if I have received a caution or conviction?	Yes. You must declare if you have received any cautions or convictions, or have any police charges pending over the three years prior to the renewal of your registration. A caution or conviction includes those received in the UK for a criminal offence, as well as a conviction received elsewhere for an offence which, if committed in the UK, would constitute a criminal offence.
	Do I have to declare driving offences?	No, you do not need to declare fixed penalty fines for traffic offences unless they have led to a disqualification or motoring offences that you have already notified the NMC about.

NMC REVALIDATION - FREQUENTLY ASKED QUESTION

	<i>Who confirms that I am in good health and of good character?</i>	You are personally and professionally responsible for making the declaration.
INDEMNITY ARRANGEMENTS	<i>How will I know if I have professional indemnity?</i>	<i>You must declare that you have, or will have when practising, appropriate cover under an indemnity arrangement.</i> By law, you must have in place an appropriate indemnity arrangement in order to practise and provide care. NHS bodies are vicariously liable for the negligent acts and omissions of their employees and should have arrangements for meeting this liability. As an employee of a public body the Trust will provide you with appropriate indemnity cover. Trust professional indemnity cover does not apply to self-employed health care professionals such as independent midwives or those undertaking a role or work (voluntary or unpaid) outside the Trust which requires the person to be a registrant.
	<i>Is this different for midwives?</i>	No, registered midwives, employed by and within the Trust are covered. Those registered midwives who also work in a private / independent capacity must arrange appropriate indemnity for when they are working outside the Trust.
	<i>What if I have a private practice as well as a Trust contract?</i>	As above, those registrants who work in a private / independent capacity must arrange appropriate indemnity for when they are working outside the Trust.
CONFIRMATION FROM A THIRD PARTY	<i>What does confirmation from a third party mean?</i>	You must ask a third party to confirm that you have complied with all NMC revalidation requirements. You must provide the name, NMC PIN or other professional identification number (where relevant), email, professional address and postcode of the confirmer / third party.
	<i>Who will be / who will choose my confirmer?</i>	If your line manager is also a registrant it is likely that the registrant discussion and confirmation will take place consecutively and will usually form part of your annual appraisal meeting. If your confirmer is an NMC registrant, s/he must have an effective registration with the NMC and must not be subject to any kind of suspension, removal or striking-off order at the time of making the confirmation.
	<i>If my line manager is not a registered nurse who will my third party confirmer be?</i>	To be agreed If there is any conflict of interest or perception of bias both you and your confirmer will need to exercise judgement to ensure that the confirmation process remains credible and objective.
	<i>What is the role of the confirmer?</i>	The role is to confirm that you have complied with the NMC's revalidation requirements.

NMC REVALIDATION - FREQUENTLY ASKED QUESTION

	<i>How long before my registration is due will I need to meet with my confirmer?</i>	To be agreed You can meet with your confirmer once you have complied with all the NMC's revalidation requirements. The NMC recommend that you obtain your confirmation during the final 12 months of the three-year registration period to ensure that it is recent. If your confirmation was obtained earlier, the NMC may ask you to explain why.
	<i>Who will arrange this meeting?</i>	You are expected to arrange the meeting with your third party confirmer.
	<i>How often will have to meet my confirmer?</i>	Ideally, and if you have complied with all the NMC's revalidation requirements, you will only have to meet with your third party confirmer once every three years. However, if your confirmer is also your line manager you will most likely meet with him / her on an annual basis to complete your appraisal and Personal Development Plan (PDP). Progress on the completing your portfolio can be discussed at your annual appraisal and any actions needed to ensure your compliance with the revalidation requirements can be discussed and agreed.
	<i>Will I be a confirmer?</i>	To be agreed – If you are a line manager of registered nurses, midwives and / or Specialist Community Public Health Nurses you will most likely be a confirmer.
APPLYING FOR REVALIDATION	<i>How do I apply for revalidation?</i>	The NMC will notify registrants at least 60 days before revalidation is due. Please make sure that the NMC has your most up-to-date contact details by checking your personal account online. You will have 60 days to log into NMC Online and complete the revalidation application form and the NMC has published a step by step guide to registering. If you are also a registered midwife practising in the UK, you will need to file your intention to practise notification form. This should be submitted annually to your named supervisor of midwives.
	<i>How do I advise the NMC that I have met the revalidation requirements?</i> <i>What information do I need to submit?</i>	By completing the online revalidation form. You will need to have all the supporting evidence from your revalidation portfolio to hand when you start your online application. You must submit your application on or before the date we specify. Failure to submit your application on time will put your registration at risk You will be asked to provide the name, NMC PIN or other professional identification number (where relevant), email, professional address and postcode of the third party that provided your confirmation. You need only complete the online verification details requested as part of the NMC's revalidation process. You do not need to upload any supporting documentation unless specifically asked to do so. If you are selected to provide further information to verify your

NMC REVALIDATION - FREQUENTLY ASKED QUESTION

		application, the NMC will ask you to provide the signed confirmation form in order to check with your confirmer that he/she provided your confirmation.
		As part of your revalidation application, you will need to pay your renewal fee.
OTHERS QUERIES	<i>What if I don't revalidate on time?</i>	The NMC will not usually consider any requests for extensions to submit a revalidation application. The requirements should be met within the three years prior to the renewal of your registration. However, if you believe that you have exceptional circumstances, please contact the NMC directly to discuss you situation.
	<i>Can I still revalidate if I am the subject of an NMC investigation?</i>	Yes, if you are subject to an NMC investigation, a condition of practice order or a caution, you will be able to apply to renew your registration as long as you fulfil all the requirements for renewal. However, you will remain subject to NMC fitness to practise processes and the outcome of those processes. If your renewal is due while you are subject to suspension from the register, you can only apply once your suspension has been lifted after which you will have three months to apply for and obtain your renewal. If you fail to do this, you will have to apply for re-admission to the register via an NMC-approved Return to Practice programme. If you have been struck-off or suspended from the register, you will not be permitted to renew your registration because you are no longer on the register.

Brief summary points / timeline on the Fitness to Practice Rule changes

- In July 2012, the Professional Standards Authority's (PSA) (then Council for Healthcare Regulatory Excellence CHRE) Strategic Review of the NMC identified problems with the NMC's fitness to practise process and recommended these should be addressed at the earliest opportunity.
- In 2013, in its response to the final report of the Mid Staffordshire Trust Public Inquiry, the Government acknowledged that outdated legislation and Rules hampered the NMC's ability to provide assurance on registrants' fitness to practise.
- In March 2013, to support the NMC in amending its fitness to practise arrangements, the Department of Health agreed that a section 60 Health Act 1999 Order should be made to amend the Nursing and Midwifery 2001 Order.
- On 11 December 2014 the section 60 Order came into force making a number of amendments to the Nursing and Midwifery 2001 Order – now the Nursing and Midwifery (Amendment) Order 2014. The amendments allow the NMC prescribe specific fitness to practice including revalidation arrangements, thereby carrying out its registration functions more effectively, improving public protection and increasing the public's confidence in the regulation of nurses and midwives.
- Specifically the Nursing and Midwifery (Amendment) Order 2014 empowers the NMC to make changes to the Rules on Fitness to Practise and Education, Registration and Registration Appeals.
- In April 2014 the Law Commission published its review of 150 years of complex health and care legislation relating to 11 regulated professional groups, including the NMC, and made recommendations for legislative changes. The Government's response will be published in during the next Parliament.
- An associated amendment to the Health Care and Associated Professions (Indemnity Order) 2014 (S.I. 2014/1887) makes it a condition of registration to have in place an indemnity arrangement providing appropriate cover. This enables the NMC to make rules which require registrants to have appropriate indemnity arrangements in place. These rules also enable the NMC to disclose to a third party information that it has received in respect of a person's indemnity arrangement for the purposes only of verifying that information.
- The amendments also introduce provisions to the Registration Rules which will allow registrants to pay the registration, retention, renewal, readmission or restoration fee by instalments and thereby help registrants meet these costs over a period of time.
- Between April and June 2014 the NMC conducted two consultations in respect of the proposed rule changes. The first was an online survey which ran in parallel to the Department of Health's Section 60 consultation from 17th April to 12th June 2014. This consultation received broad support from respondents. Outcomes available on the NMC website.
- Between August and October 2014 the NMC consulted on the ability to pay the annual registration fee in instalments in order to enable nurses and midwives to meet the payment of their registration fees in a more manageable way. This consultation received a very high level of support. Outcomes available on the NMC website.
- Both sets of Rule changes are to be introduced as a single instrument to maximise efficiency and the use of parliamentary time.
- Following consultation the NMC developed a model for the revalidation and, following a pilot in a range of facilities and across professional groups in the four countries, will approve the model at its NMC Council meeting in October 2015 with immediate effect.

NMC REVALIDATION - FREQUENTLY ASKED QUESTION

- As the notice of revalidation to registrants has been proposed as 45 days, those who are due to revalidate in April 2016 will be the first to provide evidence of compliance with the new arrangements.
- The NMC will issue supportive information on their website which will be updated along with other information leaflets and media releases and the implementation progresses.
- A Northern Ireland Programme Board for Revalidation was convened in November 2014. Chaired by the CNO and with links to the NMC. It will oversee implementation of revalidation within NI. The WHSCT has been identified as the pilot site and will be represented on the NI Revalidation Programme Board.
- A Working Group reporting to the Programme Board has now been set up. During the lifetime of the project it is envisaged that the Working Group will meet monthly.

For further information see Explanatory Memorandum to the Nursing and Midwifery Council (Fitness to Practise) (Education, Registration and Registration Appeals (Amendment) Rules Order of Council 2015, 2015 No. 52 at http://www.legislation.gov.uk/uksi/2015/52/pdfs/uksiem_20150052_en.pdf

Appendix 15- Supervision Policy



Nursing Supervision
Policy.pdf

Policy Checklist

Name of Policy:	Nursing Supervision Policy
Purpose of Policy:	To ensure that a culture of Nursing Supervision is embedded in the Southern Health and Social Care Trust and that the processes through which Supervision is carried out are integral to the organisational arrangements for the delivery of safe and effective care.
Directorate responsible for Policy	Executive Director of Nursing
Name & Title of Author:	Margaret Marshall, Assistant Director of Nursing Governance Paula Fearon, Nursing Governance Co-ordinator
Does this meet criteria of a Policy?	Yes
Trade Union consultation?	Yes
Equality Screened by:	NA
Date Policy submitted to Policy Scrutiny Committee:	9 th July 2018
Members of Policy Scrutiny Committee in Attendance: Electronically by membership of Policy Scrutiny Committee	
Policy Approved/Rejected/Amended	19 th July 2018
Policy Implementation Plan included?	N/A – reviewed policy
Any other comments:	
Date presented to SMT	N/A – reviewed policy
Director Responsible	Director of Nursing and AHP's
SMT Approved/Rejected/Amended	N/A
SMT Comments	

POLICY DOCUMENT – VERSION CONTROL SHEET	
Title	Nursing Supervision Policy Version 3 July 2018
Supersedes	Version 2_0_August 2011
Originator	Margaret Marshall, Assistant Director of Nursing Governance
Scrutiny Committee & SMT approval	Referred for approval by: Margaret Marshall Date of Referral: 10 th July 2018 Scrutiny Policy Committee Approval 9 th July 2018 SMT approval (Date)
Circulation	Issue Date: 20 th July 2018 Circulated By: Assistant Director of Nursing Governance
Review	Review Date: September 2019 Responsibility Margaret Marshall, Assistant Director of Nursing Governance



POLICY TITLE:	Nursing Supervision Policy
ACCOUNTABLE DIRECTOR:	Heather Trouton, Interim Executive Director of Nursing
POLICY AUTHOR:	Margaret Marshall, Assistant Director of Nursing Governance
CO-ORDINATOR FOR IMPLEMENTATION PLAN:	Heather Trouton, Interim Executive Director of Nursing
DATE APPROVED BY POLICY SCRUTINY COMMITTEE:	9 th July 2018
DATE APPROVED BY SMT:	N/A – Policy Review

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1.0 Introduction

The importance of effective Supervision has been highlighted in regional critical incident inquiries such as the Lewis Review (2003)¹, Murtagh Review (2005)², and McCleery Report (2006)³. The Quality Standards for Health and Social Care (DHSSPS 2007)⁴ recommend an effective system for Supervision across Health and Social Care (HSC) to help organisations meet each of the Clinical and Social Care Governance Standards.

It is recognised that effective Supervision processes improve: recruitment and retention of nursing staff; job satisfaction; professional autonomy; and reduces absenteeism⁵.

- 1.1 This revised policy and “*Guidance on Nursing Supervision*” (Appendix 1) have been produced to support the continuing development and maintenance of a robust system of Supervision for nursing staff who work within the Southern Health and Social Care Trust (SHSCT).
- 1.2 The Review of Clinical Supervision for Nursing in the Health and Personal Social Services (Ireland and UK) (HPSS) (2007)⁶ recommended action to enhance and promote professional Supervision for Nursing in Trusts throughout Northern Ireland.

The report defined Supervision as:

‘a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety’.

Following this the Chief Nursing Officer (CNO) published Standards for Supervision for Nursing⁷ which contained 2 Regional Standards.

¹ Lewis, RJ, Cole, D, Williamson, A (2003). Review of Health and Social Services in the case of David and Samuel Briggs. Belfast, DHSSPS

² Regional Quality Improvement Authority (2005). Review of the lessons arising from the death of the Late Janine Murtagh, Belfast, RQIA

³ McCleery Inquiry Panel (2006). Executive Summary and Recommendations from the report of the Inquiry Panel (McCleery) to the Eastern Health and Social Services Board, Belfast, DHSSPS

⁴ Department of Health, Social Services and Public Safety (2007). The Quality Standards for Health and Social Care. Belfast, DHSSPS

Hyrkäs, K., Appelqvist-Schmidlechner, K. and Haataja, R. (2006). Efficacy of clinical Supervision: Influence on job satisfaction, burnout and quality of care. *Journal of Advanced Nursing*.55(4), 521-535
http://www.nipec.hscni.net/download/projects/current_work/highstandards_practice/framework_for_Supervision_in_nursing_and_miwifery/documents/Supervision-in-Nursing-in-NI-Review-of-Current-Processes.pdf

Chief Nursing Officer for Northern Ireland (2007) *Standards for Supervision for Nursing*. Belfast, DHSSPS

- 1.3 Other outcomes were : a Regional Policy and Procedure document, a [Frequently Asked Questions Leaflet](#) ; standardised record keeping resources including contracts for supervisors and supervisees; a regional approach to the preparation of supervisors and supervisees.

A Supervision Regional Forum was charged with directing and supporting the implementation of the Standards. This was facilitated by Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC). The Standard Statements were revised as follows:-

Standard Statement 1 *Supervision will contribute to the delivery of safe and effective care when practitioners have access to appropriate systems that facilitate the development of knowledge and competence through a culture of learning by reflection.*

Standard Statement 2 *An organisational framework supporting effective leadership and performance management will ensure that Supervision will become an effective tool to improve the safety and quality of care.*

- 1.4 NIPEC annually evaluates Supervision process and perceived impact on practice. Each Trust receives a confidential report. The Chief Nursing Officer (CNO) monitors Trust compliance with the Standards through annual reports from each HSC Trust's Executive Director of Nursing (EDoN).

- 1.5 In June 2016 the CNO and Central Nursing and Midwifery Advisory Committee (CNMAC) agreed to the development of a single regional overarching Nursing and Midwifery Supervision Framework. The new model must provide professional accountability assurances to the CNO, Executive Directors of Nursing and the public. NIPEC is facilitating this development and has reviewed the current Supervision processes. It had been hoped the Framework would be completed by 2017, however work, although near completion, is ongoing. Progress can be tracked via the following link:

http://www.nipec.hscni.net/download/projects/current_work/highstandards_practice/framework_for_Supervision_in_nursing_and_miwifery/documents/Supervision-in-Nursing-in-NI-Review-of-Current-Processes.pdf

As an interim measure, the previously agreed Regional Nursing Supervision Policy (SHSCT) has been reviewed and revised here-in.

2.0 Aim of the Policy

This policy identifies Supervision in Nursing as a key organisational objective for all Health and Social Care (HCS) Trusts in Northern Ireland. The aim of this policy is to ensure that a culture of Nursing Supervision is embedded in the SHSCT and that the processes through which Supervision is carried out are integral to the organisational

arrangements for delivery of safe and effective care in the Trust.

- 2.1** The implementation of an effective system of Supervision for Nursing will help ensure:-
- The promotion and maintenance of Nursing Care Standards,
 - A competent and skilled workforce,
 - Delivery of safe and effective care; and
 - A supportive professional environment for nursing staff.

- 2.2** Senior management teams in the SHSCT must ensure that appropriate measures are in place to enable Supervision activities for both clinical and non-clinical teams.

3.0 Policy Statement

The SHSCT acknowledges the importance of Nursing Supervision in ensuring the delivery of safe and effective nursing care and the essential role it plays in protecting the public.

The SHSCT stipulates that all nurses it employs should have access to and avail of, a minimum of two Supervision sessions per year. The Trust must ensure there are effective systems in place to support Supervision processes. All supervisors must be supported to acquire the appropriate knowledge and skills to competently undertake this role.

4.0 Definition and Scope of the Policy

The Department of Health, Social Services and Public Safety (DHSSPS) adopted the following definition of Supervision for Nursing following *The Review of Clinical Supervision for Nursing in the HPSS* undertaken by NIPEC in 2006:

'Supervision is defined as a process of professional support and learning, undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance service-user protection, quality and safety', NIPEC 2006⁸

- 4.1** The SHSCT requires all registered nurses to have a minimum of two formal Supervision sessions per year. Registrants are likely to engage in other activities which could also support the Supervision process. The Regional Forum acknowledged that a variety of diverse approaches and activities could be employed in implementing Supervision. Some examples are included in Appendix 2.

⁸ Northern Ireland Practice and Education Council (2007) *The Review of Clinical Supervision for Nursing in the HPSS 2006* on Behalf of the DHSSPS. Belfast, NIPEC.

- 4.2 It should be noted that the scope of Safeguarding Children Supervision differs from Supervision referred to in this Policy. Safeguarding Children is separate from, but complimentary to, other forms of Supervision. Safeguarding Children Supervision provides specialist professional advice, case management and support to staff in their safeguarding of children. This includes children in need of protection; children in need; looked after children and families of concern.

The **Safeguarding Children Nursing Supervision** process includes the assessment of staff performance, professional development in relation to safeguarding children and families and quality assurance of practice to ensure compliance with best practice guidelines.

Further information is available via:

- DHSSPS Safeguarding Children Supervision Policy for Nurses (2011).
- <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/safeguarding-children-supervision-policy.pdf>
- *The SHSCT Policy, Procedures and Guidance for Registered Nurses, Midwives and Specialist Community Public Health Nurses on Safeguarding Children and Young People (Revised May 2018)*. This is available on the Trust Intranet and SharePoint
<http://sharepoint.gov/home/Policies%20and%20Procedures/Forms/AllItems.aspx?RootFolder=%2Fgov%2Fhome%2FPolicies%20and%20Procedures%2FPolicies&FolderCTID=0x0120002BE1109E37E47349B3DE6A07F51171ED&View=%7B39B022B7%2DEAF5%2D4CE3%2D8BC9%2D6EE55B567DC4%7D>

4.3 Midwifery Supervision in Northern Ireland

The awaited Framework for the overarching Supervision of Midwifery, Nursing and Safeguarding Children will be introduced on the completion of the CNO-commissioned NIPEC work. Whilst this work is ongoing, Midwifery (as well as Nursing and Safeguarding) Supervision will continue in Northern Ireland.

Northern Ireland has taken forward legislative changes to the Nursing and Midwifery Order 2001 effective from 31st March 2017. Northern Ireland has taken forward legislative changes to the Nursing and Midwifery Order 2001 effective from 31st March 2017. This removed Supervision from its statutory regulation components. Until the review of supervision is completed by NIPEC midwifery supervision will continue in the agreed format as determined by the Midwifery Working group September 2016.

Details of the arrangements from April 2017 until the overarching Supervision of Midwifery, Nursing and Safeguarding Children can be found via the following link:
<https://www.health-ni.gov.uk/articles/changes-midwife-Supervision-uk>

5.0 Supervision and Appraisal

It is important that Supervisors and Supervisees in the SHSCT recognise and differentiate Supervision activity from other processes such as appraisal. Whilst Supervision activity informs and is informed by the Agenda for Change Knowledge and Skills Framework Annual Review Process, neither activity should be substituted for the other, each activity having a different purpose.

6.0 Responsibilities

In the SHSCT there are key individuals in posts with responsibility for ensuring Nursing Supervision is implemented. They are: -

6.1 Chief Executive

The Chief Executive of the SHSCT accepts responsibility and accountability for quality service provision at Trust Board level which includes systems, such as Supervision in Nursing, which support clinical and social care governance.

6.2 Executive Director of Nursing

The Executive Director of Nursing, in conjunction with the Operational Directors in the SHSCT is accountable to the Chief Executive for the implementation and maintenance of Supervision in Nursing. The Executive Director of Nursing presents the Trust Report to both the Trust Board and the Chief Nursing Officer for Northern Ireland on an annual basis. In addition, s/he may act as a supervisor for Assistant Directors and other senior professional roles when appropriate.

6.3 Directors

All Directors have responsibility for ensuring that arrangements are in place within their directorate to evidence compliance with this policy and that resources are available to support Nursing Supervision, monitoring and reporting processes.

6.4 Assistant Director of Nursing Governance

The Assistant Director of Nursing Governance has responsibility to co-ordinate, facilitate, evaluate and maintain a system of Supervision in the Nursing workforce. S/he is accountable to the Executive Director of Nursing and for presenting information relevant to the quantity and quality of SHSCT Supervision activity in governance reports or accountability reviews.

6.5 Operational Assistant Directors

Operational Assistant Directors have responsibility to co-ordinate and facilitate

implementation and maintenance of Supervision for nurses within their individual directorates. They are responsible for agreeing the models of Supervision to be employed within the division/directorate and must ensure appropriate resources are in place to enable nurses to undertake at least two formalised sessions of Supervision annually. They are responsible for monitoring the ongoing level of Supervision activity within individual directorates and will facilitate the Assistant Director of Nursing Governance in collation of reports

6.6 Heads of Service/Nurse Managers/Lead Nurses

Heads of Service/Nurse Managers/Lead Nurses have a responsibility to promote, co-ordinate and facilitate implementation and maintenance of Supervision for nurses within their individual directorates/divisions. They are accountable to the Operational Assistant Director and can act as supervisors for Ward Managers/Team Leaders within their own division/directorate.

6.7 Ward Managers/Team Leaders

Ward Managers/Team Leaders have a responsibility to role-model and facilitate implementation and maintenance of Supervision for nurses within their staff teams. They are accountable to the Heads of Service. They can act as supervisors for other members of staff, either within or outside their own team.

6.8 Supervisors

Supervisors have a responsibility to maintain and develop their own skills and competencies relative to Supervision activity, contribute to the models of learning and to the approaches used. They must seek and undertake Supervision themselves, maintaining records for both their personal Supervision and professional Supervision of others. They must provide at least two formal sessions of Supervision annually for each supervisee, whether group or individual. They must adhere to ground rules identified and conduct Supervision sessions within the principles and process identified in these procedures. They are accountable to their line managers for this activity.

6.9 Supervisees

Supervisees have a responsibility to engage fully in the nursing supervision process, adhering to identified ground rules. They have a responsibility to prepare for, and participate in, a minimum of two formal Supervision sessions per year, keeping accurate records of relevant actions. Activities undertaken between sessions should be used to inform formal Supervision sessions. Supervisees are accountable to their line manager to engage in a minimum of two formal supervision sessions annually.

7.0 Legislative Compliance, Relevant Policies, Procedures

This policy should be read in conjunction with the:-

- Southern Trust Policy, Procedure and Guidance on Record Keeping as outlined in the content and appendices of this document.
- Safeguarding Board for Northern Ireland (SBNI) Regional Core Child Protection Policy and Procedures (2017).
- DHSSPS Safeguarding Children Supervision Policy for Nurses and Midwives (2011) - currently under Regional review

http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/RecordsManagementProcedures_001.pdf

<https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf>

<http://sharepoint.gov/home/NMC1/NMC%20Standards%20for%20Competence/NMC%20Standards%20for%20competence%20for%20Registered%20Nurses.pdf>

<http://sharepoint.gov/home/NMC1/NMC%20Standards%20for%20Competence/NMC%20Standards%20for%20Competence%20for%20Registered%20Midwives.pdf>

<http://revalidation.nmc.org.uk/>

<https://www.health-ni.gov.uk/articles/changes-midwife-Supervision-uk>

<https://www.ombudsman.org.uk/publications/midwifery-Supervision-and-regulation-recommendations-change/current-midwifery-Supervision-and-regulation-nursing-and-midwifery-councils-role>

8.0 Equality and Human Rights Considerations

This policy has been screened for equality implications as required by Section 75, Schedule 9, of the Northern Ireland Act, 1998. Equality Commission for Northern Ireland Guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be targeted at them.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. This policy will therefore not be subject to an Equality Impact Assessment.

This policy has been considered under the terms of the Human Rights Act 1998, and was deemed to be compatible with the European Convention Rights contained in that Act.

- 9.0** This policy will be included in the Trust's Register of Screening Documentation and maintained for inspection whilst it remains in force.

This document can be made available on request in alternative formats, e.g. Braille, disc, audio cassette, and in other languages to meet the needs of those who are not fluent in English.

The SHSCT audit this Policy every two years and make appropriate changes where necessary.

GUIDANCE ON NURSING SUPERVISION

Purpose of Nursing Supervision

The main purpose of Nursing Supervision is to support: -

- Nurses to develop the necessary knowledge, competencies and skills within a role or clinical area, to enhance safe and effective practice and person centeredness;
- Nurses in both clinical and non-clinical roles by providing an opportunity to discuss issues pertinent to the delivery of safe and effective care and / or professional issues;
- Nurses through difficult circumstances such as challenging patient caseloads or difficult interpersonal contact with other team members;
- Nurses to realise personal and professional growth through reflection and facilitation.

Supervision Processes

Frequency of Supervision

Formalised Supervision sessions for nursing staff should take place at least twice per year.

Nursing and Midwifery Mandatory Requirements

The Nursing and Midwifery Council (NMC) has recognised the importance of reflection and subsequent discussion as integral to professional development of nurses and midwives. It has included reflective discussion as a mandatory requirement for Revalidation.

<http://revalidation.nmc.org.uk/>

Nurses can access guidance on reflection and keeping a portfolio with corresponding templates:-

<https://www.nmc.org.uk/globalassets/sitedocuments/revalidation/reflective-discussion-guidance.pdf>

The pre-requisite Reflective Template can be completed by staff in preparation for Supervision:-

<http://revalidation.nmc.org.uk/download-resources/forms-and-templates/>

Preparation for Supervision

Registered nurses should reflect on their own practices as they engage in ongoing learning and development activities in their working environment. This experience should be used to inform the Supervision sessions. There are many ways to reflect on practice and approach supervision-some examples are included in Appendix 2.

In order to benefit from Supervision, nurses should prepare appropriately. Preparation will include becoming familiar with and agreeing to, the Ground Rules for the Supervision session. (Appendix 3) Preparation will also include a review of the current Supervision action plan and reflection on the learning activities that have been undertaken between sessions. A Supervision Preparation template to help structure this process can be found at Appendix 4.

General information and guidance on Nursing Supervision is available in the Health and Social Care Trust (HSC) 'Nursing Supervision Information Leaflet - Frequently Asked Questions (updated 2016).

Issues of Concern

Where an issue of unsafe, unethical or illegal practice is identified, it should be dealt with supportively via appropriate procedures. All parties must be informed of the intention to disclose, before revealing confidential information.

Use of Patient /Client Records

If necessary, patient/client records maybe used for the purposes of Supervision activity. The NMC states that where this happens, principles of access and confidentiality apply, namely:-

- Patients'/clients' health records should only be accessed where necessary;
- The patient/client reserves the right to refuse access to, or limit the information from his/her records; this should be respected.

The SHSCT Records Management Policy¹⁰ and associate procedures should be adhered to.

http://vsrintranet.southerntrust.local/SHSCT/HTML/PandP/documents/RecordsManagementProcedures_001.pdf

The NMC no longer have standalone guidance on record keeping, this has been incorporated into the NMC Code.

<https://www.nmc.org.uk/standards/code/record-keeping>

Recording Supervision

It is essential that written notes of individual sessions are taken, remain confidential and record clearly any agreed actions. Individual sessional notes are the responsibility of the supervisee. The supervisor should, however, keep brief notes and maintain quarterly Sessional Records information which is submitted to the Ward Manager/Team Leader or the appropriate line manager. Copies of the Record of Supervision form can be found in Appendix 5.

Each formalised Supervision session must have a written record signed by both supervisor and supervisee(s).

Storage of Records

The SHSCT Policy for the safe storage of records must be adhered to however, each registrant should also be mindful of his/her professional accountability with regard to the principle of confidentiality of information. Nurses must, therefore, take responsibility for making sure that the system used is managed in such a way that it is appropriately protected to ensure the security of confidential information.

Monitoring and Evaluation

Monitoring and evaluation of Supervision activity are essential to ensure that resources required for professional Supervision are managed effectively. It is also necessary to

monitor the benefit to individual registrants, as the quality of Supervision activities can influence professional and clinical effectiveness.

The SHSCT may seek qualitative information periodically from individual registrants to assist in the ongoing evaluation of Supervision processes.

Individual supervisors must record quarterly the number of sessions they engage in and make these returns available to line managers for collation. This information will, in turn, be collated by directorate managers and communicated to the Assistant Director of Nursing Governance, who is responsible for monitoring Nursing Supervision within the Trust.

Formal Supervision sessions (2 per year) must be recorded on the “*KSF Form for use by NMC Registrants – Part B*” and forwarded to the SHSCT Nursing Revalidation Team at the time of yearly appraisal

Part B of the Annual Personal Development Plan can be found on the Trust Intranet under Knowledge and Skills Framework section – *KSF Form for use of NMC Registrants Only*
http://vsrintranet.southerntrust.local/SHSCT/HTML/KSF/documents/KSFFormforNMCRegistrants_001.docx

Range of Supportive Activities

A range of activities can support Supervision in the Nursing workforce. Whichever activity is used each registrant must ensure he/she has the appropriate skills and competencies required to engage in the activity.

Nurses should use the many learning opportunities within their work environments to reflect on their own practice. These *informal* experiences can be used to inform *formal* Supervision sessions.

Examples of activities which support Supervision can be found in Table 1 – overleaf.

Many activities inform Supervision processes; it should, therefore, be noted that this is not a definitive list of activities, merely examples to guide professional teams.

Table 1: Range of Supportive Activities

Reflective Practice Reflective practice is the process of thinking about your own practice and that of others in a structured way; this leads to new and better ways of working and helps you develop new levels of knowledge and competence. You will learn to think critically about your practice and about what you need to do to improve it and the care you provide. Reflection allows you to describe your experience, think about it, and evaluate the outcomes. This should help you to have new understandings and insights. Reflection is what turns experience into meaningful learning, making sense of the world around you, and building on what is happening. You may also find it helpful to use one of the many reflective tools that have been developed.	Work-Based Learning A work-based learning programme is provided by an education institution, using a negotiated, project-led approach; this is managed by you and provides the best opportunities for learning and professional development in the workplace. Work-based learning acknowledges that everyone learns in different ways. It gives you control over how and when you learn and takes learning out of the classroom into the workplace. The learning is gained through work-related projects. Work-based learning opens your eyes to the fact that you can learn from anything. Work-based learning in multi-professional teams, making full use of modern technology, can produce benefits to you, the organisation and the profession. Successful completion of the programme will provide you with accredited learning and lead to an academic qualification. It is concerned with helping you to bridge the practice/theory gap.	Post Incident Review This happens when an incident has occurred in the workplace that has caused you and/or other members of the healthcare team a level of distress. The incident has usually resulted in a miss or near-miss, where there has or could have been damage to a patient or client. A post-incident review involves the reviewing of specific incidents, either individually or as a team, within a setting that provides emotional support to each person. The incident is analysed with your involvement and the involvement of all team members, using reflection, self-evaluation and/or facilitated learning to establish how the incident happened and how it could be avoided in the future. If you are involved in a post-incident review, it should result in good support from your team members and outcomes and actions for yourself and the team, with possible organisational implications. The final outcome must provide a clear description of risk factors and required action. You should also use the review process to identify personal action plans and required development. This is a learning event for all involved, with the objective of learning to improve practice.
Learning Sets The term refers to a group of people who meet regularly to work and learn together, using a structured format. The learning set can comprise of uni- or multi-professional groups and the focus is on self-directed learning; the participants decide the particular issues to be addressed. This provides you with a confidential forum in which to test issues that concern you, discuss new ideas and help you and the others to challenge working practices in new and creative ways. It is important to set ground rules to deal with issues such as confidentiality. Each member of the group is facilitated and supported by the others in the solving of issues and problems.	Critical Incident Review A critical incident is a significant event or experience that has occurred in your workplace and that you feel has had an impact on you or the people you work with. This could be negative or positive; it could be a personal experience or it could result from observing how other people work. You need to examine the incident through a process of reflection, using an evidence-based approach, to identify lessons to be learned. This could also take place with a group of practitioners working together. This should result in new learning for you and/or the group you are working with and result in a short action plan to bring about improvement in practice.	Group Supervision This is a valuable learning activity as it helps to develop critical thinking and collaborative working and brings about improvements in Nursing practice. Group Supervision needs to be set up within a structured format to ensure that nurses have the required skills and are supported by experienced colleagues.
Supervised Practice for Competency Development This is a negotiated period of supervised practice, with agreed learning and competency outcomes and may be provided for you if you require to develop specific, identified competencies. It is also likely to be arranged for you if you have poor or failing clinical competence in an area of practice. This is a period of practice where you are supervised and monitored by an experienced practitioner. The length of the supervised practice and the required outcome are set before the exercise begins. You are required to work closely with your supervisor throughout the entire period of practice. You will also be assessed at the end of the supervised practice to demonstrate that you have the necessary knowledge and competence.	Preceptorship / Mentoring A mentor is someone who has skills of working with individuals who can provide guidance and support to help you achieve your potential. Your mentor may not be from your own field of practice but should be a person with mentoring experience. Mentoring is achieved through a process of relationship building between yourself and your mentor and takes place over a period of time. The purpose of the mentoring process is to enable you to recognise your own skills and capabilities and maximise the development opportunities available to you.	Opportunistic Experiences Often in the course of a working day there is the opportunity to learn from other people or situations in which you might find yourself participating. These experiences are not planned but provide us with a rich learning ground. Examples of these could be: a medicine round where you learn about a new drug regimen; a community patient visit with a tissue viability nurse; discussing the difficulties a palliative patient in your care is experiencing with a colleague; supporting a colleague who has experienced challenging behaviour from a client. All of these situations provide learning which we often reflect on without recording. It is important to make a brief note of the learning provided by these experiences as it can inform other more formal processes in the future.

GROUND RULES FOR 1:1 SUPERVISION	
Prior to Supervision session the SUPERVISEE will have: -	
• Read all relevant/associated policies, procedures and guidance • Prepared for the session and will have considered and identified practice areas for open discussion • Undertaken relevant action(s) as agreed at previous Supervision session(s)	
During each Supervision session both SUPERVISOR and SUPERVISEE will: -	
• Maintain mutual respect • Have an attitude of open learning • Maintain strict confidentiality • Be open to constructive feedback • Engage in reflective practice • Deal appropriately with areas of disagreement according to the Ground Rules • Ensure that identified unsafe, unethical or illegal practice is dealt with supportively via appropriate procedures • All parties must be informed of the intention to disclose, before revealing confidential information • Explore the supervisee's expectations appropriately using appropriate knowledge, skills and experience	
At the end of the Supervision session both SUPERVISOR and SUPERVISEE will: -	
Agree a suitable time and venue for the next session	
After the session the SUPERVISEE will: -	
• Engage in learning and development activities that will inform subsequent Supervision sessions • Record and reflect on significant activities using a portfolio approach • Evaluate the perceived benefit of the session • Maintain and store records in line with Trust Policy	
After the session the SUPERVISOR will: -	
• Complete the Trust's Sessional form(s) • Maintain and store records in line with Trust policy • Provide the supervisee with a copy of the session if not already provided • Evaluate the perceived benefit of the session to the supervisee	

GROUND RULES FOR GROUP SUPERVISION

Prior to Supervision session the SUPERVISEES will have: -

- Read all relevant/associated policies, procedures and guidance
- Prepared for the session and will have considered and identified practice areas for open discussion
- Undertaken relevant action(s) as agreed at previous Supervision session(s)

During each Supervision session both SUPERVISOR and SUPERVISEES will: -

- Be sensitive to the needs of individuals and the overall dynamics within the group
- Maintain strict confidentiality by not disclosing or discussing information provided by any other members of a group
- Be supportive of other members of the group
- Listen to and allow other members of the group to speak
- Maintain mutual respect
- Have an attitude of open learning
- Be open to constructive feedback
- Engage in reflective practice
- Deal appropriately with areas of disagreement according to the ground rules
- Ensure that identified unsafe, unethical or illegal practice is dealt with supportively via appropriate procedures
- All parties must be informed of the intention to disclose, before revealing confidential information
- Explore the supervisee's expectations appropriately using appropriate knowledge, skills and experience

At the end of the Supervision session both SUPERVISOR and SUPERVISEES will: -

Agree a suitable time and venue for the next session

After the session the SUPERVISEES will: -

- Engage in learning and development activities that will inform subsequent Supervision sessions
- Record and reflect on significant activities using a portfolio approach
- Evaluate the perceived benefit of the session
- Maintain and store records in line with Trust policy

After the session the SUPERVISOR will: -

- Complete the Trust's Sessional form(s)
- Maintain and store records in line with Trust policy
- Provide the supervisees with a copy of the session if not already provided
- Evaluate the perceived benefit of the session to the supervisees

PREPARATION FOR SUPERVISION

NAME _____

DATE ____ / ____ / ____ **VENUE** _____ **TIME** from ____ to ____

Agreed actions from previous session	Progress on action points
Reflection on Learning from previous session	
Issues to be brought forward and discussed at the next meeting	

Date / /

Venue _____

Time from _____ to _____

*Southern Health and Social Care Trust
Nursing Supervision Policy V3 July 2018*

RECORD OF GROUP SUPERVISION

Date ____ / ____ / ____ Venue _____ Time from ____ to ____

SUPERVISEES	SIGNATURE
SUPERVISOR(S)	SIGNATURE

Review of Action Points from Previous Supervision Session**Issue / Topic for Discussion**

Agreed Action Plan for Supervisor (if applicable)		
Actions	Timescale	
If a significant issue requires onward reporting, record below outline of issues for onward reporting, to who and when it will be reported		
Issue	Report to	Timescale
Issues / areas of disagreement		
Date and Time of Next Session		
Date	Time	
Session Evaluation		

Copy to supervisee Date ____/____/____

Agreed Action Plan for Supervisees		
Actions	Timescale	
Agreed Action Plan for Supervisor (if applicable)		
Actions	Timescale	
If a significant issue requires onward reporting, record below outline of issues for onward reporting, to who and when it will be reported Issues / area of disagreement		
Issue	Report to	Timescale
Issues / areas of disagreement		
Date and Time of Next Session		
Date		Time
Session Evaluation		

Copy to supervisees ☐ Date ____/____/____



CODE OF CONDUCT FOR HSC EMPLOYEES



SEPTEMBER 2016

HSC Code of Conduct for Employees

This Code of Conduct is about the values for which we, as HSC staff, stand. The Code sets out the core standards of conduct expected of all HSC Staff. It has been written to complement existing professional codes of practice.

Professional staff are expected to follow the code of conduct for their own professions as well as this code.

The code aims:

- To guide staff, managers and employers in the work that they do and the decisions and choices they have to make; and
- To reassure the public that these important decisions are being made against a background of professional standards and accountability.

Adherence to the Code is mandatory for all employees, regardless of their status and breaches of the Code will be regarded as serious.

HSC staff are highly principled and value-driven people who will welcome this Code and exemplify the expected behaviours. All staff within HSC are responsible for, and have a duty of care, to ensure their conduct does not fall below the standards detailed in this Code and that no act or omission, within the sphere of their role, harms the safety and well-being of patients/clients and service users and their families. The Code is a set of values which should inform development programmes and training for all staff. It should make us all think exactly how we are going to work, how we make the care and safety of patients our first concern and how we respect the public, patients, clients, service users relatives and carers. If, however, the conduct and behaviours of staff falls short of the public's expectations this reflects poorly on the HSC as seriously as failures by clinical and care staff.

Breaches of the Code must be investigated fairly and employers should adopt a proportionate approach. Just as the Code sets out how all staff should behave and their responsibilities, you also have rights. You have the right to be treated with respect, evaluated consistently and fairly, encouraged to maintain and improve your knowledge and skills and to be helped to balance your work and home lives properly. HSC Employers must provide and promote an organisational culture which values and supports staff and teams.

This Code of Conduct applies to **all** HSC Staff, across all HSC Trusts and HSC Arms Length Bodies. This code incorporates the principles contained within the Code of Conduct for HPSS Managers 2003 and supersedes it.

This Code is also consistent with the 7 principles of public life, ('the Nolan Principles') which applies to everyone working as a public office-holder and therefore should govern the conduct of all health and social care staff.¹

¹ <https://www.gov.uk/government/publications/the-7-principles-of-public-life>

1. INTRODUCTION

This Code of Conduct (the Code) sets out the standards of conduct expected of all staff in the Southern Health and Social Care Trust.

It presents the standards of conduct and behaviours required of all staff and informs employers, colleagues, patients/clients service users and the public about these.

The Code refers to “employees”, however, for the purposes of this document, this definition also applies to all workers (Agency & Bank), volunteers and work placements.

Adherence to the Code is an integral part of employees’ contractual responsibilities during their employment with the Southern HSC Trust.

- The behaviour of employees should reflect the organisation’s mission and values at all times.
- Employees must not use their privileged position to neglect, harm, abuse or exploit patients/clients/service users or their families.
- Employees should familiarise themselves with the contents of the Code and should act in accordance with the principles set out in it.

1.1 Overall principles & undertakings

As an HSC employee, I will observe the following principles:

- make the **care and safety of patients and clients** my first concern and act to protect them from risk;
- contribute to improving and protecting the health of the population as appropriate to my role;
- maintain **confidentiality**, respecting and protecting, at all times patients/clients, service users and their families’ right to confidentiality, privacy and dignity;
- **communicate openly and honestly** to promote the health and well-being of patients/clients, service users and their families.

- **respect** the public, patients, clients, relatives, carers, HSC employees and teams and partners in other agencies. I will also **show my commitment** to working constructively as a team member by working collaboratively with all my colleagues in the HSC and the wider community;
- **be accountable** and accept **responsibility** for my own work and be **honest and act with integrity**;
- sharing **responsibility for my own learning and development** in order to improve the quality of care to patients/ clients/service users and their families

Managers' Responsibilities

I will also endeavour to ensure that;

- HSC staff in my team are:
 - valued as individuals, colleagues and are treated with dignity and respect;
 - appropriately informed about the management of the HSC;
 - given appropriate opportunities to take part in continuous design, review and improvement of services;
 - have their ideas and realistic ambitions taken seriously;
 - given protection from harassment and bullying;
 - provided with a safe working environment;
 - helped to maintain and improve their knowledge and skills and developed to achieve their potential; and
 - helped to achieve a reasonable balance between their working and personal lives.

These principles are described in more detail in *Section 2* below.

2. DESCRIPTION OF PRINCIPLES

2.1 Care & safety of patients & clients

I will;

- use the resources available to me in an effective, efficient and timely manner having proper regard to the best interests of the public, patients and clients;
- be guided by the interests of patients and clients;
- ensure a safe working environment;
- act to protect patients and clients from risk by adhering to relevant legislation and putting into practice appropriate policies and procedures;
- work collaboratively with colleagues across all disciplines to support person-centred care/services.

2.2 Confidentiality

I will;

- respect patient, client and staff confidentiality;
- not, except in the performance my job role and duties with the organisation, divulge to any person in any manner whatsoever, any confidential information covering the business or transactions of the organisation and its activities and/or its patients, clients or employees², unless ordered to do so by a Court or Tribunal. I will make every effort to prevent disclosure of such information. I will not use social media to share information about the environment I work in or the patients/clients/service users for whom I care.
- comply with all relevant organisation policies in relation to the use of information associated with my role and in particular with reference to the personal use of social networking sites³.

²[Code of Practice on Protecting the Confidentiality of Service User Information](#)

³[Social Media Policy](#)

- comply with my obligations under the Data Protection Act (1998) and Freedom of Information Act (2000) through the Organisation's information governance training.⁴

2.3 Respect for others & working as a team

I will;

- respect and treat with dignity and fairness, the public, patients and clients, relatives, carers, HSC employees and partners in other agencies. I will not unlawfully discriminate against, victimise or harass against anyone on grounds of their gender, marital/civil partnership status, sexual orientation, community background, political opinion, religious belief, race, age disability, family status, whether or not they have dependents or are persons who have undergone, are undergoing or intend to undergo gender reassignment.
- seek to ensure that anyone with a genuine concern is treated reasonably and fairly
- show my commitment to working as part of the department and Organisation team

I will show my commitment to team working by working constructively with all my colleagues across the HSC and in the wider community, contributing to an environment in which:

- teams of staff are able to work together in the best interests of service users; and
- leadership is encouraged and developed at all levels and in all staff groups

2.4 Accountability, Responsibility, Honesty & Integrity

I will;

- establish and maintain clear and appropriate boundaries at all times in my relationships with patients/clients/service users and their families, and with colleagues, always behaving in a professional manner;

⁴ [Data Protection Policy](#)

- accept responsibility for my own work and ensure that I am responsible for answering any questions and complaints in an open, honest way.
- be honest and act with integrity and probity at all times and ensure that HSC resources are protected from fraud, bribery and other forms of corruption⁵
- not use my official position to receive, agree to accept or attempt to obtain any financial or other advantage for doing, or not doing, anything or showing favour, or disfavour, to any person⁶.
- not receive benefits of any kind from a third party which might reasonably be seen to compromise my personal judgment and integrity.
- not deceive or mislead my employer, or any other organisation it deals with, or the public during the course of my employment with the HSC.
- abide by the rules adopted by my employer in relation to private interest and possible conflict with public duty, the disclosure of official information and in any political activities.
- not misuse my official position or information acquired in my official duties to further my private interests or those of others.

I will ensure proper management of the performance of my team and I will seek to ensure that those I manage accept that they are responsible for their actions to both;

- the public and their representatives; and
- service users, relatives and carers by answering questions and complaints in an open and honest manner.

I will also;

- accept responsibility for the management of the performance of the people I manage;
- seek to ensure that judgements about colleagues (including appraisals and references) are consistent, fair and unbiased and include all information which

⁵ [Fraud Policy](#)

⁶ [Gifts, Hospitality & Sponsorship Policy](#), [Conflicts of Interest Policy](#), [Fraud Policy](#), [Bribery Policy](#)

affects a colleague's performance, eligibility for advancement/reward and conduct; and

- play my part in making sure that no-one is unlawfully discriminated against and that policies on equality, diversity and human rights are promoted and adhered to at all times.

2.6. Responsibility for my own learning and development

I will seek to;

- Participate in training and personal development required by my employer and take responsibility for the achievement of the competence essential for your role, in line with KSF and organisational requirements
- Keep up to date with best practice and maintain an up-to-date record of your own learning and development
- Share my learning as appropriate and contribute to the learning and development of others

3. Employee concerns about improper conduct

If you believe you are being required to act in a way which:

- is illegal, improper, or unethical;
- is in breach of a professional code;
- may involve possible maladministration, fraud or misuse of public funds; or
- is otherwise inconsistent with this Code

you should either raise the matter through your line management or alternatively, approach in confidence, a nominated officer under the Trust's Whistleblowing Policy⁷.

You should make yourself aware of the provisions of the Trust's Whistleblowing Policy.

The Chief Executive, who is the designated accounting officer for the Trust, has overall responsibility for propriety in a broad sense, including conduct and discipline.

⁷ [Whistleblowing Policy](#)

I will;

- act to protect service users from harm, injury or loss by identifying and reducing risk by putting into practice the appropriate support, supervisory and disciplinary procedures for staff;
- seek to ensure that anyone with a concern is taken seriously and treated fairly in accordance with relevant procedures; and
- contribute to the creation of an open and learning organisation where concerns about individuals perceived to be breaking the Code of Conduct can be raised without fear

4. AFTER LEAVING EMPLOYMENT

You should continue to observe your duty of confidentiality after you have left your employment with the HSC.

The Code

Professional standards of practice
and behaviour for nurses, midwives
and nursing associates

prioritise people

practise effectively

preserve safety

promote professionalism and trust

About us

The Nursing and Midwifery Council exists to protect the public. We do this by making sure that only those who meet our requirements are allowed to practise as a nurse or midwife in the UK, or a nursing associate in England. We take action if concerns are raised about whether a nurse, midwife or nursing associate is fit to practise.

It is against the law to claim to be, or to practise as, a nurse or midwife in the UK, or as a nursing associate in England, if you are not on the relevant part of our register.

It is also a criminal offence for anyone who, with intent to deceive, causes or permits someone else to falsely represent them as being on the register, or makes a false representation about them being on the NMC register.

Publication date: 29 January 2015

Effective from: 31 March 2015

Updated to reflect the regulation of nursing associates:
10 October 2018

A note on this version of the Code

All regulators review their Codes from time to time to make sure they continue to reflect public expectations. This new version of the Code is substantially similar to the 2015 version, but it has been updated to reflect our new responsibilities for the regulation of nursing associates. In joining the register, nursing associates will uphold the Code.

The current versions of our Code, standards and guidance can always be found on our website. Those on our register should make sure they are using the most up to date version of the Code.

For more information about the Code, please visit:

www.nmc.org.uk/code

Nursing and Midwifery Council

Introduction

The Code contains the professional standards that registered nurses, midwives and nursing associates¹ must uphold. Nurses, midwives and nursing associates must act in line with the Code, whether they are providing direct care to individuals, groups or communities or bringing their professional knowledge to bear on nursing² and midwifery practice in other roles, such as leadership, education, or research. The values and principles set out in the Code can be applied in a range of different practice settings, but they are not negotiable or discretionary.

Our role is to set the standards in the Code, but these are not just our standards. They are the standards that patients and members of the public tell us they expect from health professionals. They are the standards shown every day by those on our register.

When joining our register, and then renewing their registration, nurses, midwives and nursing associates commit to upholding these standards. This commitment to professional standards is fundamental to being part of a profession. We can take action if those on our register fail to uphold the Code. In serious cases, this can include removing them from the register.

- 1. Anyone practising as a registered nurse or midwife in the UK, or a nursing associate in England, has to be registered with us. The nursing associate role is being used only in England.*
- 2. We have used the word 'nursing' in this document to apply to the work of nurses and nursing associates. Nursing associates are a distinct profession with their own part of our register, but they are part of the nursing team.*

The Code sets out common standards of conduct and behaviour for those on our register. This provides a clear, consistent and positive message to patients, service users and colleagues about what they can expect of those who provide nursing or midwifery care.

The professions we regulate have different knowledge and skills, set out in three distinct standards of proficiency. They can work in diverse contexts and have different levels of autonomy and responsibility. However, all of the professions we regulate exercise professional judgement and are accountable for their work.

Nurses, midwives and nursing associates uphold the Code within the limits of their competence. This means, for example, that while a nurse and nursing associate will play different roles in an aspect of care, they will both uphold the standards in the Code within the contribution they make to overall care. The professional commitment to work within one's competence is a key underpinning principle of the Code (see section 13) which, given the significance of its impact on public protection, should be upheld at all times.

In addition, nurses, midwives and nursing associates are expected to work within the limits of their competence, which may extend beyond the standards they demonstrated in order to join the register.

The Code should be useful for everyone who cares about good nursing and midwifery.

- Patients and service users, and those who care for them, can use it to provide feedback to nurses, midwives and nursing associates about the care they receive.
- Those on our register can use it to promote safe and effective practice in their place of work.
- Employer organisations should support their staff in upholding the standards in their professional Code as part of providing the quality and safety expected by service users and regulators.
- Educators can use the Code to help students understand what it means to be a registered professional and how keeping to the Code helps to achieve that.

For the many committed and expert practitioners on our register, this Code should be seen as a way of reinforcing professionalism. Through revalidation, nurses, midwives and nursing associates provide evidence of their continued ability to practise safely and effectively. The Code is central to the revalidation process as a focus for professional reflection. This gives the Code significance in the professional life of those on our register, and raises its status and importance for employers.

The Code contains a series of statements that taken together signify what good practice by nurses, midwives and nursing associates looks like. It puts the interests of patients and service users first, is safe and effective, and promotes trust through professionalism.

Prioritise people

You put the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.

1 Treat people as individuals and uphold their dignity

To achieve this, you must:

- 1.1 treat people with kindness, respect and compassion
- 1.2 make sure you deliver the fundamentals of care effectively
- 1.3 avoid making assumptions and recognise diversity and individual choice
- 1.4 make sure that any treatment, assistance or care for which you are responsible is delivered without undue delay
- 1.5 respect and uphold people's human rights

2 Listen to people and respond to their preferences and concerns

To achieve this, you must:

- 2.1 work in partnership with people to make sure you deliver care effectively
- 2.2 recognise and respect the contribution that people can make to their own health and wellbeing

The fundamentals of care include, but are not limited to, nutrition, hydration, bladder and bowel care, physical handling and making sure that those receiving care are kept in clean and hygienic conditions. It includes making sure that those receiving care have adequate access to nutrition and hydration, and making sure that you provide help to those who are not able to feed themselves or drink fluid unaided.

- 2.3 encourage and empower people to share in decisions about their treatment and care
- 2.4 respect the level to which people receiving care want to be involved in decisions about their own health, wellbeing and care
- 2.5 respect, support and document a person's right to accept or refuse care and treatment
- 2.6 recognise when people are anxious or in distress and respond compassionately and politely

3 Make sure that people's physical, social and psychological needs are assessed and responded to

To achieve this, you must:

- 3.1 pay special attention to promoting wellbeing, preventing ill-health and meeting the changing health and care needs of people during all life stages
- 3.2 recognise and respond compassionately to the needs of those who are in the last few days and hours of life
- 3.3 act in partnership with those receiving care, helping them to access relevant health and social care, information and support when they need it
- 3.4 act as an advocate for the vulnerable, challenging poor practice and discriminatory attitudes and behaviour relating to their care

4 Act in the best interests of people at all times

To achieve this, you must:

- 4.1 balance the need to act in the best interests of people at all times with the requirement to respect a person's right to accept or refuse treatment
- 4.2 make sure that you get properly informed consent and document it before carrying out any action

- 4.3 keep to all relevant laws about mental capacity that apply in the country in which you are practising, and make sure that the rights and best interests of those who lack capacity are still at the centre of the decision-making process
- 4.4 tell colleagues, your manager and the person receiving care if you have a conscientious objection to a particular procedure and arrange for a suitably qualified colleague to take over responsibility for that person's care

5 Respect people's right to privacy and confidentiality

As a nurse, midwife or nursing associate, you owe a duty of confidentiality to all those who are receiving care. This includes making sure that they are informed about their care and that information about them is shared appropriately.

To achieve this, you must:

- 5.1 respect a person's right to privacy in all aspects of their care
- 5.2 make sure that people are informed about how and why information is used and shared by those who will be providing care
- 5.3 respect that a person's right to privacy and confidentiality continues after they have died
- 5.4 share necessary information with other health and care professionals and agencies only when the interests of patient safety and public protection override the need for confidentiality
- 5.5 share with people, their families and their carers, as far as the law allows, the information they want or need to know about their health, care and ongoing treatment sensitively and in a way they can understand

You can only make a 'conscientious objection' in limited circumstances. For more information, please visit our website at www.nmc.org.uk/standards.

Practise effectively

You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative care) without too much delay, to the best of your abilities, on the basis of best available evidence. You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.

6 Always practise in line with the best available evidence

To achieve this, you must:

- 6.1 make sure that any information or advice given is evidence-based including information relating to using any health and care products or services
- 6.2 maintain the knowledge and skills you need for safe and effective practice

7 Communicate clearly

To achieve this, you must:

- 7.1 use terms that people in your care, colleagues and the public can understand
- 7.2 take reasonable steps to meet people's language and communication needs, providing, wherever possible, assistance to those who need help to communicate their own or other people's needs
- 7.3 use a range of verbal and non-verbal communication methods, and consider cultural sensitivities, to better understand and respond to people's personal and health needs
- 7.4 check people's understanding from time to time to keep misunderstanding or mistakes to a minimum
- 7.5 be able to communicate clearly and effectively in English

8 Work co-operatively

To achieve this, you must:

- 8.1 respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate
- 8.2 maintain effective communication with colleagues
- 8.3 keep colleagues informed when you are sharing the care of individuals with other health and care professionals and staff
- 8.4 work with colleagues to evaluate the quality of your work and that of the team
- 8.5 work with colleagues to preserve the safety of those receiving care
- 8.6 share information to identify and reduce risk
- 8.7 be supportive of colleagues who are encountering health or performance problems. However, this support must never compromise or be at the expense of patient or public safety

9 Share your skills, knowledge and experience for the benefit of people receiving care and your colleagues

To achieve this, you must:

- 9.1 provide honest, accurate and constructive feedback to colleagues
- 9.2 gather and reflect on feedback from a variety of sources, using it to improve your practice and performance
- 9.3 deal with differences of professional opinion with colleagues by discussion and informed debate, respecting their views and opinions and behaving in a professional way at all times
- 9.4 support students' and colleagues' learning to help them develop their professional competence and confidence

10 Keep clear and accurate records relevant to your practice

This applies to the records that are relevant to your scope of practice. It includes but is not limited to patient records.

To achieve this, you must:

- 10.1 complete records at the time or as soon as possible after an event, recording if the notes are written some time after the event
- 10.2 identify any risks or problems that have arisen and the steps taken to deal with them, so that colleagues who use the records have all the information they need
- 10.3 complete records accurately and without any falsification, taking immediate and appropriate action if you become aware that someone has not kept to these requirements
- 10.4 attribute any entries you make in any paper or electronic records to yourself, making sure they are clearly written, dated and timed, and do not include unnecessary abbreviations, jargon or speculation
- 10.5 take all steps to make sure that records are kept securely
- 10.6 collect, treat and store all data and research findings appropriately

11 Be accountable for your decisions to delegate tasks and duties to other people

To achieve this, you must:

- 11.1 only delegate tasks and duties that are within the other person's scope of competence, making sure that they fully understand your instructions
- 11.2 make sure that everyone you delegate tasks to is adequately supervised and supported so they can provide safe and compassionate care
- 11.3 confirm that the outcome of any task you have delegated to someone else meets the required standard

12 Have in place an indemnity arrangement which provides appropriate cover for any practice you take on as a nurse, midwife or nursing associate in the United Kingdom

To achieve this, you must:

- 12.1 make sure that you have an appropriate indemnity arrangement in place relevant to your scope of practice

For more information, please visit our website at

www.nmc.org.uk/indemnity.

Preserve safety

You make sure that patient and public safety is not affected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

13 Recognise and work within the limits of your competence

To achieve this, you must, as appropriate:

- 13.1 accurately identify, observe and assess signs of normal or worsening physical and mental health in the person receiving care
- 13.2 make a timely referral to another practitioner when any action, care or treatment is required
- 13.3 ask for help from a suitably qualified and experienced professional to carry out any action or procedure that is beyond the limits of your competence
- 13.4 take account of your own personal safety as well as the safety of people in your care
- 13.5 complete the necessary training before carrying out a new role

14 Be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place

To achieve this, you must:

- 14.1 act immediately to put right the situation if someone has suffered actual harm for any reason or an incident has happened which had the potential for harm.

- 14.2 explain fully and promptly what has happened, including the likely effects, and apologise to the person affected and, where appropriate, their advocate, family or carers
- 14.3 document all these events formally and take further action (escalate) if appropriate so they can be dealt with quickly

15 Always offer help if an emergency arises in your practice setting or anywhere else

To achieve this, you must:

- 15.1 only act in an emergency within the limits of your knowledge and competence
- 15.2 arrange, wherever possible, for emergency care to be accessed and provided promptly
- 15.3 take account of your own safety, the safety of others and the availability of other options for providing care

16 Act without delay if you believe that there is a risk to patient safety or public protection

To achieve this, you must:

- 16.1 raise and, if necessary, escalate any concerns you may have about patient or public safety, or the level of care people are receiving in your workplace or any other health and care setting and use the channels available to you in line with our guidance and your local working practices
- 16.2 raise your concerns immediately if you are being asked to practise beyond your role, experience and training

The professional duty of candour is about openness and honesty when things go wrong. "Every healthcare professional must be open and honest with patients when something goes wrong with their treatment or care which causes, or has the potential to cause, harm or distress." Joint statement from the Chief Executives of statutory regulators of healthcare professionals

- 16.3 tell someone in authority at the first reasonable opportunity if you experience problems that may prevent you working within the Code or other national standards, taking prompt action to tackle the causes of concern if you can
- 16.4 acknowledge and act on all concerns raised to you, investigating, escalating or dealing with those concerns where it is appropriate for you to do so
- 16.5 not obstruct, intimidate, victimise or in any way hinder a colleague, member of staff, person you care for or member of the public who wants to raise a concern
- 16.6 protect anyone you have management responsibility for from any harm, detriment, victimisation or unwarranted treatment after a concern is raised

For more information, please visit our website at www.nmc.org.uk/raisingconcerns.

17 Raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection

To achieve this, you must:

- 17.1 take all reasonable steps to protect people who are vulnerable or at risk from harm, neglect or abuse
- 17.2 share information if you believe someone may be at risk of harm, in line with the laws relating to the disclosure of information
- 17.3 have knowledge of and keep to the relevant laws and policies about protecting and caring for vulnerable people

18 Advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations

To achieve this, you must:

- 18.1 prescribe, advise on, or provide medicines or treatment, including repeat prescriptions (only if you are suitably qualified) if you have enough knowledge of that person's health and are satisfied that the medicines or treatment serve that person's health needs
- 18.2 keep to appropriate guidelines when giving advice on using controlled drugs and recording the prescribing, supply, dispensing or administration of controlled drugs
- 18.3 make sure that the care or treatment you advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving, including (where possible) over-the-counter medicines
- 18.4 take all steps to keep medicines stored securely
- 18.5 wherever possible, avoid prescribing for yourself or for anyone with whom you have a close personal relationship

Prescribing is not within the scope of practice of everyone on our register. Nursing associates don't prescribe, but they may supply, dispense and administer medicines. Nurses and midwives who have successfully completed a further qualification in prescribing and recorded it on our register are the only people on our register that can prescribe.

For more information, please visit our website at www.nmc.org.uk/standards.

19 Be aware of, and reduce as far as possible, any potential for harm associated with your practice

To achieve this, you must:

- 19.1 take measures to reduce as far as possible, the likelihood of mistakes, near misses, harm and the effect of harm if it takes place
- 19.2 take account of current evidence, knowledge and developments in reducing mistakes and the effect of them and the impact of human factors and system failures (see the note below)
- 19.3 keep to and promote recommended practice in relation to controlling and preventing infection
- 19.4 take all reasonable personal precautions necessary to avoid any potential health risks to colleagues, people receiving care and the public

Human factors refer to environmental, organisational and job factors, and human and individual characteristics, which influence behaviour at work in a way which can affect health and safety – Health and Safety Executive. You can find more information at www.hse.gov.uk.

Promote professionalism and trust

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the professions from patients, people receiving care, other health and care professionals and the public.

20 Uphold the reputation of your profession at all times

To achieve this, you must:

- 20.1 keep to and uphold the standards and values set out in the Code
- 20.2 act with honesty and integrity at all times, treating people fairly and without discrimination, bullying or harassment
- 20.3 be aware at all times of how your behaviour can affect and influence the behaviour of other people
- 20.4 keep to the laws of the country in which you are practising
- 20.5 treat people in a way that does not take advantage of their vulnerability or cause them upset or distress
- 20.6 stay objective and have clear professional boundaries at all times with people in your care (including those who have been in your care in the past), their families and carers
- 20.7 make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way

- 20.8 act as a role model of professional behaviour for students and newly qualified nurses, midwives and nursing associates to aspire to
- 20.9 maintain the level of health you need to carry out your professional role
- 20.10 use all forms of spoken, written and digital communication (including social media and networking sites) responsibly, respecting the right to privacy of others at all times

For more guidance on using social media and networking sites, please visit our website at www.nmc.org.uk/standards.

21 Uphold your position as a registered nurse, midwife or nursing associate

To achieve this, you must:

- 21.1 refuse all but the most trivial gifts, favours or hospitality as accepting them could be interpreted as an attempt to gain preferential treatment
- 21.2 never ask for or accept loans from anyone in your care or anyone close to them
- 21.3 act with honesty and integrity in any financial dealings you have with everyone you have a professional relationship with, including people in your care
- 21.4 make sure that any advertisements, publications or published material you produce or have produced for your professional services are accurate, responsible, ethical, do not mislead or exploit vulnerabilities and accurately reflect your relevant skills, experience and qualifications
- 21.5 never use your status as a registered professional to promote causes that are not related to health
- 21.6 cooperate with the media only when it is appropriate to do so, and then always protecting the confidentiality and dignity of people receiving treatment or care

22 Fulfil all registration requirements

To achieve this, you must:

- 22.1 keep to any reasonable requests so we can oversee the registration process
- 22.2 keep to our prescribed hours of practice and carry out continuing professional development activities
- 22.3 keep your knowledge and skills up to date, taking part in appropriate and regular learning and professional development activities that aim to maintain and develop your competence and improve your performance

For more information, please visit our website at

www.nmc.org.uk/standards.

23 Cooperate with all investigations and audits

This includes investigations or audits either against you or relating to others, whether individuals or organisations. It also includes cooperating with requests to act as a witness in any hearing that forms part of an investigation, even after you have left the register.

To achieve this, you must:

- 23.1 cooperate with any audits of training records, registration records or other relevant audits that we may want to carry out to make sure you are still fit to practise
- 23.2 tell both us and any employers as soon as you can about any caution or charge against you, or if you have received a conditional discharge in relation to, or have been found guilty of, a criminal offence (other than a protected caution or conviction)
- 23.3 tell any employers you work for if you have had your practice restricted or had any other conditions imposed on you by us or any other relevant body.

- 23.4 tell us and your employers at the first reasonable opportunity if you are or have been disciplined by any regulatory or licensing organisation, including those who operate outside of the professional health and care environment
- 23.5 give your NMC Pin when any reasonable request for it is made

For more information, please visit our website at www.nmc.org.uk.

24 Respond to any complaints made against you professionally

To achieve this, you must:

- 24.1 never allow someone's complaint to affect the care that is provided to them
- 24.2 use all complaints as a form of feedback and an opportunity for reflection and learning to improve practice

When telling your employers, this includes telling (i) any person, body or organisation you are employed by, or intend to be employed by, as a nurse, midwife or nursing associate; and (ii) any person, body or organisation with whom you have an arrangement to provide services as a nurse, midwife or nursing associate.

25 Provide leadership to make sure people's wellbeing is protected and to improve their experiences of the health and care system

To achieve this, you must:

- 25.1 identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first
- 25.2 support any staff you may be responsible for to follow the Code at all times. They must have the knowledge, skills and competence for safe practice; and understand how to raise any concerns linked to any circumstances where the Code has, or could be, broken

Throughout their career, all our registrants will have opportunities to demonstrate leadership qualities, regardless of whether or not they occupy formal leadership positions.

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www.nmc.org.uk

The nursing and midwifery regulator for England,
Wales, Scotland and Northern Ireland

Registered charity in England and Wales (1091434)
and in Scotland (SC038362)

Appendix 19-

[Code of conduct - GMC \(gmc-uk.org\)](http://gmc-uk.org)

Appendix 20- Cancer Tracking Guidelines for Urology



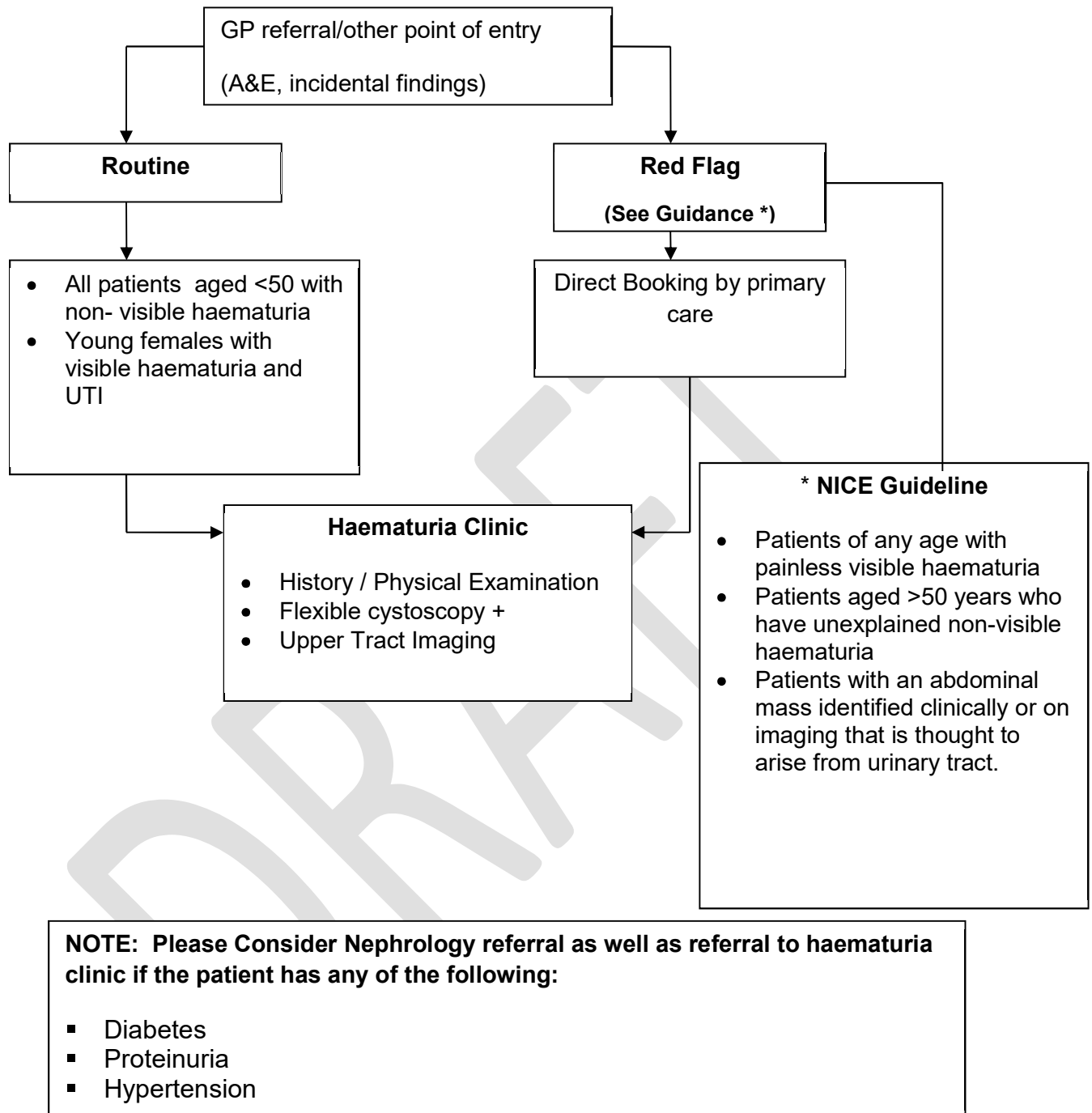


Urology Care Pathways

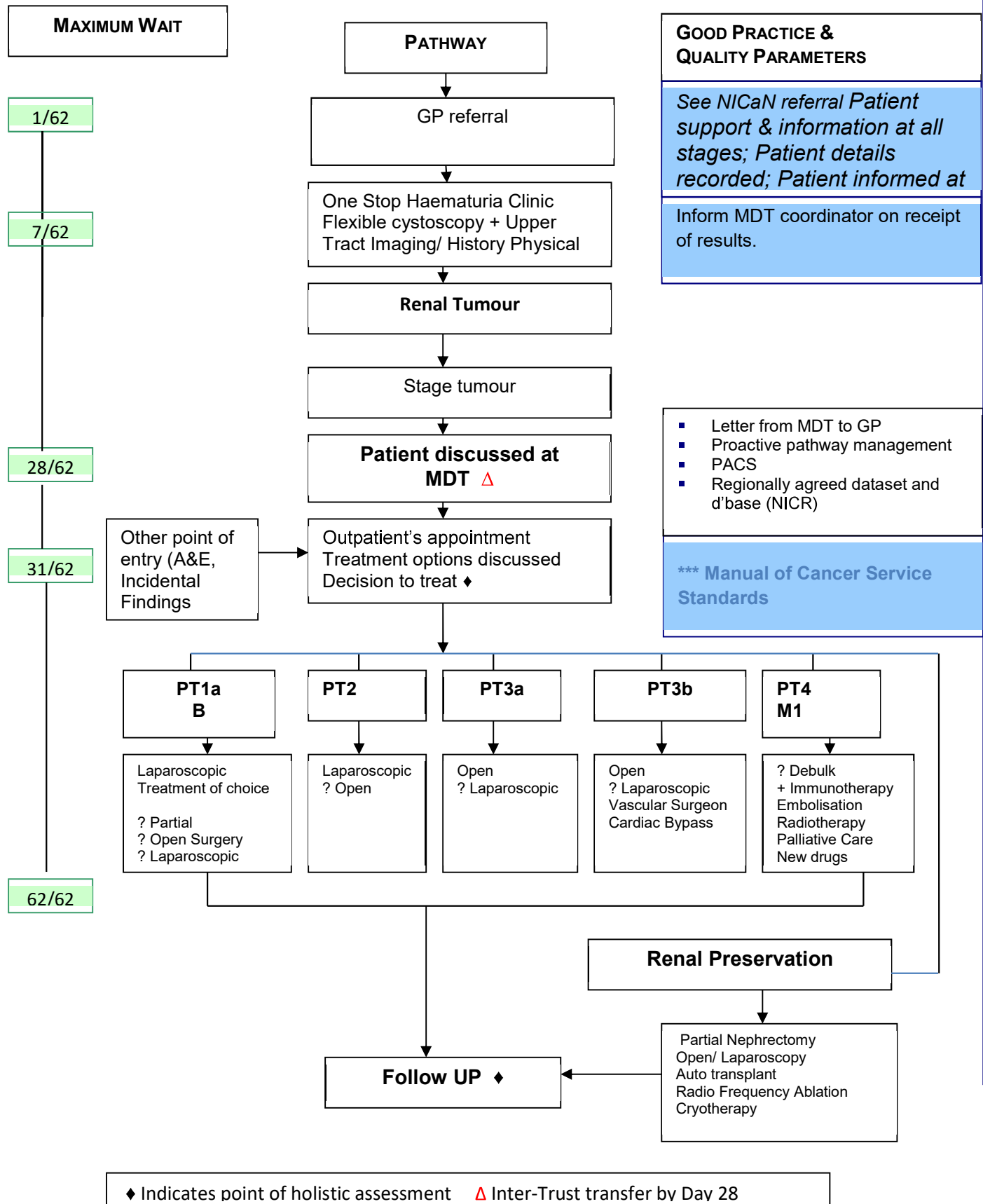
Cancer Care Pathways outline the steps and stages in the patient journey from referral through to diagnostics, staging, treatment, follow up, rehabilitation and if applicable onto palliative care.

Timed effective care pathways are central to delivering quality and timely care to patients throughout their cancer journey and to the delivery of an equitable service. These pathways have been developed following with reference to available best practice guidance. They represent an 'ideal' pathway that can be adapted for local use. The timelines on the pathway are intended to facilitate the proactive management of patients within the access standards and it is to be noted that for some urological tumours, the patient will move much quicker through the pathway (e.g. testicular cancer).

Haematuria Referral Guideline



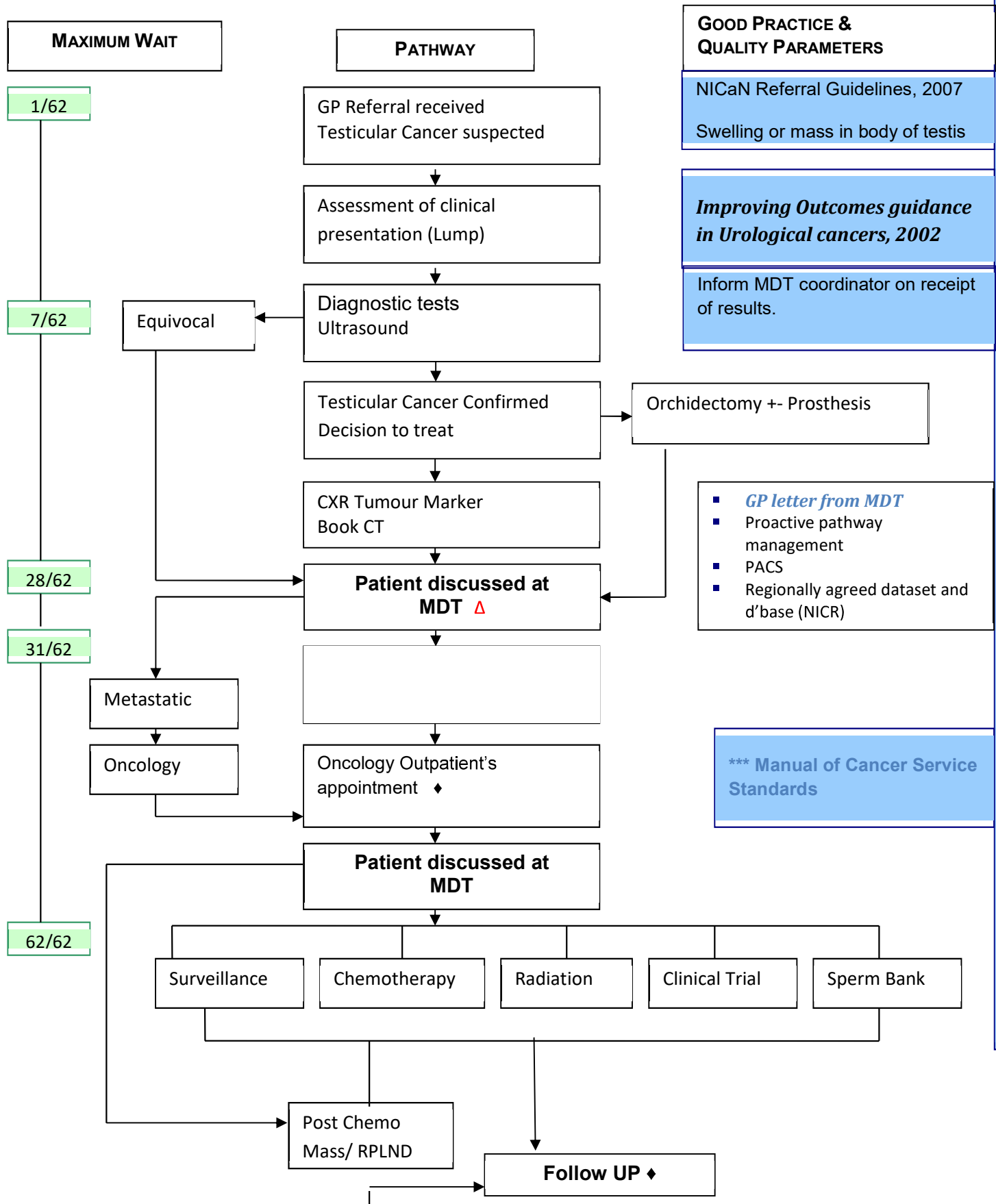
Renal Tumour



Patient support & information at all stages; Patient details recorded; Patient informed at appropriate points *****NICE

Testicular Cancer Pathway

Patient support & information at all stages; Patient details recorded; Patient informed at appropriate points *****NICE

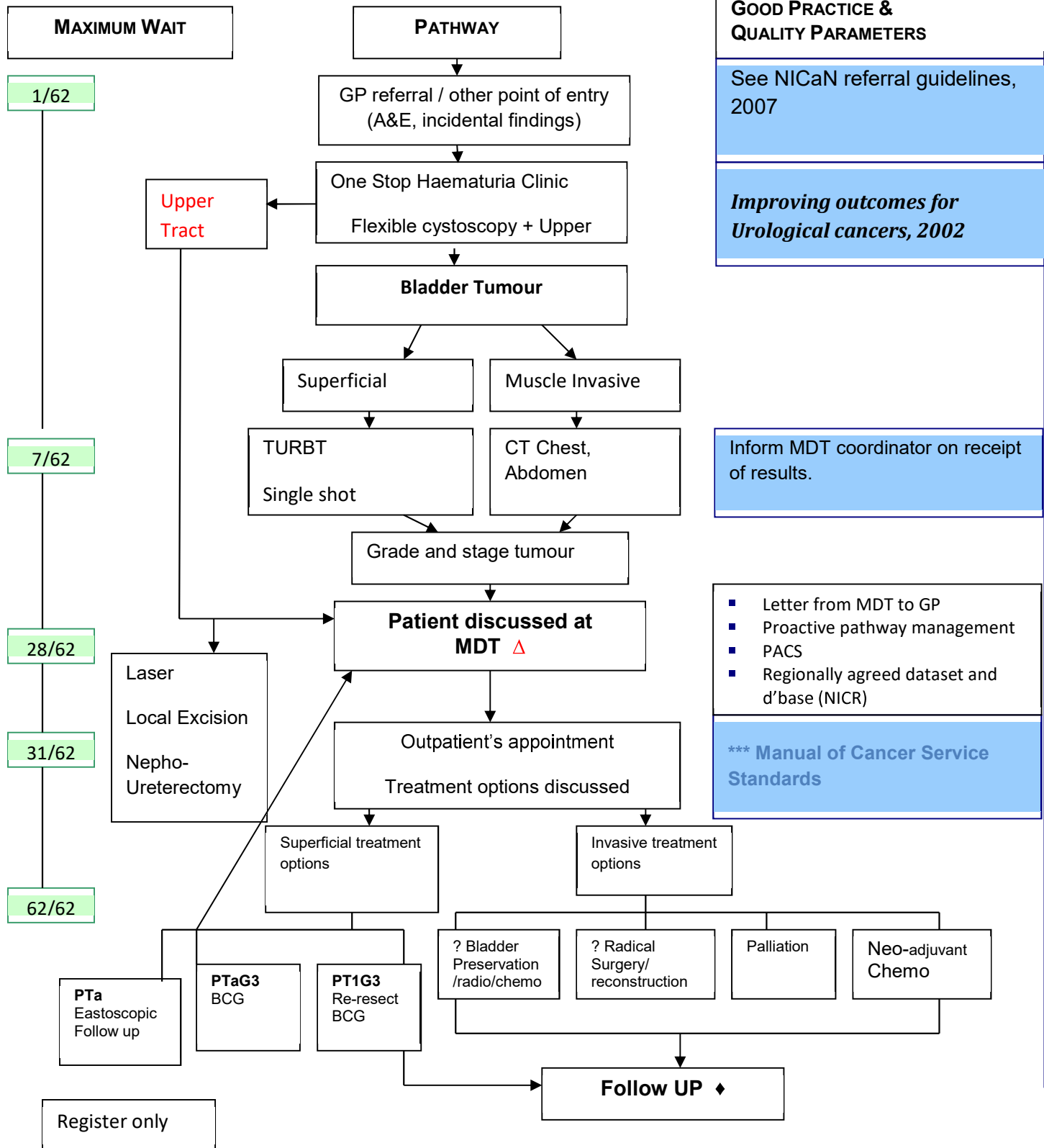


♦ Indicates point of holistic assessment Δ Inter-Trust transfer by Day 28

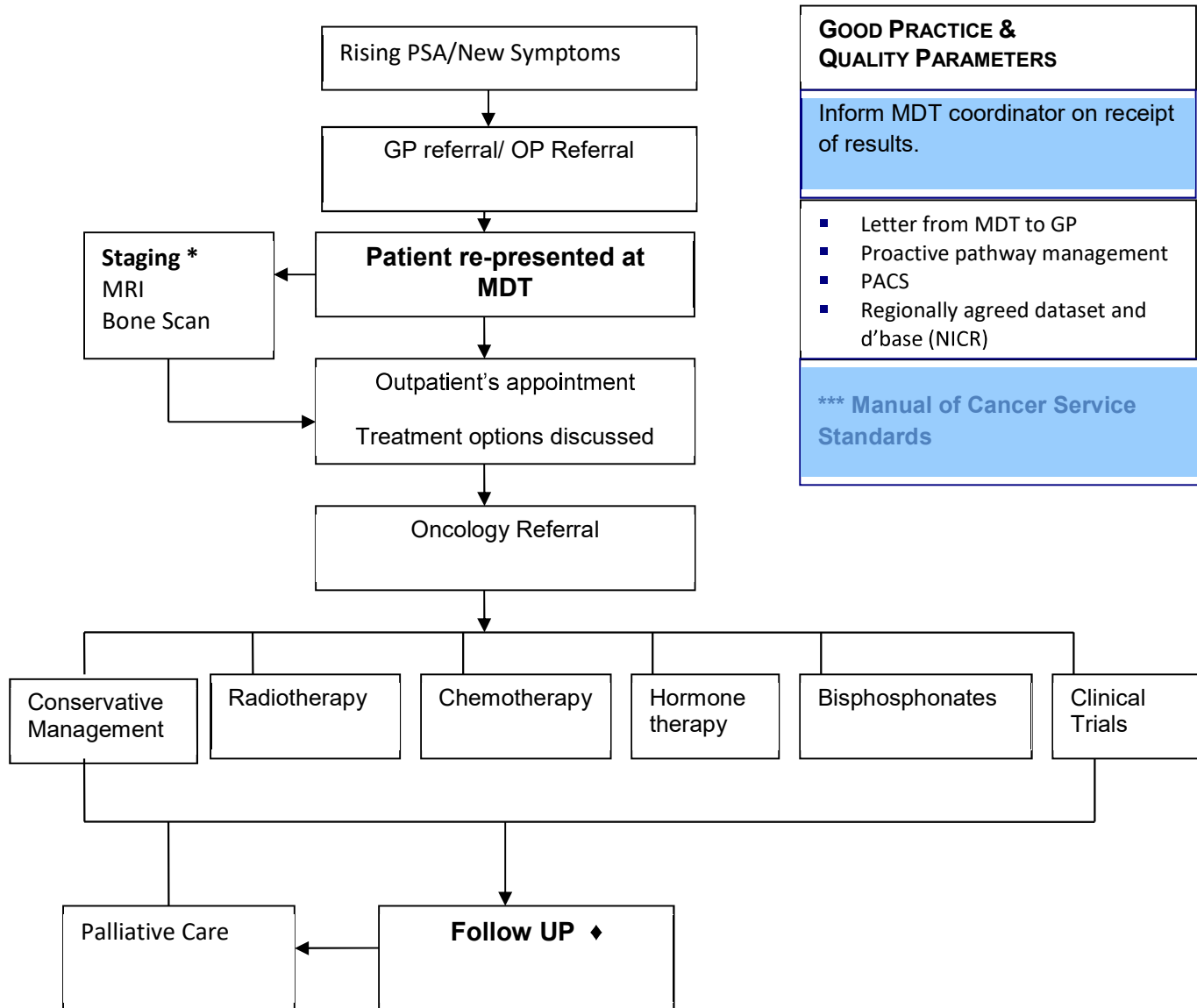
Appendix 3 of NICA Urology Cancer Clinical Guidelines

Patient support & information at all stages; Patient details recorded; Patient informed at appropriate points *****NICE

♦ Indicates point of holistic assessment ▲ Inter-Trust transfer by Day 28



Castration Resistant Prostate Cancer

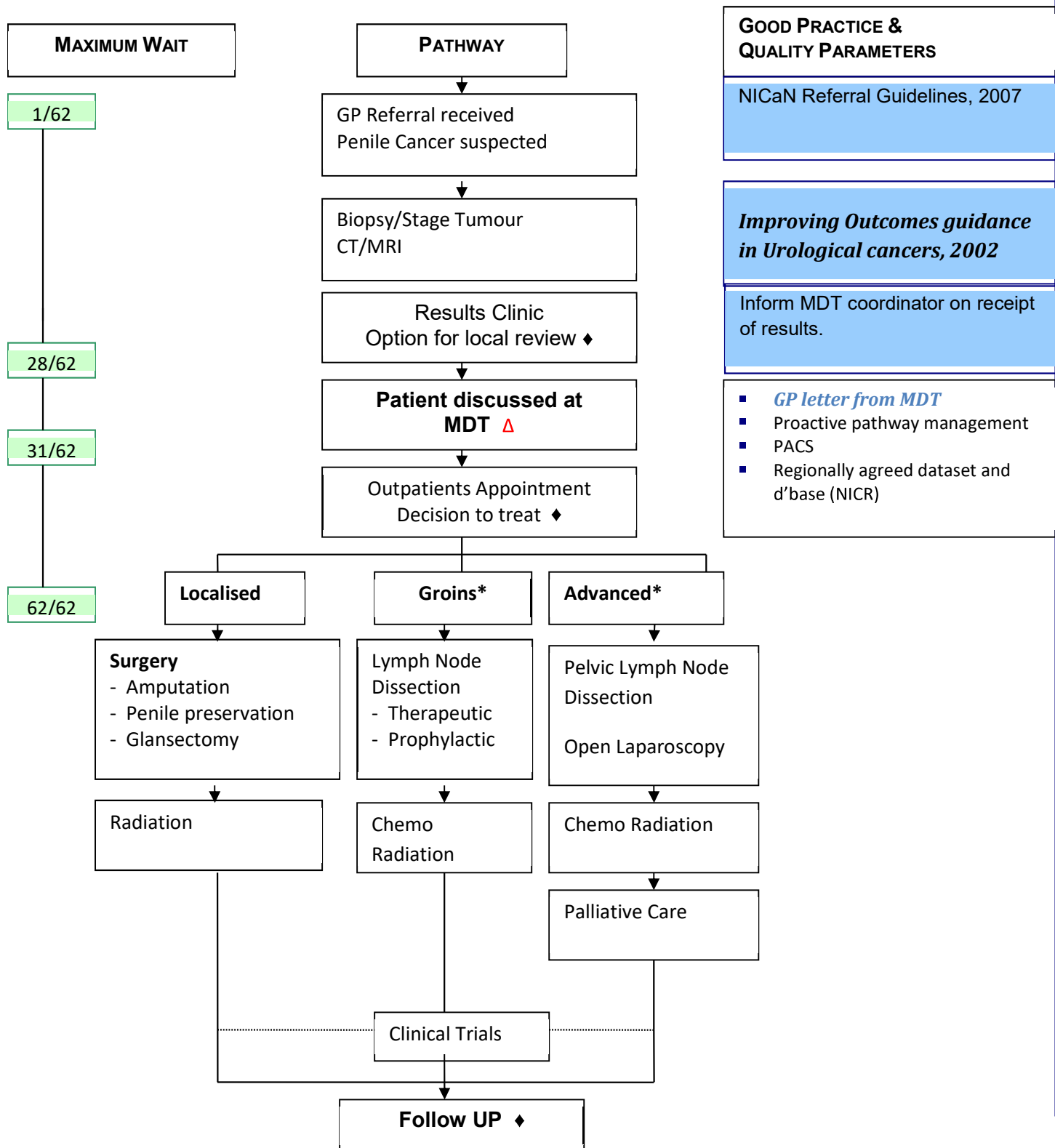


Patient support & information at all stages; Patient details recorded; Patient informed at appropriate points *****NICE

* MRI/Bone Scan as clinically indicated

Penile Cancer Pathway (Currently Under Review as part of development of local penile service 2019)

Patient support & information at all stages; Patient details recorded; Patient informed at appropriate points *****NICE



♦ Indicates point of holistic assessment ▲ Inter-Trust transfer by Day 28

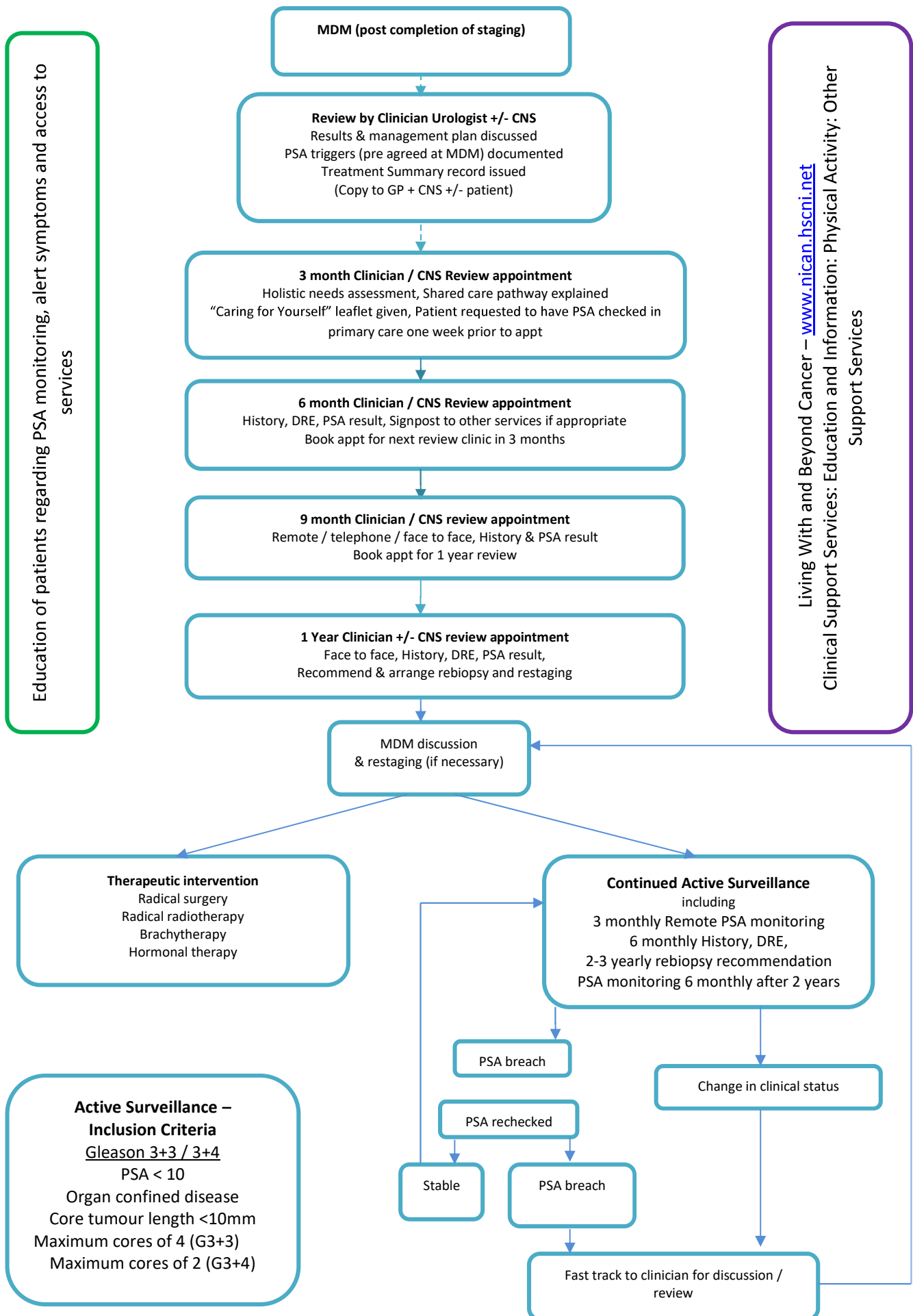
Trust Logo

Policy Code / Reference No:

Appendix 3 of NICA Urology Cancer Clinical Guidelines

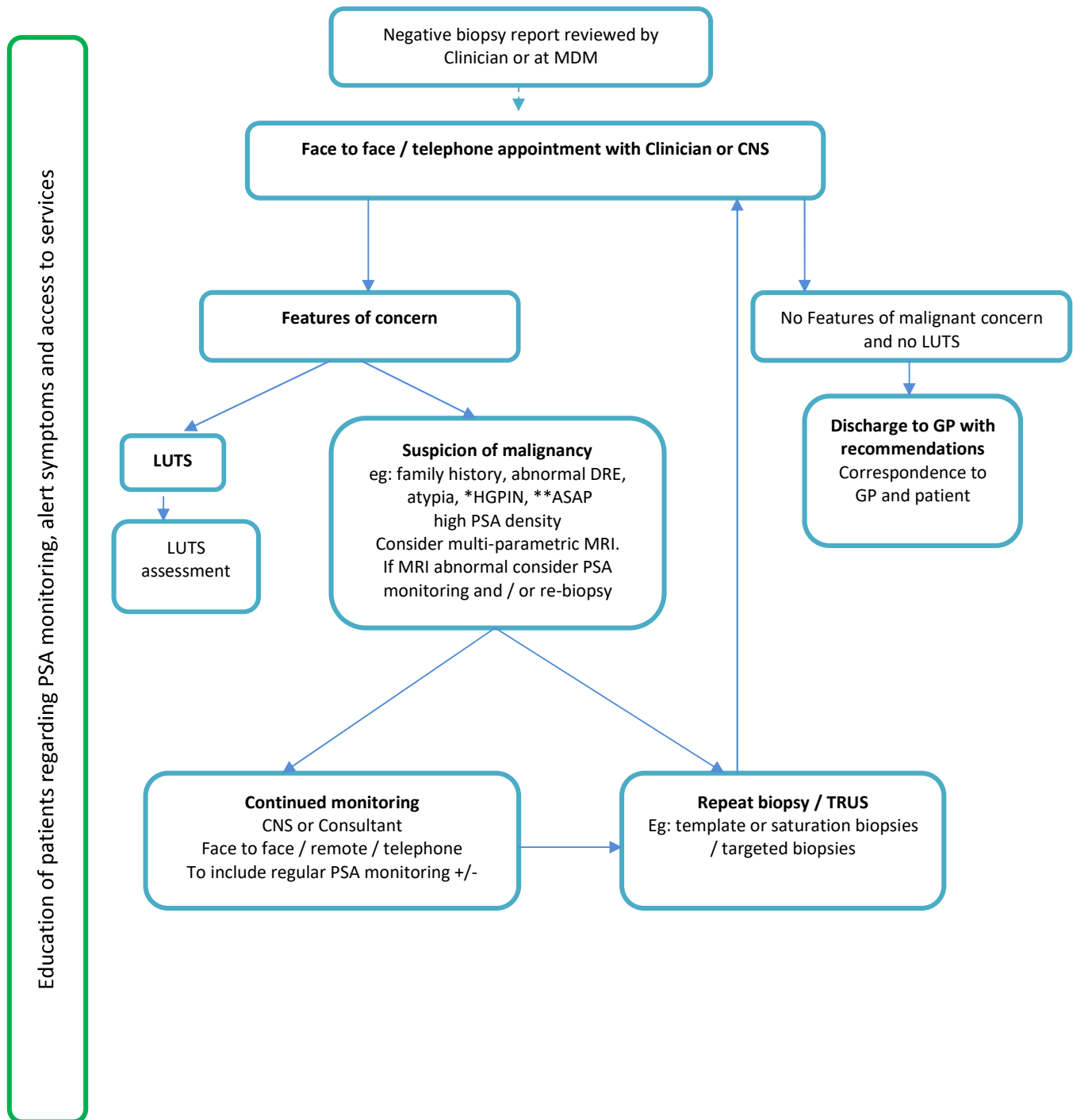
Pathway 2

Prostate Cancer: Active Surveillance



Pathway 3

Raised PSA & Negative Biopsy

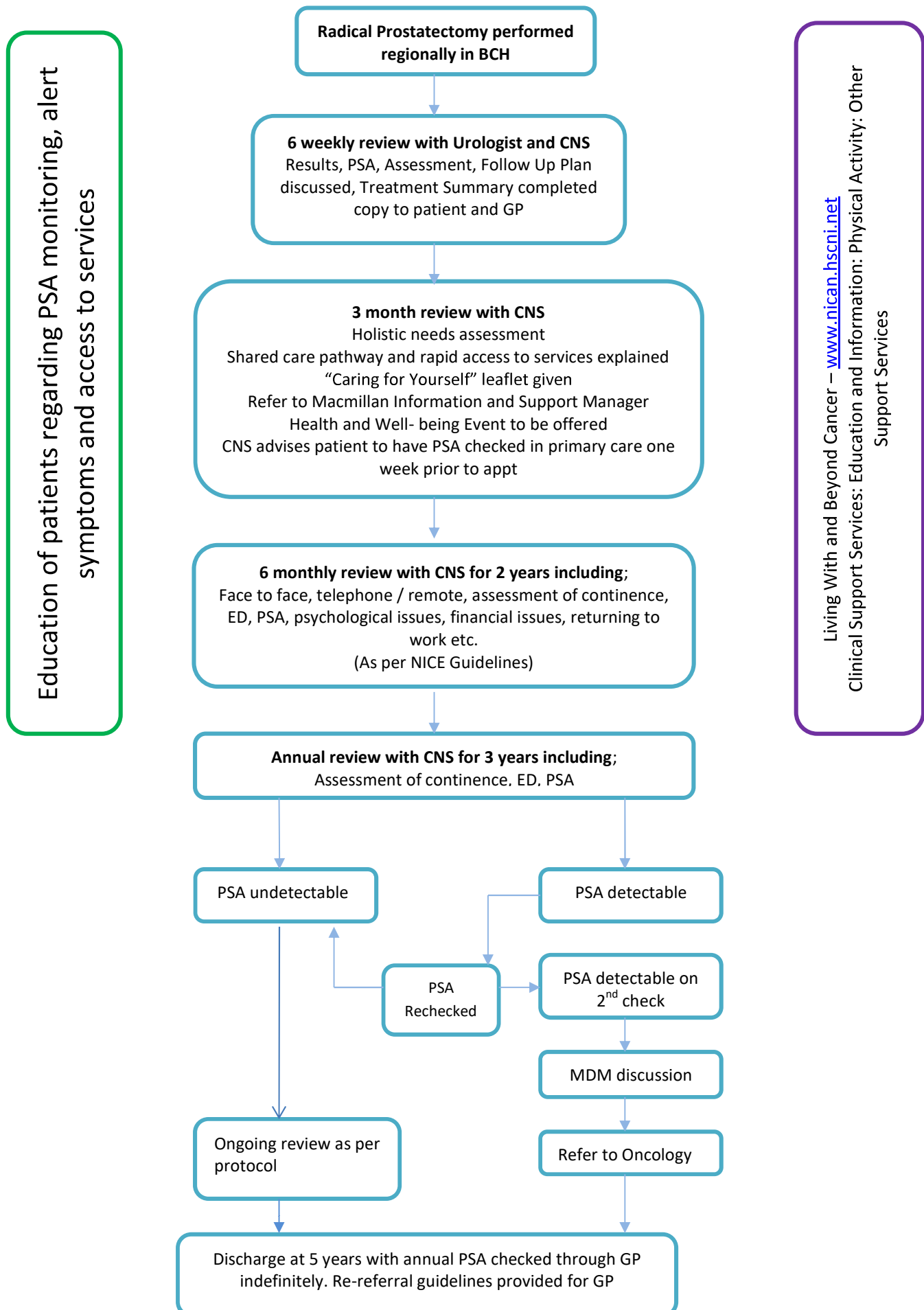


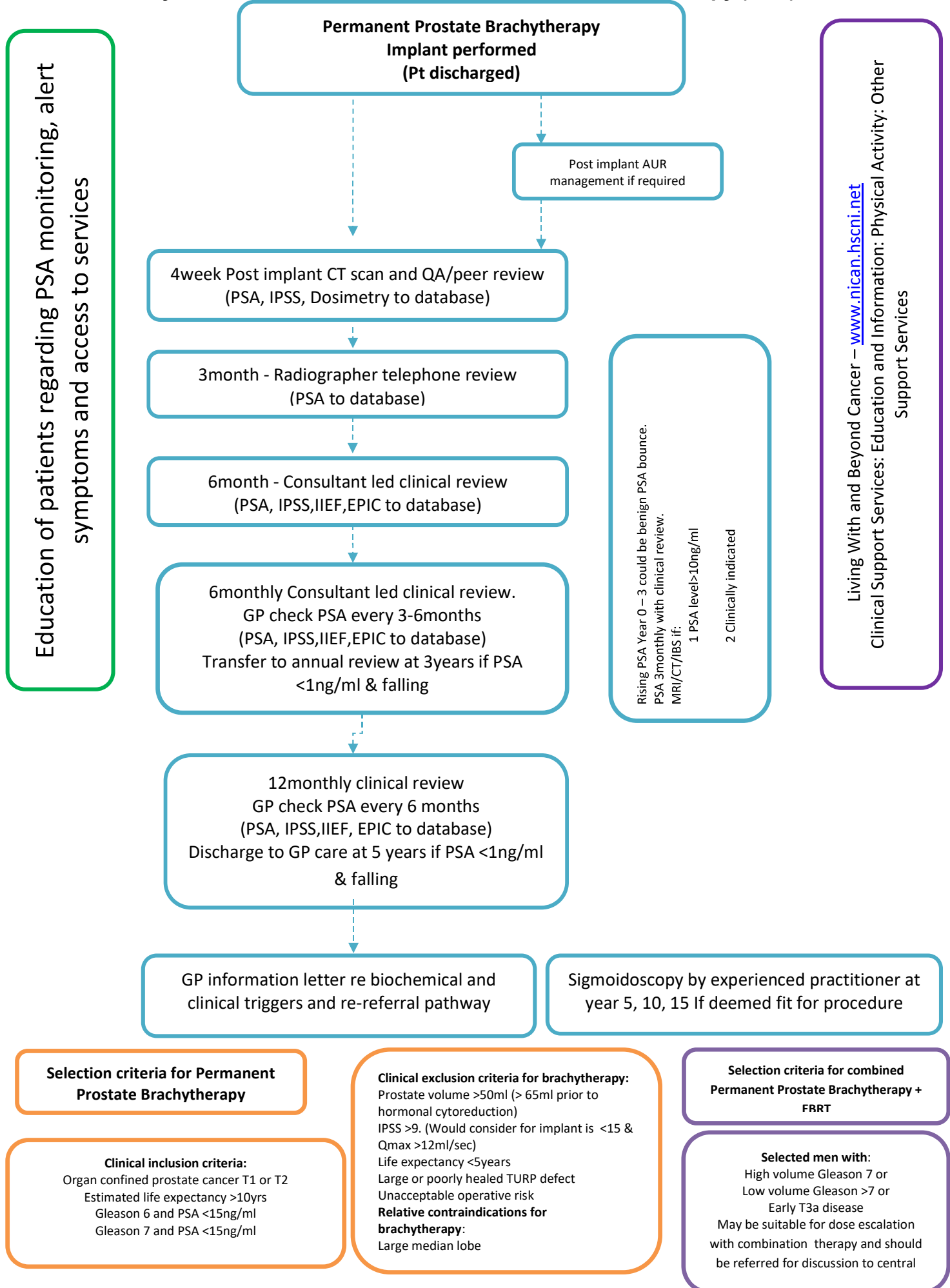
*HGPIN – High grade prostatic intra-epithelial neoplasia

**ASAP – Atypical small acinar proliferation

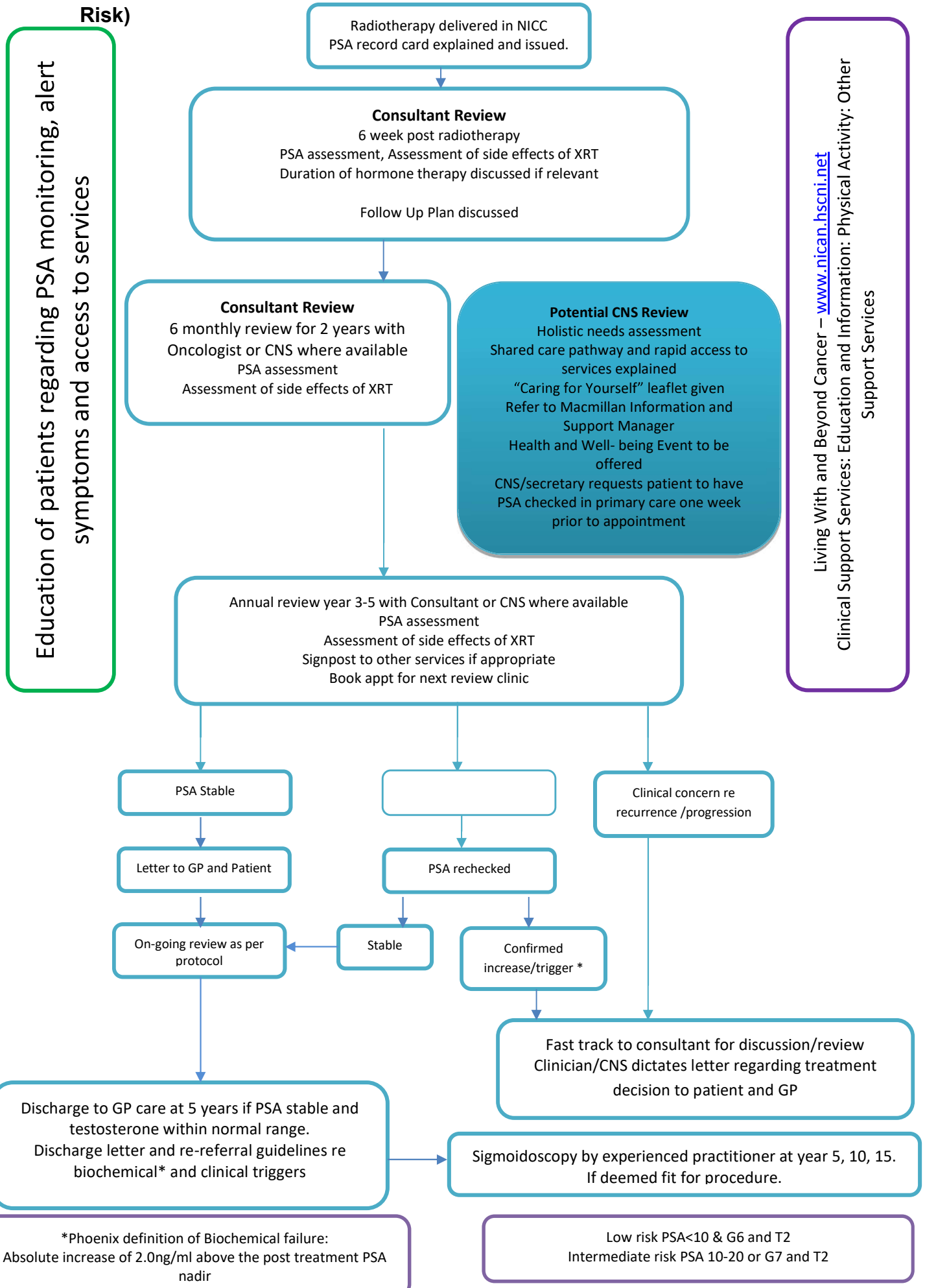
Pathway 4

Prostate Cancer: Radical Surgery – Negative margins



Pathway 5 Prostate Cancer: Permanent Prostate Brachytherapy (LDR)

Appendix 3 of NICA Urology Cancer Clinical Guidelines

Pathway 6: Prostate Cancer: Radiotherapy+/-Hormones (Low Intermediate Risk)

Appendix 21- NiCan Clinical Management Guidelines

Sharepoint link to all tumour site guidance- [Clinical Management Guidelines - Home \(hscni.net\)](https://www.hscni.net/clinical-management-guidelines)

Urology NiCan guidelines- [Urology - All Documents \(hscni.net\)](https://www.hscni.net/urology)

Appendix 22- Key Performance Indicators for Cancer Nurse Specialists from Macmillan

<https://www.macmillan.org.uk/documents/aboutus/commissioners/excellenceincancer/carethecontributionoftheclinicalnursespecialist.pdf>

National Cancer Action Team
Part of the National Cancer Programme



Excellence in Cancer Care: The Contribution of the Clinical Nurse Specialist

**WE ARE
MACMILLAN.**
CANCER SUPPORT

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Foreword



Together we share an ambition to achieve the best cancer outcomes for patients in the UK, recognising that, at a time of tightened budgets, it is critical that NHS resources are deployed to best effect. Now more than ever, clinical nurse specialists (CNSs) have a vital role to play in delivering high quality and compassionate care, including care closer to home, and supporting a drive for efficiency that improves health outcomes and maximises resources.

Cancer CNSs have played an important role in the successful implementation of initiatives to improve NHS cancer services. Despite an increasing incidence of the disease and an ageing population, death rates from many cancers are dropping, survival rates are improving and many patients' experiences of care have been enhanced. CNSs are at the front line of cancer care; they are the main point of contact for patients and as a result help to shape services for each patient according to need and patient choice, which contributes to wider cancer priorities. For example, CNSs play an important role in enabling care to be delivered closer to home and in improving patients' and their families' ability to self-manage symptoms and side-effects of treatment.

CNSs contribute to increasing the quality of care provided by the NHS; indeed, in the face of rising patient expectations, more patients report being treated with dignity and respect and having trust and confidence in their care team. Increasingly, they have an ongoing role in supporting cancer survivors as well as cancer patients. Overall it is estimated that there are now 2 million people living with cancer and this is set to rise to 4 million by 2030.¹

For people affected by cancer, the effective management of their care pathway is

essential to maintain quality of life. People whose care is unplanned and uncoordinated are more likely to be high users of health and social care services, including emergency

care. CNSs work closely with patients and with their clinical colleagues to adapt to patients' emerging needs thus reducing the need for unplanned care.

This short guide is designed to support clinical teams, commissioners, employers and managers to understand and evaluate the contribution of CNSs in cancer as they plan their local workforce and service improvement strategies. With examples drawn from front-line services across a range of cancers, this guide sets out how effective CNS deployment drives innovation, reduces inefficiency and improves the quality of cancer care across the UK.

We still have further to go if we are to improve outcomes for all cancers, with the aim of bringing us in line with the best in Europe. Ensuring provision of CNSs where they are needed, coupled with effective use of their skills and expertise will enable us to move faster towards this goal.

Professor Sir Mike Richards
National Cancer Director

Personal Information redacted by USI

Ciarán Devane
Chief Executive
Macmillan Cancer Support

Personal Information redacted by USI

Dame Christine Beasley DBE
Chief Nursing Officer (England)
Department of Health

Personal Information redacted by USI

The role of the Clinical Nurse Specialist in cancer care

The roles undertaken by Clinical Nurse Specialists (CNSs) are many and varied; however, there are core clinical practice functions and a level of practice that could be reasonably expected of all CNSs in cancer care.

CNSs in cancer care can be described as registered nurses, who have graduate level nursing preparation and who would usually be expected to be prepared at Master's level. They are clinical experts in evidence-based nursing practice within a specialty area. The specialty may be focused on a population (e.g. young people), type of care (e.g. palliative care), type of problem (e.g. lymphoedema), type of treatment (e.g. chemotherapy) or tumour type (e.g. lung cancer).

CNSs treat and manage the health concerns of patients and work to promote health and wellbeing in the patients they care for. CNSs in cancer care practice autonomously and integrate knowledge of cancer and medical treatments into assessment, diagnosis, and treatment of patients' problems and concerns.² Whilst many specialist nurses may function at an advanced level, this level of practice is not common to all, thus the title Clinical Nurse Specialist does not in itself indicate that the nurse is an 'advanced practitioner'.

The high-level activities of CNSs can be separated into four main functions.³ In the context of cancer care these consist of:

- 1 Using and applying technical knowledge of cancer and treatment to oversee and coordinate services, personalise 'the cancer pathway' for individual patients

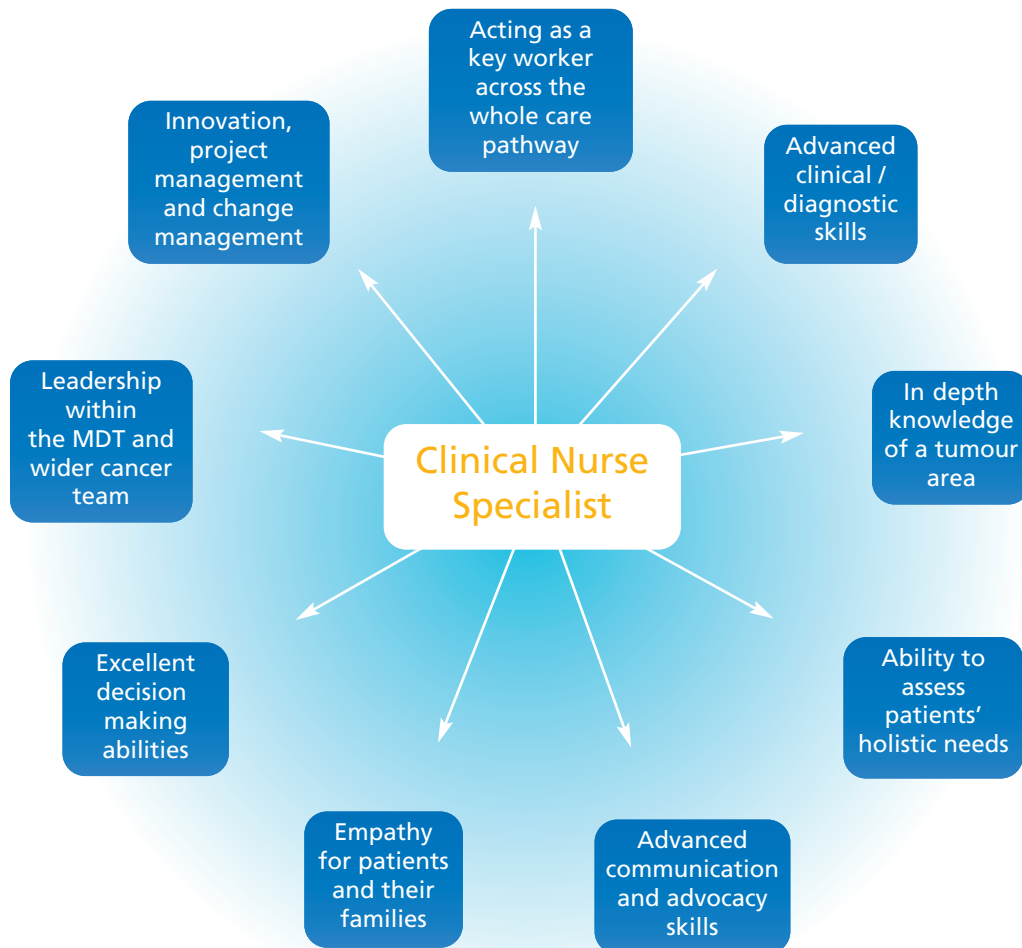
and to meet the complex information and support needs of patients and their families

- 2 Acting as the key accessible professional for the multidisciplinary team, undertaking proactive case management and using clinical acumen to reduce the risk to patients from disease or treatments
- 3 Using empathy, knowledge and experience to assess and alleviate the psychosocial suffering of cancer including referring to other agencies or disciplines as appropriate
- 4 Using technical knowledge and insight from patient experience to lead service redesign in order to implement improvements and make services responsive to patient need

Furthermore, some cancer CNSs have developed their roles to include technical elements, for example: physical examinations and diagnostic tests; and insertion of central venous lines for the delivery of chemotherapy or for nutritional purposes.

Many cancer CNSs work as part of a tumour specific team, whereas others may work across more than one service or setting. Although many are based within acute trusts, post-holders are also located in primary care and community settings or private and voluntary sector organisations. They may be responsible for whole client groups, or for episodes of care and nursing services more widely. They are also typically core members of a multidisciplinary team.⁴

Key contributions that CNSs make to cancer care



The cost of managing cancer

The cost to the NHS in England of patient care for cancer in 2007/8 was £5 billion.⁵ Department of Health figures for 2007-08 showed that:

- Over half (i.e. over £2 billion) of the total expenditure on cancer in England went on inpatient care⁶
- Inpatient care for cancer patients accounted for 12% of all inpatient beds in England⁶
- The number of emergency admissions for cancer increased by 47% in the past 8 years⁶
- 4.7 million bed days were cancer related⁶

Statistics from 2006-07 for England show:

- 417,646 emergency inpatient admissions for cancer representing 2,963,987 bed days⁶
- 339,038 elective inpatient admissions for cancer representing 1,750,223 bed days⁶

Reducing the financial burden of cancer – the potential of the CNS

The specialist nature of the cancer CNS and their role as key worker to individual patients means that they can quickly identify emerging issues that might require medical attention, enabling care to be planned and emergency admissions averted. CNSs also support enhanced recovery after surgery – equipping patients to manage their recovery at home and reducing the need for lengthy hospital stays. These two important contributions help the NHS to improve patient experience and safety.

There are also sound economic arguments for supporting patients to manage their care at home and helping them through the complex systems of health care provision.

The National Audit Office's End of Life Care report estimated £104m savings by reducing emergency admissions by 10 per cent, and reducing the length of stay by 3 days.⁷

An economic modelling analysis by Macmillan Cancer Support in 2009⁸, focusing on the role of the CNS, suggested that service improvements along the cancer pathway could release about 10% of cancer expenditure in the Manchester area. This related only to breast and lung patients admitted through the two week wait system in one health economy. If extrapolated to a national level then the economic benefits could be significant.

CNSs: 'leading quality and productivity in cancer care

Patients rightly expect high quality, effective healthcare and CNSs have an important role to play in meeting their needs and expectations.

The proposed NHS Outcomes Framework⁹ is structured around five high level outcome domains. These are intended to cover everything the NHS is there to do. These five outcome domains are:

- Preventing people from dying prematurely
- Enhancing the quality of life for people with long-term conditions
- Helping people to recover from episodes of ill health or following injury

- Ensuring people have a positive experience of care
- Treating and caring for people in a safe environment and protecting them from avoidable harm

As practitioners and partners at the heart of multidisciplinary teams, CNSs have influence and credibility across the care pathway. They are increasingly taking a leadership role in refining systems and smoothing care pathways, making a demonstrable contribution to effectiveness, patient experience and safety.

Experience from the front line – CNSs transforming cancer care



CNSs across the country are already transforming patients' experiences of cancer care. The following case studies provide a flavour of the kinds of initiatives

that CNSs are leading – highlighting their pivotal role in maximising resource and benefitting patients.

Case Studies



Innovation, project management, change management

Lesley Barnett, Macmillan Lead Cancer Nurse, Doncaster
Gina Wibberley, Macmillan Lung CNS, Lincoln

CNSs in Doncaster and Lincolnshire have implemented rapid alert systems to ensure that they are immediately informed when one of their patients enters hospital with an unplanned admission. Using mobile technology and integrated IT systems, a text message and email is sent to the CNS who can immediately attend the patient or discuss the case with the treating clinicians.

Using their specialist knowledge in lung cancer, and their understanding of individual patients' needs, CNSs in Lincolnshire use this as an opportunity to re-assess the patient's cancer pathway outside of scheduled patient planning, or identify where a quick specialist intervention can turn around an inappropriate admission. The nurses in Doncaster have identified

length-of-stay reductions of one to two days per patient, they work to ensure that the patient is admitted to the correct ward and in some cases prevent admission altogether. Added to these productivity benefits is the increased quality of care experienced by patients who report feeling completely supported, knowing that they are receiving coordinated care.

Empathy for patients and their families

Frances McKay, Macmillan Mesothelioma and Lung CNS, Medway

Frances, and her colleagues Caroline Williams and Pat Cameron, run the only lung cancer and mesothelioma support group in their Cancer Network. Up to 28 people each month attend the group.

The CNSs work in collaboration with a local hospice to facilitate the

monthly group meetings with a hospice volunteer managing the meeting practicalities. A successful buddy system has been established for patients and carers who face the challenging and complex issues of a terminal disease.

The group also enables the CNSs to identify emerging health issues,

including helping patients to self-manage symptoms such as shortness of breath, reducing anxiety and maintaining quality of life. Importantly, the CNSs are able to mediate between patients and hospital services and quickly address any issues of concern raised by patients and their families.



Advanced clinical and diagnostic skills

Sharon McGeary and Amanda Gerrard, Paediatric Oncology Outreach Network CNSs, Newcastle Upon Tyne

Nurses from the children's oncology outreach service in Newcastle work with children and young people throughout their cancer journeys. Using specialist knowledge of symptom management, palliative and complex care, the nurses work a 24/7 on call system, allowing for timely, effective interventions which maximise care delivery. The nurse team are trained as non medical prescribers, and more than half are practising prescribers.

Working in a large geographical region, the nurses have developed effective collaborative working practices with local primary care service providers. This is particularly important in enabling children and young people with progressive disease to be cared for, and die, in their preferred place of choice, often their home.

The nurses are leading the way in the implementation of new technologies in their hospital trust. Smart Pump technology,

considered to be the next generation of ambulatory infusion devices, allows the release of medication over seven days maximising symptom management and minimising hospital attendance. Corresponding drug libraries, managed by the nurses, help to improve safety by reducing drug errors, improving workflow and providing a new source of data for continuous quality improvement.



Acting as key worker across the whole care pathway

Tina Lightfoot, Lead Specialist Nurse for GI services (surgery), Chester

Tina and the colorectal specialist nurses provide quality services to enhance recovery for patients with colorectal cancer at the Countess of Chester Hospital. Through a pre operative counselling initiative, patients and carers have an increased understanding of recovery and discharge expectations, helping

them to make plans for managing care at home. In addition, patients who are expected to have a stoma are visited at home by the stoma nurse for a 'dummy' teaching session, reducing the time it takes to become self-sufficient in stoma management.

Patients on the enhanced recovery programme are discharged as early as two days after surgery, and

there is evidence that this is significantly reducing care costs. The colorectal specialist nurses contact the patient daily after discharge for up to 10 days to assess their progress. This vigilance ensures that complications are picked up early enabling timely intervention, and patients report feeling supported through their recovery.



Excellent decision making abilities

Debbie Fitzgerald, Gynaecology CNS, Torbay

Debbie has developed an innovative early-alert service for women with ovarian cancer who suffer from a painful and distressing build up of fluid in the abdominal area.

Patients are alerted to the possibility of fluid build-up, and encouraged to phone her if they begin to experience symptoms. When contacted, Debbie makes a clinical assessment, organising an abdominal scan if required and booking blood tests pre-admission. The drainage can then be done as a day patient, preventing emergency

admission to A&E and lengthy inpatient stays as well as improving patients' quality of life.

The CNS's coordinating role ensures that phlebotomists, radiographers, and the medical team are all available at the right time. Debbie has developed this into a protocol - now widely used.

Advanced communication and advocacy skills

Judith Clarke, Surgical Breast Care CNS, Coventry

Judith has developed an innovative system to monitor and best manage anxiety among patients recalled to the breast screening clinic for further assessment following attendance to the NHS breast screening programme. Judith devised a simple tool that encourages patients to reflect on their anxiety and prompt them to seek

additional support from the breast care nurse (BCN). It also promotes greater collaboration with radiographers and a more coordinated patient-centred experience.

Designed to look like a thermometer, the assessment tool asks women to score themselves from 0-10 (low to high anxiety) enabling BCNs to triage the more

vulnerable women (scoring 5 and above) and ensure they are offered a BCN consultation before being re-screened. Radiographers also use the self-assessment to ensure more patient-focused care, taking into account women's concerns. Feedback from patients shows that women find this activity useful and many have commented on how it helped to reduce their anxiety.

Case Studies (continued)

Demonstrating Leadership

Catherine Oakley, Nurse Consultant, London

Catherine and the team of chemotherapy nurse specialists at Guy's and St Thomas' Hospital have been working together to redesign the way chemotherapy is delivered. Nurses in the chemotherapy unit now work in four specialised teams according to tumour types to improve consistency for patients and maximise the nurses' clinical expertise.

Catherine piloted an intervention in urology in which a specialist nurse and pharmacist delivered an improved pre-treatment consultation. The key to its success is structuring the consultation to ensure that patients' educational and supportive care needs are met to optimise safety and empower patients to actively participate in their treatment plan. Additionally,

CNSs proactively call patients to monitor their progress during the course of their treatment. Closely monitoring patients in this way ensures that any side-effects can be quickly managed and that patients are supported through this sometimes difficult part of their cancer journey.

In-depth knowledge of tumour area

Tessa Fitzpatrick, Macmillan Lung CNS, North Tees

Analysis of patient experience at University Hospital of North Tees suggests that lung cancer patients and carers can encounter problems following admission to the Emergency Assessment Unit (EAU). These include unnecessary investigations, poor symptom management, lack of recognition of end of life, delays in discharge and inadequate communication.

This has a negative impact on patients' confidence in the service and also on the length of stay which has a cost implication.

The CNSs at North Tees use their specialist knowledge of lung cancer to support patients who are admitted as emergency cases, reducing inpatient stays and helping patients and carers to

understand and manage symptoms. University Hospital of North Tees examined a total of 94 inpatient episodes resulting in 964 bed days. The average length of stay for those patients not referred to the lung CNS was 10.8 days however there was a reduction in length of stay to 9.7 days for those patients who had lung CNS input during their admission.



Ability to assess patients' holistic needs

Anita Pabla, Sarcoma CNS, Leicester

Anita works with patients throughout their cancer

journey but has particularly focussed on supporting survivorship and smoothing the transition from secondary to primary care.

Six to eight weeks post-treatment, she provides patients with detailed

and individual 'end of treatment' summaries within the context of a holistic consultation. This captures their initial diagnosis and treatment history, medication and follow up schedule incorporating the wider services they have accessed, such as limb fitting and support groups. The summary also acts as an important communication tool for their GP,

enabling greater integration between different parts of the patient pathway.

The summary and assessment has proved valuable to patients increasing their confidence and ability to self-manage as well as to primary care improving appropriate referral if and when needed.

Delivering the future for cancer patients

The NHS White Paper, *Equity and Excellence: Liberating the NHS*, puts patients and clinicians at the heart of decision-making in the NHS. The phrase “no decision about me without me” is used in the White Paper to emphasise patients’ involvement in their own care.¹⁰ CNSs are often the main point of contact for cancer patients and their families, and work closely with colleagues throughout the patient’s cancer journey. As a result, they are well placed to support patients at each stage and to promote integration within care teams.

Equity and Excellence proposes a shift away from measuring clinical inputs and processes in favour of achieving improved clinical outcomes and higher quality patient experience. Here too, CNSs already demonstrate their skills in assessing and putting in place interventions to achieve these.

The Cancer Reform Strategy (2007) stated that: “Commissioners and providers should ensure that the critical roles of clinical nurse specialists in information delivery, communication and coordination of care

are supported”.¹¹ This remains essential to achieving safe and high quality cancer care and we expect to see this reflected in the refreshed Cancer Reform Strategy.

Nursing is changing, reflecting and rewarding the skills and expertise of its workforce. Career pathways have been updated and transferable skills identified to enable nurses to shape their careers within and across different care pathways.¹² Embracing new models of care, the CNS role extends beyond the hospital setting into local community and specialist settings and increasingly includes informed individual care planning that enables patients to self-manage their condition where possible.

There is wide variation in the types of tasks that CNSs are carrying out. While some of these make good use of their skills, there is evidence that CNSs are also being diverted into general ward duties and tied up in administrative tasks. This does not represent good value to the NHS. Commissioners, employers and managers therefore need to consider whether CNSs are being deployed to best effect.

Matching workforce planning to patient need

Clinical teams will be considering whether provision of CNSs in their local area is sufficient to meet need. Understanding the patterns of access is fundamental to being able to match the CNS workforce to patients’ needs. Despite the expansion in overall CNS numbers since the 1980s, workforce shortages are still an issue.¹³

The best available data indicates that not every cancer patient has access to a CNS, despite the recommendations made in the *Improving Outcomes Guidance*. The National Cancer Action Team’s Workforce Review Team 2010 census demonstrates significant variation in provision of cancer

CNSs in England, which cannot be accounted for by geographical differences in cancer incidence or in patient flows.¹⁴ Since the last census in 2008,¹⁵ there appears to have been an increase in CNS posts in rarer cancers, but the 2010 census revealed no significant growth in other tumour groups despite increasing cancer prevalence. Inequities remain across England and also between different tumour types. Patient advocacy groups have argued that in some cancers - notably lung and urological cancers - CNS provision falls significantly short of patient need and that CNSs face variable case-loads.

Issues for Employers and Managers to consider

CNSs provide quality care and contribute to improved outcomes for cancer patients. They lead innovation, and can drive efficiency in their teams. They also contribute to the delivery of health strategies and policy guidance including:

- Cancer Reform Strategy
- Improving Outcomes
- Quality, Innovation, Productivity and Prevention Challenge
- High Impact Actions for nursing and midwifery
- Equity and Excellence: Liberating the NHS
- Chemotherapy Services in England
- Vital Signs
- End of Life Care Strategy

Employers and managers may wish to ask the following questions when considering their cancer services and assessing their CNS provision, to identify to what extent cancer services are configured to maximise the safety, quality and productivity of care:

Your community

- What is the all-age, all-cause cancer incidence rate in your PCT?
- What are the demographics of your PCT in terms of: age; socioeconomic and deprivation factors; prevalence of risk factors; ethnicity?
- Are there communities with particular unmet needs?
- What priority issues for cancer have been identified through the Joint Strategic Needs Assessment?
- How have you reflected these in the selection of local priorities and incentives for health care providers e.g CQUINs? QOF?
- How do you plan to measure and improve outcomes in these areas?

Provision and capacity

- How many whole-time equivalent CNSs posts are there in your PCT?
- What is the distribution of these across different cancers?
- How does this compare to patterns in neighbouring areas and to the national picture?
- Does each specialist team dealing with a particular cancer type have at least one CNS member?
- How good is CNS attendance at MDT meetings for each team?
- How many new patients does each CNS see each year?
- Have you considered using the expertise of the Macmillan Cancer Support Service Development Team to redesign CNS roles and services should you have concerns that CNSs may not be working to the best potential of their roles?

Where can CNSs make most impact?

- How many unplanned admissions are there for cancer each year in your PCT? And how does this vary by cancer type?
- Do audited records demonstrate that at least 80% of patients receive information about their diagnosis, treatment and care plan?
- Can it be demonstrated that care is effectively coordinated across boundaries?
- Are CNSs working in roles that reflect and demand their knowledge and skills or are they undertaking general ward duties?

Further sources of information

- Cancer Commissioning Guidance
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110115
- Cancer Commissioning Toolkit
<https://www.cancertoolkit.co.uk>
- Cancer Reform Strategy and Annual Reports
<http://www.dh.gov.uk/en/Healthcare/Cancer/ReformStrategy>
- National Cancer Intelligence Network
<http://www.ncin.org.uk>
- Association of Public Health Observatories
<http://www.apho.org.uk/>
- Public Health Observatory Handbook of Health Inequalities Measurement
<http://www.sepho.org.uk/viewResource.aspx?id=9707>
- Guidance on Joint Strategic Needs Assessment
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097
- The Operating Framework for the NHS in England, 2010/11 (December 2009)
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_110107
- Specialist nurses. Changing lives, saving money. Royal College of Nursing, London. 2010
http://www.rcn.org.uk/__data/assets/pdf_file/0008/302489/003581.pdf
- Programme Budgeting data for 2007-08
http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/Programmebudgeting/DH_075743
- National Audit Office, End of Life Care, November 2008 available here:
http://www.nao.org.uk/publications/0708/end_of_life_care.aspx
- Department of Health, Equity and excellence: Liberating the NHS, July 2010
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf
- To download this publication go to:
<http://ncat.nhs.uk/our-work/ensuring-better-treatment/quality-in-nursing>

Acknowledgments

The Department of Health, National Cancer Action Team and Macmillan Cancer Support would like to thank all those who have contributed to the development of this publication, in particular the Clinical Nurse

Specialists who provided examples of good practice, and the members of the National Quality in Cancer Nursing Steering Group for their advice and guidance.

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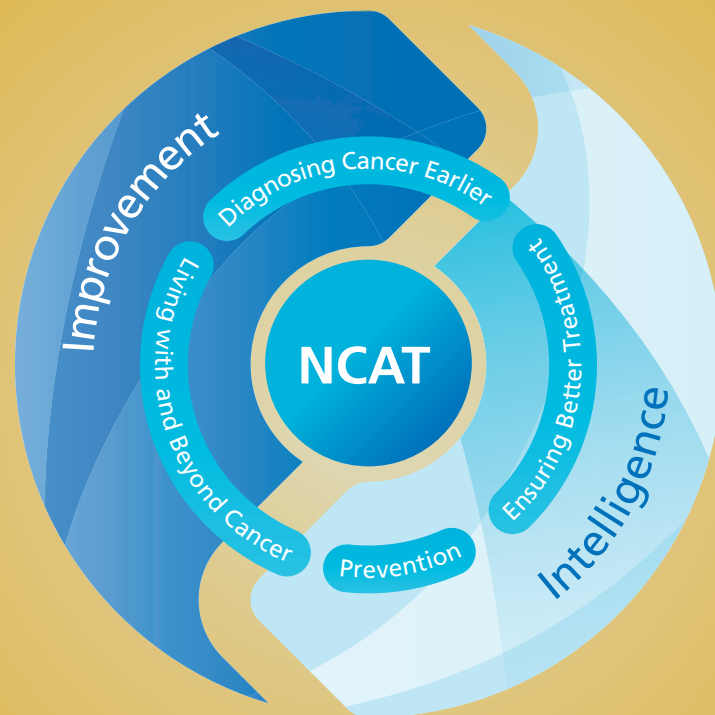
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- 3 Leary A (2011) in Leary A (Ed) Lung cancer a multidisciplinary approach, Wiley-Blackwell Oxford In press
- 4 National Cancer Peer Review Programme Manual for Cancer Services 2008: Breast Measures
- 5 Department of Health, Programme Budgeting data for 2007-08
- 6 NHS Improvement Transforming Care for Cancer Inpatients - Spreading the Winning Principles and Good Practice: July 2009
- 7 National Audit Office, End of Life Care, November 2008
- 8 Macmillan Cancer Support, Demonstrating the economic value of co-ordinated cancer services. An examination of resource utilisation in Manchester , March 2010
- 9 Department of Health , Transparency in outcomes a framework for the NHS, July 2010
- 10 Department of Health, Equity and excellence: Liberating the NHS, July 2010
- 11 Department of Health, Cancer Reform Strategy, December 2007
- 12 Department of Health, Towards a framework for post-registration nursing careers - consultation response report, July 2008
- 13 National Cancer Action Team, National Cancer Peer Review Programme 2004 – 2007. An overview of the findings from the second national round of peer reviews of cancer services in England, June 2008
- 14 National Cancer Action Team Workforce Review Team, Census of Cancer Specialist Nurses in English Cancer Networks, 2010
- 15 Trevatt, P., Leary, A., A Census of the advanced and specialist cancer nursing workforce in England, Northern Ireland and Wales, European Journal of Oncology Nursing (2009) 14:1 (68-73)

Endorsements

The content of this publication is endorsed by the following organisations:



Gateway Number: 14851





**Belfast Health and
Social Care Trust**

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JOB DESCRIPTION

POST: Data Officer/MDT Co-ordinator

LOCATION: RVH, BCH and MPH

GRADE: Band 4

REPORTS TO: Business Support Officer, Cancer Services

RESPONSIBLE TO: Assistant Service Manager Cancer Services

JOB SUMMARY / MAIN PURPOSE:

The post holder will play a key role in the production of information to support Cancer Services business objectives in conjunction with the Cancer Services Information Officer. They will undertake processes to ensure the completeness and validity of cancer datasets held in Trust systems. The post holder will collect, record, analyse and report cancer information as requested in order to meet national, regional and local reporting requirements.

The post holder will be responsible for the co-ordination and organisation of Multidisciplinary Team (MDT) meetings. They will attend meetings obtaining and recording relevant information to facilitate the timely provision of care for patients.

The post holder will be required to be flexible with regards to the duties and demands. They will participate in audit collection and production of audit reports.

Main Duties / Responsibilities

DATA OFFICER:

1. Assist in the production of activity information reports both standard and ad-hoc, required to support the Cancer Services Team.
2. Assist in the delivery of a high quality information service to support the business needs of services groups and performance management.
3. Data validation to ensure complete and accurate performance reports, MDT annual reports and operational policies.
4. Use Trust information systems to facilitate collection of data for all cancers and enter this onto CaPPs in conjunction with clinical leads and Information Officer
5. Collect audit data and information for Cancer Services

6. Participate in developing information reports to ensure data quality within the Trust's information systems.
7. Provide accurate and timely data to the Cancer Management Team
8. Assist in the analysis and preparation of information for reports for monitoring waiting times, monthly/quarterly, for Trust Board and Cancer Management Team.
9. Maintain timely and accurate data collection, maintaining Cancer Patient Pathway System (CaPPS) and taking corrective action when data is incomplete or inaccurate.
10. Provide access and training for the Cancer Patient Pathway System (CaPPS)

MDT CO-ORDINATOR:

1. Responsible for the co-ordination, organisation and management of the weekly MDT meetings Trust wide, ensuring all relevant people are notified and all required information, notes, reports and results are available.
2. Generate a list of relevant patient names for the meetings and distributing this to the MDT members prior to meeting.
3. To work with the members of the MDT to ensure that all patients diagnosed with a new primary cancer are discussed at an MDT meeting.
4. Attend weekly MDT meetings. Complete the relevant information on the Cancer Patient Pathway System (CaPPS) for each patient discussed, including ensuring the details are sent to the relevant GP within 24 hours of MDT.
5. Responsible for typing live on CaPPS, noting action points and following up to ensure actions are taken in a timely manner.
6. Ensure all referrals made from MDT are forwarded to relevant professional.
7. Maintain a record of treatment decisions made at multi-disciplinary team meetings and ensure that the MDT proformas are filed in the patient notes.
8. Maintain an accurate record of attendance at MDT meetings ensuring all cancelled meetings are recorded with a cancellation reason. Provide annual MDT attendance figures to MDT members and the cancer services management team.
9. Ensure all documentation is kept in such a manner that any cancer patient tracker is able to take on the work.
10. When required receive telephone calls, communication with patients and/or their relatives.
11. Coordinate MDT business meetings and take minutes as required
12. Act as a point of contact for issues relating to videoconference equipment

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.

Records Management

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 and Data Protection Act 1998. Employees are required to be conversant with the Belfast Health and Social Care Trust policy and procedure on records management and to seek advice if in doubt.

Environmental Cleaning Strategy

The Trusts Environmental Cleaning Strategy recognizes 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 (HCIs) 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 ie. cleaned, disinfected and/or sterilised;
- Ensuring compliance with High Impact Interventions.

Values:

The Belfast Trust aims to recruit staff not only with the right skills but also with the right values to ensure the delivery of excellent patient care and experience. Staff will be expected to be committed to provide safe, effective, compassionate and person centred care by:-

- Treating Everyone with Dignity and Respect
- Displaying Openness and Trust
- Being Accountable
- Being Leading Edge
- Maximising Learning and Development

By embedding the above values we will make a significant contribution to the delivery of the Trust's Vision.

Personal Public Involvement

Staff members are expected to involve patients, clients, carers and the wider community where 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.***



**Belfast Health and
Social Care Trust**

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JOB SPECIFICATION

POST: Data Officer/MDT Co-ordinator **Band 4**

LOCATION: RVH, BCH and MPH

ESSENTIAL CRITERIA:

1. 4 GCSEs Grade C or above, to include English (excluding English Literature) and Mathematics or equivalent qualifications and 2 years' administrative experience

OR

HNC/HND or equivalent / higher qualification preferable in an administrative related field and 1 years experience in a clerical /administrative role

OR

Three years' administrative experience

AND

2. Working experience of the Patient Administrative System (PAS) and other Hospital Information Systems
3. Excellent communication skills both orally and in writing
4. Excellent keyboard skills and experience in the use of computerised systems/packages including Microsoft Excel.
5. Experience of medical Terminology or OCR stage 2 text processing (Part 1) and stage 2 word processing
6. Ability to work as part of a team

DESIRABLE CRITERIA

1. Experience of collecting data and running reports

VALUE BASED RECRUITMENT

* Values Based Recruitment is a process adopted by the Belfast Trust to attract and select employees on the basis that their individual values and behaviours align with those of the Trust and incorporating the Healthcare Leadership Model.

It focuses on the 'how' and 'why' people do what they do.

Candidates who are short-listed for interview will need to demonstrate at interview that they have the required knowledge, skills, competencies and values to be effective in this new role.

In answering the value based questions you have the opportunity to share examples of when you have demonstrated values relevant to the Belfast Trust.

Belfast HSC Trust Values

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



RESPECT & DIGNITY

- Being respectful to others
- Showing compassion to those who need our care
- Acting fairly and even-handed
- Acknowledging the good work of others
- Supporting others to achieve positive results



OPENNESS & TRUST

- Communicating openly and consistently
- Listening to the opinions of others and acting sensitively
- Being trustworthy & genuine
- Ensuring that appropriate information is shared honestly



ACCOUNTABILITY

- Taking responsibility for your own decisions and actions
- Openly admitting your mistakes and learning from them
- Using all available resources appropriately
- Challenging failures and poor practice courageously



LEADING EDGE

- Actively seeking out innovative practice
- Participate in new approaches & service development opportunities
- Share best practice with others
- Promote the Trust as a centre of excellence



MAXIMISING LEARNING & DEVELOPMENT

- Act as a role model for the development of others
- Continuing to challenge my own practice
- Fulfil my own statutory mandatory training requirements
- Actively support the development of others

PATHWAYS TO A CANCER DIAGNOSIS:

Monitoring variation in the patient journey across Northern Ireland 2012 – 2016

Technical Document

1. Introduction

This document provides a summary of the data sources and methodology used for the first 'Pathways to Cancer Diagnosis in Northern Ireland' project. Extracted data covers tumours diagnosed in 2009 to 2016.

The origin of Pathway to Cancer Diagnosis Analysis

The National Cancer Registration and Analysis Service (Public Health England) have produced an award winning Routes to Diagnosis study which defined a methodology to determine the route a patient took through the healthcare system before receiving a cancer diagnosis. It is from this that the Pathways to Cancer Diagnosis project in Northern Ireland has taken its lead.

Routes to diagnosis are an important and often modifiable prognostic indicator in cancer care. Patients who present as an emergency have poorer one year survival than those who present via the 'red flag' route or via screening.

Quantifying incidence by route or pathway to diagnosis data has potential to highlight variation across a range of different variables such as age, deprivation, health geography.

The 'Pathways to Cancer Diagnosis in Northern Ireland' project adapts the Public Health England methodology to provide the first analysis of this type for cancer patients in Northern Ireland.

2. Overview of the Routes to Diagnosis project

2.1 Project goals

The aim of this project is to produce, for the first time, measures on pathways to diagnoses in Northern Ireland for all cancers and by individual cancer site, as well as by Trust of residence, urban/rural and deprivation category. The diagnosis pathways used are those categorised by the National Cancer Registration and Analysis Service (Public Health England).

The study examines first whether it is feasible to apply the Public Health England Routes to Diagnosis methodology and algorithm to the Northern Ireland setting.

On the basis that this is feasible, for at least some years of data, the project looks to identify whether there is an association between pathways to diagnosis and survival for cancer patients. Also, do age, sex, deprivation, cancer stage and geographical area of residence on diagnosis have any influence on routes?

The study uses funnel plots to explore the variation in pathways to diagnosis in order to aid interpretation and identify areas for follow-up analysis and subsequent development of intervention strategies.

2.2 Technical overview

Data from the Northern Ireland Cancer Registry is combined with Patient Administration System data for Inpatient and Outpatient activity and Cancer Patient Pathway System data. Using these datasets cases of cancer registered in Northern Ireland diagnosed in 2009 to 2016 are categorised into one of 8 principle 'Routes to Diagnosis' as identified by the National Cancer Registration and Analysis Service (Public Health England) Routes to diagnosis study.

2.3 Policy Context

The project forms part of the Health Foundation's Applying Advanced Analytics Project.

The Health Foundation is an independent charity committed to bringing about better health and health care for people in the UK. Under its 'Applying Advanced Analytics Project', the charity is funding pilot projects, to be carried out from within the UK health-service, to build up analytical capacity to drive monitoring and improvement of service delivery.

The Pathways to Cancer project proposal was submitted by BSO in partnership with the Centre for Public Health in Queens's University of Belfast and was supported by the Northern Ireland Cancer Registry and the Director of Commissioning for the Health and Social Care Board.

3. Methods

The methodology used to produce the pathways to cancer diagnosis for Northern Ireland is detailed in the sections below.

The original algorithm which assigns a route to diagnosis was produced by the National Cancer Registration and Analysis Service (Public Health England). An overview of the original Routes to Diagnosis algorithm is set out within the PHE technical documentation.

“The algorithm takes as a starting point the date of cancer diagnosis, as defined by the UK and Ireland Association of Cancer Registries (UKIACR) using European Network of Cancer Registries (ENCR) rules. Routine data immediately prior to this date are examined and a series of rules is used to classify the ‘Route to Diagnosis’ for each case. The routes are categorised in detail by 3 variables: the end-point, the pathway group, and the start-point. These detailed routes have been aggregated into 8 broader categories to facilitate analysis.

It is important to note that patient records being used to describe the route to diagnosis may not have a cancer code assigned to them, as the episodes and attendances will have taken place before a cancer diagnosis has been coded. It is therefore not possible to be absolutely certain that the episodes and attendances related to the patient prior to diagnosis were directly related to the process of diagnosis of cancer. However, the frequency of hospital attendance and admission in the period immediately before diagnosis greatly exceeds the ‘background’ rate making the assumption that they are related to the cancer diagnosis reasonable.”

Source: http://www.ncin.org.uk/publications/routes_to_diagnosis

This PHE methodology has been followed as closely as possible to allow for potential comparisons of data across regions. However, a number of variations have been introduced in order to best fit Northern Ireland’s different recording systems.

As with the PHE hospital data extracts, hospital information used to assign routes cannot be matched to cancer diagnoses from the NICR with absolute certainty as, having taken place before diagnosis, they may not have a cancer code assigned to them. As with the PHE project, the decision has been taken that the proximity of the hospital attendance or admission to the cancer diagnosis makes it reasonable to assume that they are related.

4. Data Sources

4.1 Northern Ireland Cancer Registry (NICR)

The NICR is a population based cancer registry collecting data on all malignant and certain non-malignant tumours diagnosed in Northern Ireland.

For this project, all cancer registrations across Northern Ireland between 2009 and 2016 inclusive, with ICD-10 diagnosis codes **C00–C97**, **D00-D09**, **D13**, **D15**, **D27**, **D29**, **D32**, **D33**, **D35** and **D37-D48** (all neoplasms) were extracted from the NICR.

A subset of this data for tumours with ICD-10 diagnosis codes **C00–C97** excluding **C44** which were diagnosed in calendar years 2009 to 2016 was used for reporting. A number of other exclusions were also made from the NICR extract following validations and based on experience of the PHE research. These are detailed below:

- all D codes with the exception of **D05**, **D06**, **D090**, **D32**, **D330-D332**, **D333**, **D334**, **D352-D354**, **D42**, **D430-D432**, **D433-D434**, **D437-D439** and **D443-D445** were excluded from the reporting dataset
- the records for patients with non-melanoma skin cancer
- records where the sex code and cancer site code are incompatible
- records with invalid ages
- duplicate records identified
- records with invalid ICD10 site codes

Routes were derived for all tumours fitting the criteria specified above. This includes incidences where more than one tumour is recorded in the same person.

4.2 Patient Administration System (PAS)

Patient Administration Systems are principally used to manage and record inpatient, day case and outpatient activity within Health and Social Care hospital sites in Northern Ireland.

4.2.1 Hospital Inpatient System (HIS)

The Hospital Inpatient System (HIS) is formed in the HSC Data Warehouse from PAS data and provides information on admitted patient care delivered by health and social care hospitals in Northern Ireland. It is a patient level administrative data source and each record relates to an individual consultant episode.

For the pathways to diagnosis project, an extract containing 2008/09 to 2015/16 records was used to identify patients from the NICR with a hospital admission for any cause during the six months prior to their cancer diagnosis.

4.2.2 Outpatient Universe

The Outpatient Universe is formed in the HSC Data Warehouse from PAS data and provides information on outpatient appointments at Health and Social Care (HSC) hospitals in Northern Ireland. It is a patient level administrative data source and each record relates to an appointment. This can include a change in appointment details.

For the pathways to diagnosis project an extract containing 2008/09 to 2015/16 records was used to identify patients from the NICR with an outpatient attendance for any reason during the six months prior to their cancer diagnosis.

4.3 Cancer Patient Pathway System (CaPPS)

The Cancer Patient Pathway System (CaPPS) is a bespoke data system used to administer cancer treatment services within Health and Social Care (HSC) Trusts in Northern Ireland. This dataset contains patient level information and is used to monitor and report on the number of patients treated for cancer following a decision to treat being taken.

For the pathways to diagnosis project an extract containing 2008/09 to 2015/16 records was used to identify patients from the NICR who received an urgent GP referral for suspect cancer.

5. Data Preparation

5.1 Northern Ireland Cancer Registry (NICR)

Variables requested from the Data Warehouse were as follows –

HCN – Health and Care Number, replaced by honest broker with **STUDY_ID**

SEX – Sex of patient

AGE – Age of patient

DEPRIV2010 – deprivation quintile, based on patient postcode (2010 values)

URBAN_RURAL – urban/rural indicator, based on patient postcode

LGD2014 – Local Government District, based on patient postcode

TRUST – HSC Trust of residence of the patient

GP_Practice – replaced by **GP_ANON**. Produced by Honest Broker, anonymised GP practice of the patient at time of diagnosis.

DODIAG – Date of diagnosis of tumour

SCREEN – Screen detected flag placed on data by cancer registry

BASIS – Clinical variable relating to tumour

SITE_ICD10 – Site of tumour with 4 character ICD10 code

SITECLASS – Aggregated tumour site grouping

MORPH – Clinical variable relating to tumour

GRADE – Clinical variable relating to tumour

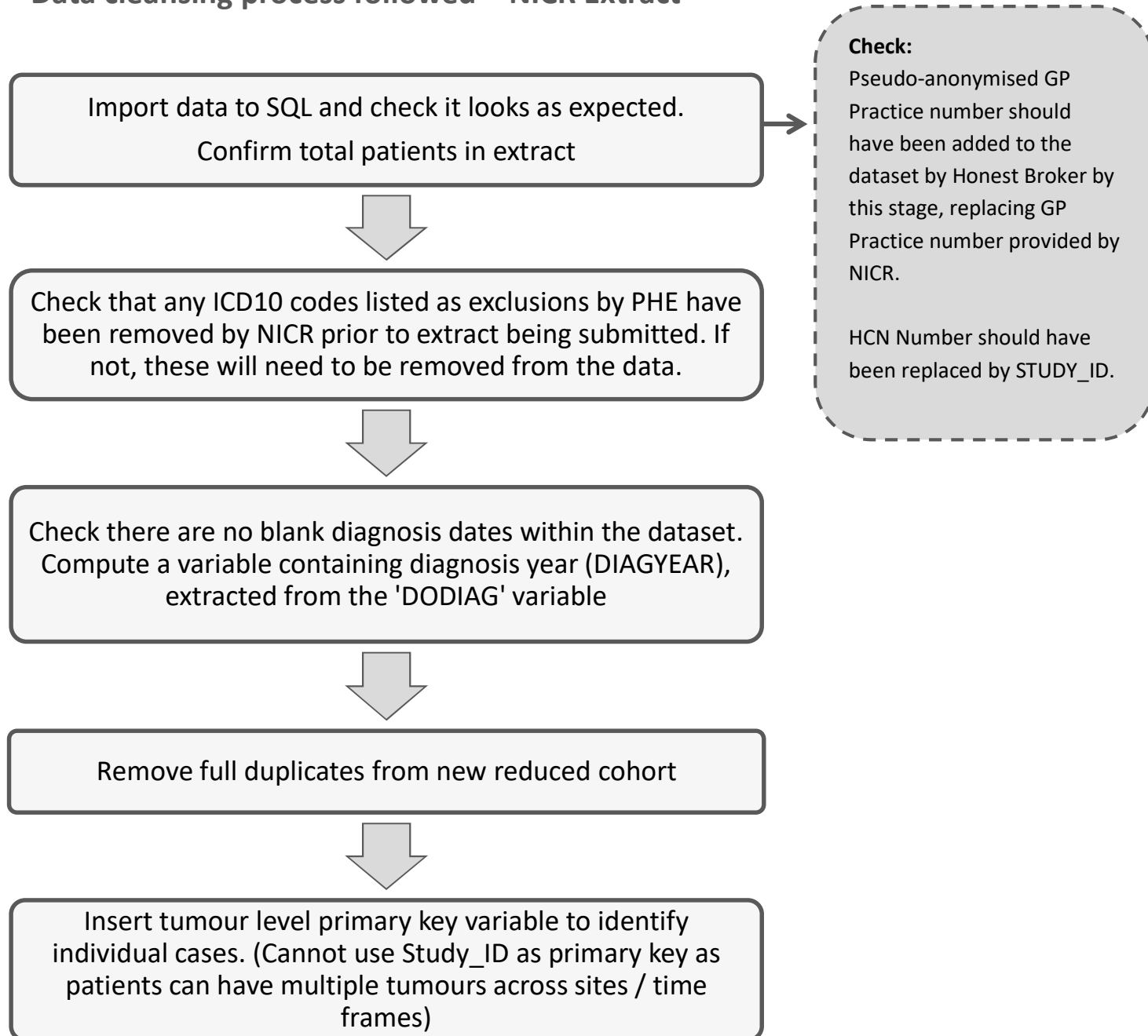
STAGE – Clinical variable relating to tumour

DODEATH – Date of death of patient

CAUSED – Flag to identify patient cause of death (*Cancer / Other*) or if patient is alive (*Alive*)

The above information was extracted for all patients appearing on the Northern Ireland Cancer Registry between the years 2009 and 2016.

Data cleansing process followed – NICR Extract



Preparing the Northern Ireland Cancer Registry (NICR) extract

The NICR extract was submitted to the Honest Broker Service (HBS) where the data was anonymised with each HCN being replaced with a variable which will enable linkage across extracts (**STUDY_ID**) before being made available for use.

A variable was added to identify the year of diagnosis (**DIAG_YEAR**) for each tumour. The pathways have been calculated on individual years of data so this variable was used to filter the data accordingly.

The original data extract included some codes which had been excluded by the PHE and so had to be removed prior to analysis (list can be found in the NICR section above as well as in the SQL code). However in the updated extract these codes were removed by the NICR. It would be good practice in future to check that this have been done in any future extracts, for that reason this portion of code on has purposely been left in.

A check was completed to confirm there were no missing values against the date of diagnosis (any such cases would need removed) and that the number of cases across each year was broadly consistent.

All full duplicates were removed from the file. There were a small number of cases where the only difference was the marital status variable. Since this variable was not of interest it was removed and the remaining duplicate cases deleted. In future extracts there is no need to ask for marital status information and as such have removed it from the list of extract variables above.

Finally a primary key variable (**TUMOUR_ID**) was added for analysis.

The file has been saved as '**HONESTBROKER.E024.NICR_FINAL**'

5.2 Outpatient Universe

Variables requested from the Data Warehouse were as follows –

HCN – Health and Care Number, replaced by Honest Broker with **STUDY_ID**

Appointment_date – date and time of appointment

Attendance_code – denotes whether the appointment took place or not

Attendance_desc – descriptor variable for attendance code

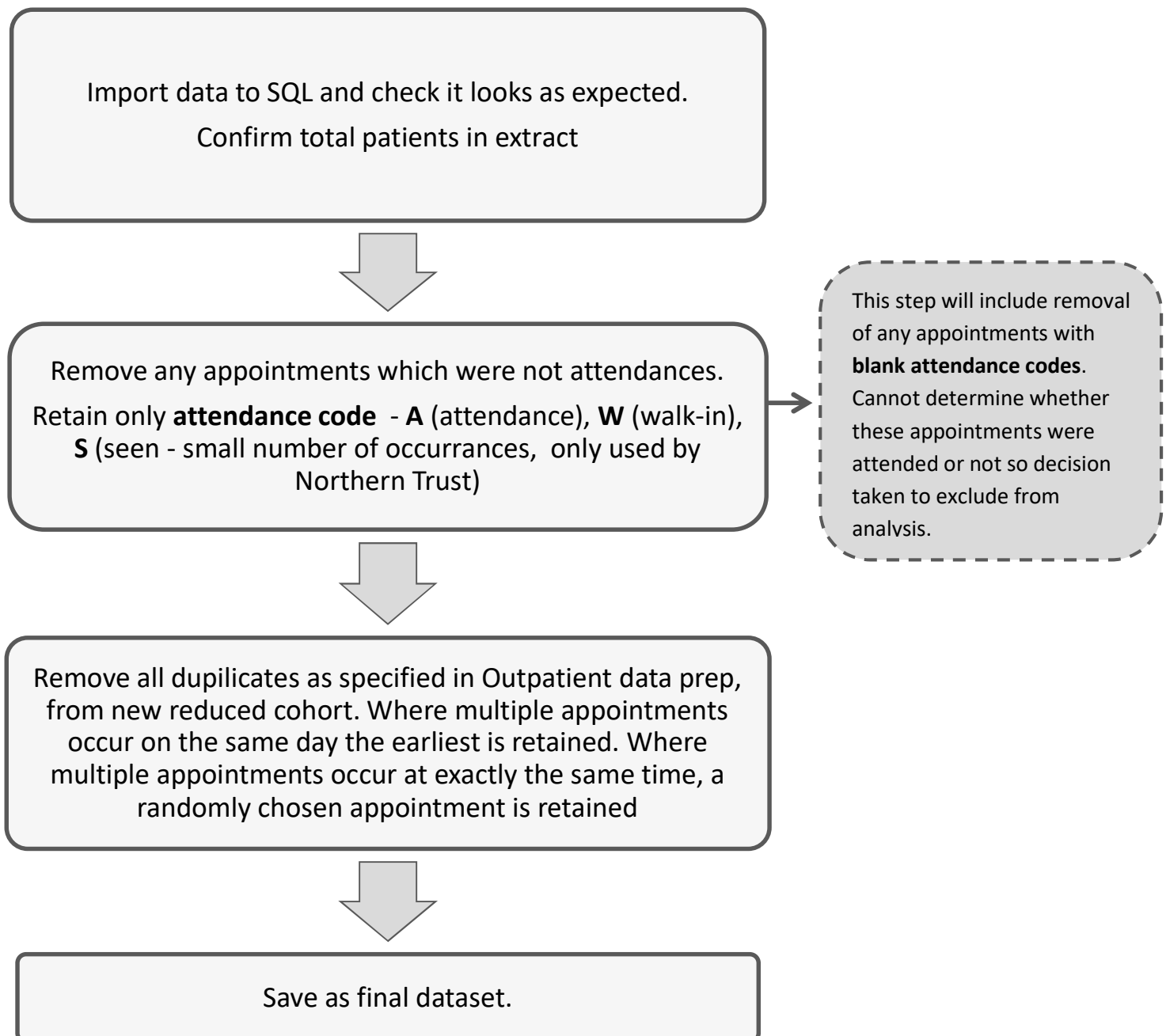
Appointment_type_r – regional variable classifying appointment as first or review

Referral_code – local code identifying the source of the referral

Referral_desc – local descriptor variable for source of referral code

CMDS_value – closest matching value to the PHE referral source mapping

The above information was extracted for all patients appearing on the Northern Ireland Cancer Registry between the years 2009 and 2016. Outpatient appointments were obtained for the years 2008-2016 to enable identification of appointments attended during the 6 month period prior to cancer diagnosis.

Data cleansing process followed – Outpatient Extract

Preparing the Outpatient data extract

The outpatient extract was submitted to the Honest Broker Service (HBS) where the data was anonymised with each HCN being replaced with a variable which will enable linkage across extracts (**STUDY_ID**) before being made available for use.

Unnecessary variables were removed, for the next extract we could exclude these from the DAA.

Only appointments that were actually attended were needed for analysis so I have removed any that were cancelled or missed. I also removed any appointments where the attendance code was blank. This left only appointments that were attended (A), seen (S) or walk-ins (W).

I have then looked at the new reduced cohort and carried out a validation of the referral source variable (CMDS Value) using the local descriptions. Any regional codes that looked to be incorrect I have recoded in line with their local code. I have also recoded all action cancer cases to be picked up as screen detected. This recoding will need done manually again with any new extracts.

Using the recoded referral information, I have checked the file for full duplicates and have removed any such cases.

There are a number of other types of duplicates that need to be identified and removed from the file. To help with identifying them I have created an extra variable which only has the date of the appointment and drops the time element (**APP_DATE_ONLY**). This variable will also be used later when calculating proximity of outpatient activity to cancer diagnosis in the NICR extract.

Where there appear to be multiple appointments attended on the same day at exactly the same time but with different referral sources I have selected a random one to retain.

Where a patient attended more than one appointment identical appointment on the same day I have retained the earliest appointment in the day.

Where a patient attended more than one appointment on the same day with different referral sources I have retained the earliest appointment in the day.

Where a patient attended more than one appointment on the same day with different referral sources and different attendances codes I have retained the earliest appointment in the day.

Where a patient attended more than one appointment on the same day at the same time but with different referral sources and different attendances codes I have randomly selected an appointment to retain.

The file has been saved as '**HONESTBROKER.E024.OUTPATIENT_FINAL_FILE**'

5.3 Inpatient Universe

Variables requested from the Data Warehouse were as follows –

HCN – Health and Care Number, replaced by honest broker with **STUDY_ID**

EPS_START_DATE – This field contains the episode start date (without time) on which a patient was under the continuous care of one consultant. For each new episode, which may be due to transfer to another consultant or hospital, there will be a new episode start date.

EPS_END_DATE - This field contains the episode end date (without time) on which a patient finished under the continuous care of one consultant. It may be that the patient was discharged, but also may be due to transfer to another consultant or hospital, for which there will be a new episode start date.

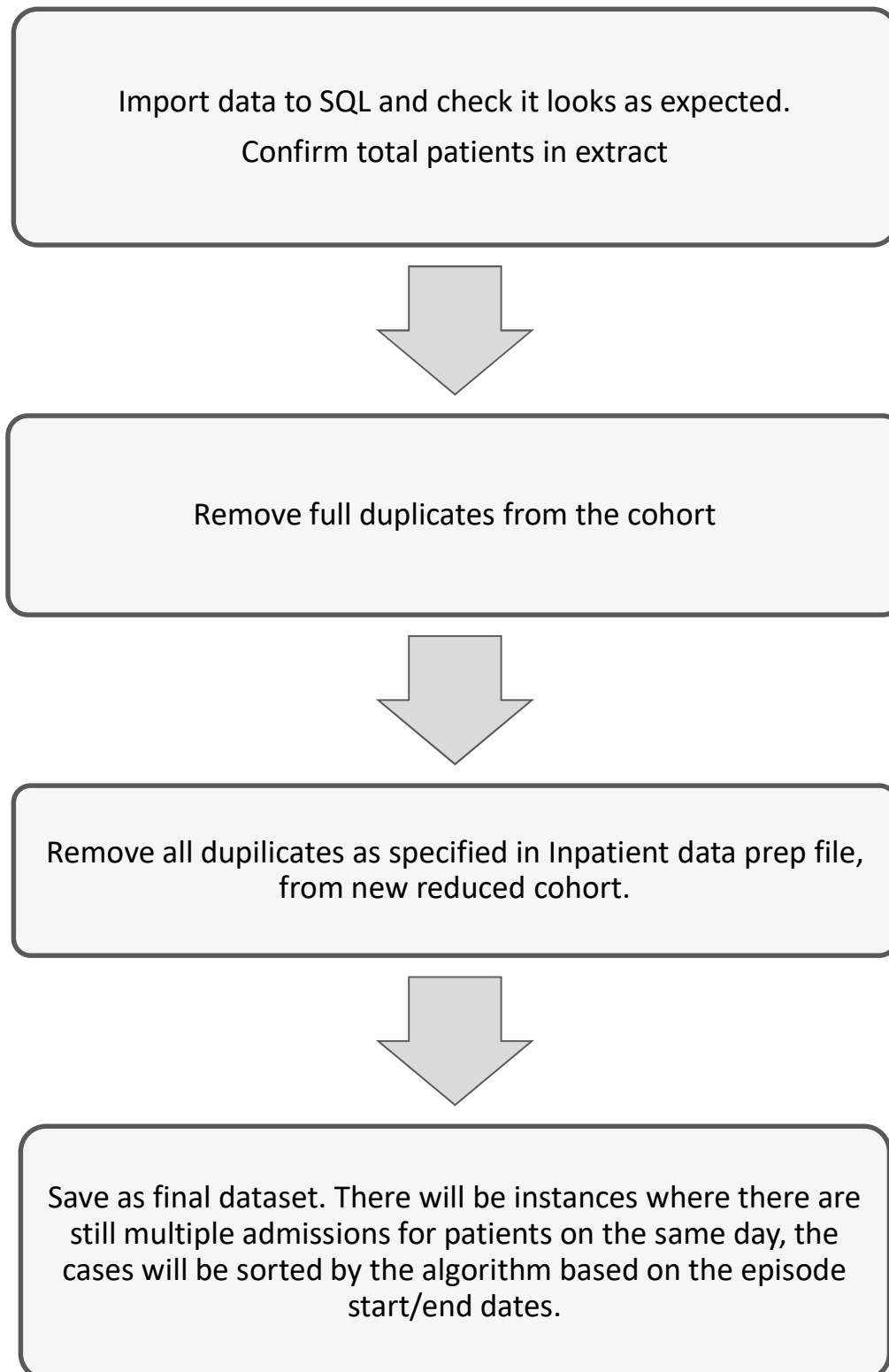
EPS_ORDER - This field contains the order of the episode within the hospital admission.

ADMIT_DATE - Date of admission with time of the first or only episode within a hospital stay. ADMIT_DATE is recorded on all episodes within a hospital admission.

ADMIT_METHOD_CODE - Method of Admission. This is recorded on the first and all subsequent episodes within the admission.

The above information was extracted for all patients appearing on the Northern Ireland Cancer Registry between the years 2009 and 2016. Inpatient admissions were obtained for the years 2008-2016 to enable identification of admissions occurring during the 6 month period prior to cancer diagnosis.

Data cleansing process followed – Inpatient Extract



Preparing the Inpatient data extract

The Inpatient extract was submitted to the Honest Broker Service (HBS) where the data was anonymised with each HCN being replaced with a variable which will enable linkage across extracts (**STUDY_ID**) before being made available for use.

All full duplicates were removed from the file.

Local codes for admission method had been requested in the original extract but they weren't needed for the analysis, regional coding was used which is more consistent and matches the categories used by PHE. Local codes were deleted and any duplicates that were created by doing this were then removed.

There were a number of cases where all information was identical apart from the admission method. In other words it looked as though the patient was admitted via two different methods at exactly the same date/time. In these cases only one record was retained and this was selected at random.

The file has been saved as '**HONESTBROKER.E024.INPATIENT_FINAL_FILE**'

5.4 Cancer Patient Pathway System (CaPPS)

Variables requested from the Data Warehouse were as follows –

HCN – Health and Care Number, replaced by honest broker with **STUDY_ID**

DATEDECISIONTOTREAT – Date of decision to treat

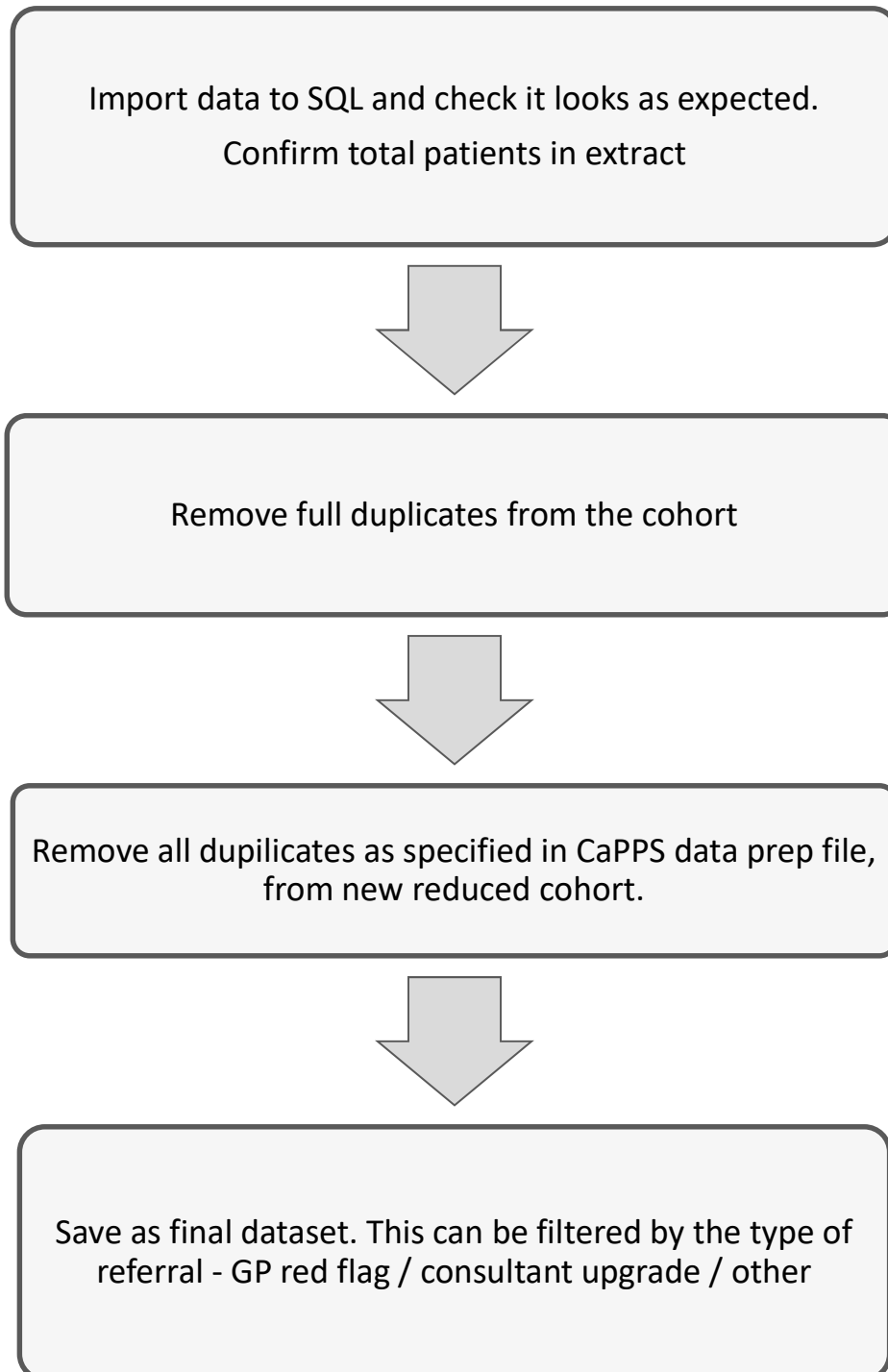
TUMOURSITE – Suspected tumour site code contained in the referral

TUMOURSITE_DESC – Suspected tumour site description contained in the referral

CONFIRMED TUMOUR_SITE – Confirmed tumour site (may differ from suspect)

PRIMARY_REF_TYPE_DESC - Description for the primary referral type, grouped into regional categories

The above information was extracted for all patients appearing on the Northern Ireland Cancer Registry between the years 2009 and 2016. CaPPS records were obtained for the years 2008-2016.

Data cleansing process followed – CaPPS Extract

Preparing the CaPPS data extract

The CaPPS extract was submitted to the Honest Broker Service (HBS) where the data was anonymised with each HCN being replaced with a variable which will enable linkage across extracts (**STUDY_ID**) before being made available for use.

Any unnecessary variables were removed, for future extract these should be excluded from the DAA.

All full duplicates within the extract were removed to leave only single instances of each.

Where there is only a difference in tumour site these duplicates were removed to leave only one instance. The tumour site is not used for the linkage so a random case has been retained.

The file has been saved as '**HONESTBROKER.E024.CAPPS_FINAL3**'

6. Calculating the Pathways to Cancer

6.1 Data Matching

All records have been allocated a STUDY_ID by the Honest Broker Service to enable linkage to take place. This anonymised 'STUDY_ID' variable was added to all datasets based on the HCN from the original extracts. HCN details have been removed prior to their release by the Honest Broker Service.

Records from the NICR, Inpatient and Outpatient datasets have been matched based on STUDY_ID and their proximity to each other.

Records from NICR and CaPPS have been matched on STUDY_ID. Only CaPPS records with a valid decision to treat date have been matched; where the date of diagnosis lies between 62 days before and 31 days after the decision to treat date.

6.2 Producing the Pathway to Diagnosis

The Pathways to Diagnosis algorithm has been constructed to replicate, as closely as possible, the methodology of the PHE Routes to Diagnosis algorithm. The algorithm assigns a three part code to each tumour within the NICR based on available inpatient and outpatient hospital data. The three part codes are then mapped into broad categories for analysis purposes. Finally, the presence of screening or CaPPS information is checked for. This data will take precedence over assigned route.

Calculating the end point of the pathway to cancer diagnosis

End points have been identified for each tumour based on the proximity of the patient's inpatient and outpatient hospital interactions to the date of diagnosis. The end point is assumed to be the clinical care event that led most immediately to diagnosis. The following rules have been applied, in line with Public Health England.

- Where both inpatient and outpatient activity occurred on the date of diagnosis the inpatient episode was defined as the end-point of the route.
- Otherwise, if there was an episode within 28 days prior to the date of diagnosis then this was assigned as the end-point of the route, with inpatient episodes taking precedence over outpatient episodes and the most recent episode taking precedence if there were multiple episodes.
- If there was no hospital activity within 28 days of diagnosis then the most recent episode within 6 months (inpatient or outpatient) was used as the end-point of the route.

Based on these rules, the one of five end-point codes were assigned:

Special cases (SC) – patients with a cancer diagnosis date on the same day as an inpatient admission date and an outpatient attendance date, or whose closest hospital interactions to diagnosis are an inpatient and outpatient record occurring on the same date. These are a special case of inpatient diagnosis.

Inpatient diagnosis (IP) – patients with a cancer diagnosis date related to a preceding inpatient episode (excluding patients already defined as special cases). An inpatient diagnosis is defined where the cancer diagnosis date is within the start and end of an episode. In addition, due to the potential for diagnosis to be confirmed following a relevant inpatient episode, a cancer diagnosis date that is within 6 months after the end of an episode and with no outpatient activity between would also be regarded as an inpatient diagnosis.

Outpatient diagnosis (OP) – patients with no inpatient episodes preceding the cancer diagnosis date (as defined above) but with an outpatient attendance preceding the cancer diagnosis date or with an inpatient elective admission, or were emergencies via an outpatient clinic, or were unresolved inpatient transfers.

Unknown (UN) – Unable to match cancer diagnosis date to any informative inpatient episodes or outpatient attendances within the valid timeframe. It is likely that, for these patients, the cancer diagnosis date was obtained from pathology records only, indicating diagnosis or treatment that only took place outside of a hospital setting (eg NHS patients seen in primary care, independent treatment centres or a community setting, and private patients seen and treated only in private hospitals).

Death Certificate Only diagnosis (DCO) - The cancer registry receives a small number of cancer related death notifications, for which they are unable to obtain additional information to register the disease details fully. This registration is regarded as Death Certificate Only (DCO) and the date of diagnosis is the same as that of the date of death.

Calculating the start point of the pathway to cancer diagnosis

The start point has been calculated by working backwards from the end point of each pathway. The start-points have been categorised based on the following rules, in line with Public Health England.

- Routes that originated in an outpatient attendance use the outpatient source of referral of that attendance as the 'start-point' code.
- Routes that originated in an inpatient episode use the inpatient method of admission as the 'start-point' code.
- Routes where inpatient or outpatient data were unavailable the start-point codes may be assigned as null or unknown (this also includes DCOs).

The start point will determine the initial source of the pathway – ie the outpatient referral source or inpatient admission method of the initial appointment. A breakdown of all possible start codes is provided in the following table.

Available inpatient admission methods
Not known (0, 99)
Elective – Waiting List (11)
Elective – Booked (12)
Elective – Planned (13)
Emergency – A&E Department in the same Board (21)
Emergency – General Practitioner (22)
Emergency – Bed Bureau / Central Bed Bureau (23)
Emergency – Consultant Outpatient Clinic (24)
Emergency – Domiciliary Visit by Consultant (25)
Emergency – Other means (28)
Maternity – Ante Partum (31)
Maternity – Post Partum (32)
Other – Patients from another hospital (81)
Other – Babies born in the hospital (82)
Other – Baby born outside the provider (83)

Available outpatient referral sources
Initiated by consultant responsible for the appointment
Consultant – Following emergency admission (1)
Consultant – Following a domiciliary visit (2)
Consultant - Following A&E Attendance (10)
Consultant – Other (11)
Not initiated by consultant responsible for the appointment
Referral from General Practitioner (GP) (3)
From an A&E Department (4)
From consultant other than in A&E Department (5)
Self-referral (6)
Referral from prosthetist (7)
Referral from GP with special interest (12)
Referral from Specialist Nurse (13)
Referral from allied health professional (14)
Referral from optometrist (15)
Referral from orthoptist (16)
Referral from a national screening programme (17)
Referral from general dental practitioner (92)
Referral from community dental service (93)
Other source of referral (8)
Other (97)
Not known (99)

Pathway grouping of the cancer diagnosis

Each tumour has been assigned one of the following pathway group codes based on the available inpatient and outpatient data.

Pathway Group	Description
A	Inpatient hospital interaction only within 6 months prior to diagnosis
B	Outpatient hospital interaction only within 6 months prior to diagnosis
C	Special case, an inpatient elective or Emergency via outpatient clinic, and there is outpatient interaction within 6 months prior to diagnosis
D	There are no hospital data 6 months prior to diagnosis
E	No hospital data at all prior to diagnosis

Assigning the final route and category for each cancer diagnosis

For each record in the Northern Ireland Cancer Registry, the route end-point, the pathway group and the route start-point are concatenated to produce a final route code. These codes are then aggregated up into eight broad categories. These categories have been classified in line with PHE Routes to Diagnosis. Detail on the categories and how they are mapped is included below.

GP Referral: includes routine and urgent referrals where the patient was not flagged as a suspect cancer referral

Urgent GP Red Flag Referral: urgent GP referrals with a suspicion of cancer (Reported as 'Two Week Wait' by

Emergency Presentation: an emergency route via A&E, emergency GP referral, emergency transfer, emergency admission or attendance

Other Outpatient: an elective route starting with an outpatient appointment that is either a self-referral, consultant to consultant referral, other or unknown referral (these referrals would not include patients originally referred under the Two Week Wait referral route)

Screen Detected: flagged by the cancer registry as detected via the breast or cervical screening programmes

Inpatient Elective: where no earlier information can be found prior to admission from a waiting list, booked or planned

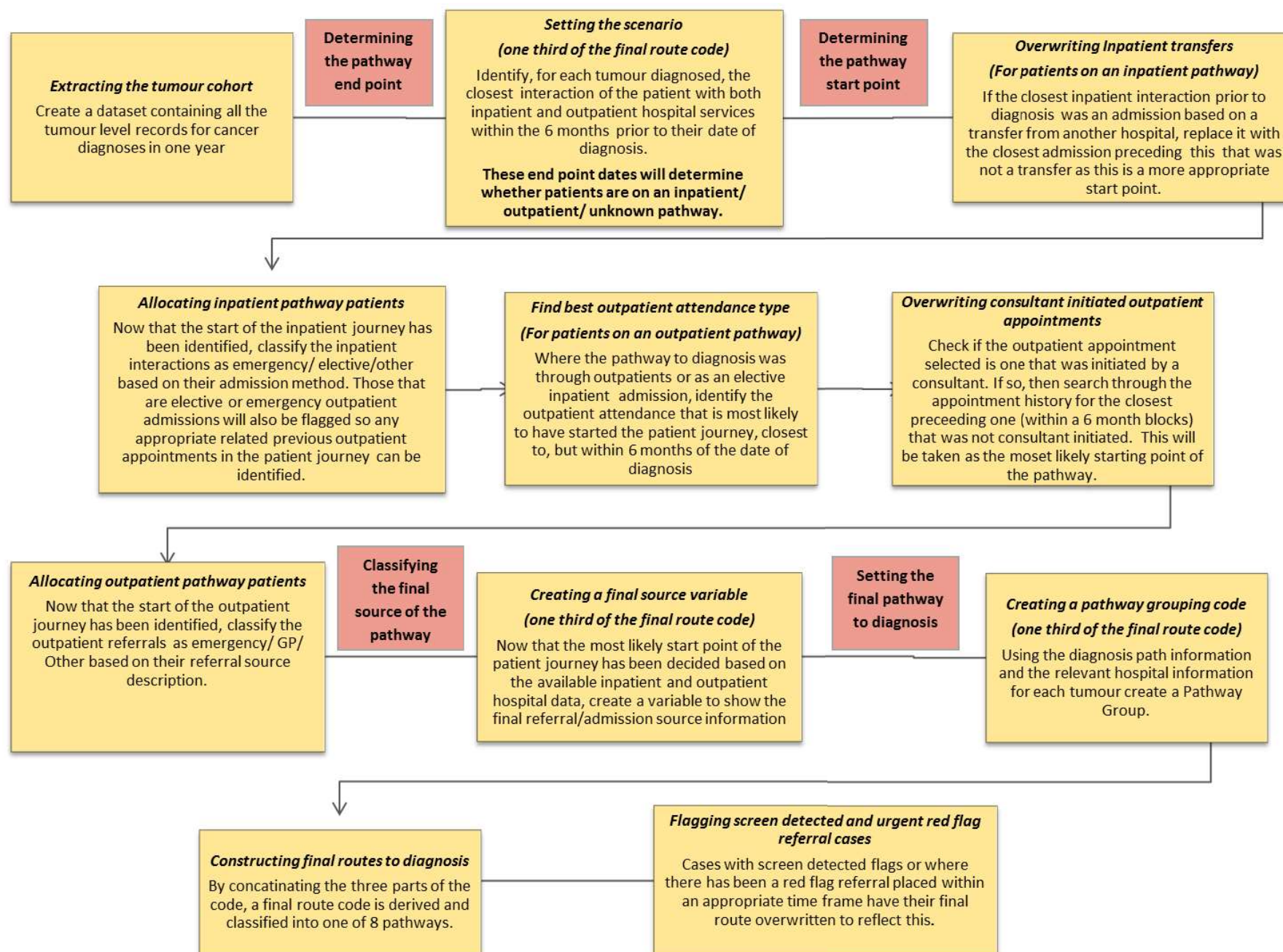
DCO: diagnosis by death certificate only

Unknown: no relevant data available from hospital inpatient or outpatient records, CaPPS or screening information on the Cancer Registry.

Final Route to Category Mapping

No.	Route code	Route group	No.	Route code	Route group
1	DC-D-DCO	DCO	43	OP-B-O3	GP referral
2	DC-E-DCO	DCO	44	OP-B-O4	Emergency presentation
3	IP-A-I0	Unknown	45	OP-B-O5	Other outpatient
4	IP-A-I11	Inpatient Elective	46	OP-B-O6	Other outpatient
5	IP-A-I12	Inpatient Elective	47	OP-B-O7	Other outpatient
6	IP-A-I13	Inpatient Elective	48	OP-B-O8	Other outpatient
7	IP-A-I21	Emergency presentation	49	OP-B-O10	Emergency presentation
8	IP-A-I22	Emergency presentation	50	OP-B-O11	Other outpatient
9	IP-A-I23	Emergency presentation	51	OP-B-O12	GP referral
10	IP-A-I24	Emergency presentation	52	OP-B-O13	Other outpatient
11	IP-A-I25	Emergency presentation	53	OP-B-O14	Other outpatient
12	IP-A-I28	Emergency	54	OP-B-O15	Other outpatient

		presentation			
13	IP-A-I31	Inpatient Elective	55	OP-B-O16	Other outpatient
14	IP-A-I32	Inpatient Elective	56	OP-B-O17	Screening
15	IP-A-I81	Inpatient Elective	57	OP-B-O92	Other outpatient
16	IP-A-I82	Inpatient Elective	58	OP-B-O93	Other outpatient
17	IP-A-I83	Inpatient Elective	59	OP-B-O97	Other outpatient
18	IP-A-I99	Unknown	60	OP-B-O99	Unknown
19	IP-C-O0	Unknown	61	SC-C-null	Unknown
20	IP-C-O1	Emergency presentation	62	SC-C-O1	Emergency presentation
21	IP-C-O2	Other outpatient	63	SC-C-O2	Other outpatient
22	IP-C-O3	GP referral	64	SC-C-O3	GP referral
23	IP-C-O4	Emergency presentation	65	SC-C-O4	Emergency presentation
24	IP-C-O5	Other outpatient	66	SC-C-O5	Other outpatient
25	IP-C-O6	Other outpatient	67	SC-C-O6	Other outpatient
26	IP-C-O7	Other outpatient	68	SC-C-O7	Other outpatient
27	IP-C-O8	Other outpatient	69	SC-C-O8	Other outpatient
28	IP-C-O10	Emergency presentation	70	SC-C-O10	Emergency presentation
29	IP-C-O11	Other outpatient	71	SC-C-O11	Other outpatient
30	IP-C-O12	GP referral	72	SC-C-O12	GP referral
31	IP-C-O13	Other outpatient	73	SC-C-O13	Other outpatient
32	IP-C-O14	Other outpatient	74	SC-C-O14	Other outpatient
33	IP-C-O15	Other outpatient	75	SC-C-O15	Other outpatient
34	IP-C-O16	Other outpatient	76	SC-C-O16	Other outpatient
35	IP-C-O17	Screening	77	SC-C-O17	Screening
36	IP-C-O92	Other outpatient	78	SC-C-O92	Other outpatient
37	IP-C-O93	Other outpatient	79	SC-C-O93	Other outpatient
38	IP-C-O97	Other outpatient	80	SC-C-O97	Other outpatient
39	OP-B-null	Unknown	81	SC-C-O99	Unknown
40	OP-B-O0	Unknown	82	UN-D-UNK	Unknown
41	OP-B-O1	Emergency Presentation	83	UN-E-UNK	Unknown
42	OP-B-O2	Other outpatient			



Running the Pathways to diagnosis SQL Code

There are 13 files to be run to produce the pathway to diagnosis for each of the tumour level records. Each of these process files will need to be run separately for each applicable year of diagnosis

All the files are stored and numbered in the **Project 024** folder in the subfolder called '**Jen Algorithm Replication**'.

1. Extract Tumour Cohort from NICR dataset

(You need to update the selected year in this section)

This section of code extracts the cohort and variables from the pre-prepared NICR dataset that are required for determining the pathway to diagnosis. These variables are saved into a new table which matches the PHE structure and this can then be updated to produce the finalised Pathways dataset.

2. Set Scenario

(You don't need to update any code in this section)

This file calculates the 'Route Scenario' for each record in the file. The Route Scenario is the end point for each patient that is the final contact point of the patient before they are diagnosed with cancer (based on the NICR date of diagnosis). This will form one third of the final route code.

There are a number of additional variables that will be used for the calculation; these are created in the first section. Once this has been done the code takes the Outpatient and Inpatient extracts and joins them to each tumour record in the NICR based on the STUDY_ID. Next the code selects the dates of the hospital inpatient and outpatient interactions which happened closest in time to the date of diagnosis of each record in the NICR extract. We only check within 180 days prior to the diagnosis date, anything outside this timeframe is not assumed to be connected.

The number of days between the closest Outpatient appointment and Inpatient admission for each tumour diagnosis is calculated. This information is then used to determine the route scenario number. The route scenarios are then aggregated into five different end point categories according to the rules

detailed [above](#) – Inpatient, Outpatient, Special Case, Death Certificate and Unknown.

3. Inpatient Transfer Overwrite

(You don't need to update any code in this section)

This file identifies instances where the closest Inpatient admission has an admission method of '81' meaning they were a transfer from another hospital. For these cases we want to look back to the inpatient admission that was closest before this that was not a transfer. In other words we want to try and identify the start point of the patient entering hospital. This change is only needed for patients who have been assigned to an inpatient pathway in the previous section.

There are a number of additional variables that will be used for the calculation; these are created in the first section. Once added, the code then places a flag against all cases where the admission method is '81' and the diagnosis path is classified as inpatient ('IP').

For this subset only, the code now identifies the closest admission prior to the one flagged that has an admission method other than '81' (i.e. not a transfer from another hospital). We only check within 180 days prior to the flagged date, anything outside this timeframe is not assumed to be connected. As a patient can have multiple admissions within the six month time period, the code uses the rank function order by clause to sure identify the closest. If there are two admissions on the same day episode end date then episode order are used to rank them.

The relevant information relating to these newly selected admissions is populated into the 'IP_PreTransfer_Admmimeth',' IP_PreTransfer_Epistart' and 'IP_Elective_Admidate' variables.

Next this section of code assigns a 'final' admission method to each of the cases on the inpatient diagnosis pathway. For the cases above where we

identified a non-transfer admission, that admission method is used. Otherwise, the original method is used. There will likely be some of the '81' cases where we weren't able to override the admission with a more appropriate earlier one, in these cases the '81' is retained.

Finally, the final admission date information is updated for the cases where we now have a different admission to the one originally identified.

We have now identified the start point for all the inpatient pathway cases.

4. Allocate Inpatient Records

(You don't need to update any code in this section)

Now that we have identified a final admission method for all patients on the inpatient diagnosis pathway, this section of code buckets all the cases into 'emergency', 'elective' or 'other' categories.

Each group is populated based on the final admission method codes. There is some divergence from the PHE code here. For **emergency inpatients** codes 2A 2B 2C 2D have been removed as they don't exist in NI, all of these methods are included under code 28 instead. Also, code 25 (emergency admission following domiciliary visit by consultant) has been included; this doesn't appear in the English HES codes.

Where the inpatient method was non-elective then we need to remove the 'IP_Elective_Admidate' information. The next section of the code performs this step. Admission method code '24' needs to have the 'IP_Elective_Admidate' retained; this is an emergency code but is for outpatients so different to the other emergency categories.

Where an inpatient admission was elective (or via and emergency outpatient referral) we will go on to look for preceding outpatient appointments. For this reason these cases are now flagged so they can be identified easily.

Elective inpatients are now identified and flagged, including the emergency outpatients as well as the transfers that we were unable to overwrite before.

Finally, all remaining cases falling into the 'other' category are flagged. Again there is some divergence from PHE. Codes 84 and 89 which were in the PHE code have been removed as they don't apply in NI; these are included under 0 which has been included here instead. These codes are all used to classify 'Unknown' admission method.

5. Find Best Outpatient Attendance Type

(You don't need to update any code in this section)

Having dealt with those patients on the Inpatient pathway this section addresses the outpatient initiated cases. This will be those bucketed into the 'OP' or 'SC' categories of those flagged as elective inpatients in the previous section. The code is used to find the most appropriate outpatient appointment prior to the date of diagnosis (i.e. the one most likely to have initiated the pathway to diagnosis).

There are a number of variables used by this section of code which must be set to null, also the 'OP_Step_Flag' must be set to 1 to identify the subset being examined.

It is important to note that some of the emergency outpatient cases were flagged for this in the previous section so it is important not to clear this flag or they will be dropped from the subset.

The code splits the outpatient appointments into first, review and unknown and examines each of these groups in relation to every tumour to find the closest in time to date of diagnosis, within a six month period. The appointments are placed in separate tables.

When selecting final appointments for the NICR extract preference is ranked in the following order; first appointments, then review and finally unknown (our dataset currently has no unknown cases). The appointment details are inserted into the appropriate columns in the main table and the temporary tables dropped as they are no longer required.

6. Outpatient Consultant Overwrite

(You don't need to update any code in this section)

This section is used to flag outpatient appointments where the appointment identified as the start point closest to the date of diagnosis was initiated by a consultant. For these appointments we will look to see if there is an earlier more appropriate one that wasn't initiated by a consultant.

There are a number of additional variables that will be used for the calculation; these are created and populated as either 0 or null in the first section. Once this has been done the code flags all the selected outpatient appointments where the referral source is consultant initiated.

7. Outpatient Consultant Overwrite

(You don't need to update any code in this section)

Now that the consultant initiated outpatient appointments have been flagged, this section of code is used to overwrite these, where possible, with the closest non-consultant initiated appointment that preceded it (again within a six month time frame). As before, the appointments are split into type and ranked with first being preferable, followed by review and unknown last.

The cases that are selected for the Outpatient Consultant Overwrite have specific referral source codes and cases are only selected where the outpatient appointment has not been initiated by the consultant responsible for the appointment.

In Northern Ireland we have noticed that there are a number of cases with a final Outpatient Route-to-Diagnosis who have a referral Source of 11.

This equates to "Initiated by consultant responsible for the appointment – Consultant – Other (11)".

These cases are not selected as part of the consultant overwrite and maintain their "outpatient" route-to-diagnosis status.

The code has been written deliberately this way by PHE however this could be investigated to see if the same rationale in terms of coding applies in Northern Ireland.

Examination of a sample of these cases does show that earlier GP Referrals were present for a number of cases so altering the code to include these cases in the consultant overwrite could potentially lead to a decrease in the outpatient routes and an increase in GP Referrals.

However before making this amendment consultation with PAS Systems managers and clinicians would be required to assess the type of cases that are being assigned this referral source in the outpatient universe.

Finally, the PHE code preforms a looping process to keep looking back in 6 month blocks, at present this has not been automated for NI but was done on a manual basis. There are small numbers of cases involved. Further development is required to introduce a loop to the NI analysis.

8. Allocate Outpatient Records

(You don't need to update any code in this section)

This section of code is used to 'bucket' the final selection of outpatient appointments based on their referral source. Appointments are classified into three groups – 'GP referral', 'Emergency referral' and 'Other source of referral'. This information is not necessary for the pathway definition but is a useful extra insight into the data.

9. Consultant HES Related Route Code

(You need to update the year in the section used to code pathway group 'B')

This portion of code is used to construct the pathway grouping of the route to diagnosis and the final referral source. These are the other two thirds of the

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

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

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

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

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

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

10. Check for Screening Data

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

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

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

11. Check for Suspect Red Flag Data

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

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

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

12. Derive Final Route

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

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

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

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

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



NICaN policy on
patient information.p



Title	Guidance for HSC staff on the provision of information to people affected by cancer	
Developed by	HSC Trust Cancer Information Leads – see Appendix 3	NICaN Service Improvement Lead for Patient Information – see Appendix 4
Version Control	Final version 1.0 issued May 2017	
Implementation	All Trusts	
Contact Person (s)	HSC Trust Cancer Information Leads	NICaN Office Tel: Personal information redacted by USI
Review Date	June 2019	
Group Responsible	HSC Trust Cancer Information Leads	



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Section 1: General Information

1. Purpose

This Guidance has been developed to support the implementation of generic information packs across cancer health and social care (HSC) services.

2. Scope

This Guidance relates to all HSC staff. It is not limited to specialist cancer services and staff.

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

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

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

3. Aims/objectives

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



4. Roles and responsibilities:

4a. HSC Trust leads for cancer patient information

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

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

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

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

4b. NICaN role for Patient Information

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

4c. Staff providing specialist and non-specialist cancer care

The main roles of staff relevant to this Guidance are to provide appropriate information to patients in line with cancer information pathways and to record such provision as evidence for audit.

5. Context

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

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

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

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

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

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



of patients reported having received information on the type of cancer they had at diagnosis compared to 72% in England. It also showed that only 66% of patients reported having received information on the type of operation they were having compared to 76% in England (i).

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

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

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

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

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

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

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

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

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

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



Section 2: Generic Information Packs

6. What is a generic information pack?

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

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

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

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

7. Where can staff find information packs?

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

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



Section 3: Providing information

8. The interaction between information provider and recipient

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

These steps are outlined in Appendix 1.

See section 9 below for reference to complex interactions.

9. Skills development in information provision

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

10. Recording information provision

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

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

Section 4: Monitoring and review

11. Monitoring:

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

12. Review:

This Guidance will be reviewed in June 2019



References

- i. Northern Ireland Cancer Patient Experience Survey, 2015
- ii. Improving Supportive and Palliative Care for Adults with Cancer, National Institute for Clinical Excellence, 2004
- iii. NHS Cancer Plan, 2000
- iv. The Quality of Life. Fallowfield L. London Human Horizons Series Souvenir Press 1990
- v. Information needs of cancer patients in the west of Scotland Meredith C, Symonds P, Webster L, Lamont D, Pyper E, Gillis CR, Fallowfield L. BMJ 1996 313 724-726
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Appendices

Appendix 1 - The information interaction

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

Appendix 2 - Cancer Information Leads as at January 2017

Appendix 3 - HSC Information post holders as at January 2017



Appendix 1: The information interaction

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

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



Appendix 2: Cancer Information Leads

Trust	Name	Designation
BHSCT	Margaret McManus	Information Manager, Macmillan Support and Information Centre
NHSCT	Pat McClelland	Clinical Services Manager
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Appendix 4: NICaN Service Improvement Lead for Patient Information (Oct 14- ? 15)

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



Title	Guidance for HSC staff on the provision of information to people affected by cancer	
Developed by	HSC Trust Cancer Information Leads – see Appendix 3	NICaN Service Improvement Lead for Patient Information – see Appendix 4
Version Control	Final version 1.0 issued May 2017	
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Contact Person (s)	HSC Trust Cancer Information Leads	NICaN Office Tel: Personal Information redacted by USI
Review Date	June 2019	
Group Responsible	HSC Trust Cancer Information Leads	



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Section 3: Providing information

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12. Review:

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Clarify and summarise	1.Clarify the question to ensure you have interpreted their needs correctly 2.Describe and agree together what they need 3.If there are a range of issues, consider prioritising some– do this with the person and check that they are happy to do so
Guide enquirer through range of options appropriate to them and their query These options may be you providing information yourself, or you signposting them somewhere else	1. Consider resources listed in the information pathway. –Published leaflets –Non-print resources, e.g. CD –Guided internet search –Listening support –Counselling –Signposting to specialist services 2. Consider the person's information capacity. Do they need information in another language, an 'alternative format' or at a higher/lower literacy level? Remember you may have a statutory duty here (you can ask your Equality Manager for more information about this) 3.Go through the benefits and limitations of the options 4.Do not overwhelm the person 5.Agree and provide the information materials 6. If you don't know the answer to their question, signpost the person to an appropriate source. Do not risk giving wrong information 7.Offer the person written details of any websites or organisations and any resources you do not have to hand
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Appendix 2: Cancer Information Leads

Trust	Name	Designation
BHSCT	Margaret McManus	Information Manager, Macmillan Support and Information Centre
NHSCT	Pat McClelland	Clinical Services Manager
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SHSCT	Fiona Reddick	Head of Service
WHSCT	Elizabeth England	Lead Cancer Nurse

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Trust	Name	Designation
BHSCT	Margaret McManus(BCH),	Information Manager
	Angela Small (RVH)	Information Manager
	Lindsey Anderson (BCH)	Information and Support Radiographer
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NHSCT	Norma Adams	Information and Support Manager
WHSCT	Martha Magee	Information Manager
SHSCT	Sharon Clarke	Health and Wellbeing Coordinator

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

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

JOB DESCRIPTION

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

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Care

ACCOUNTABLE TO: Medical Director

COMMITMENT: 3 PAs

LOCATION: Trustwide

Context:

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

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

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

Job Purpose:

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

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

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.

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

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

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

Leadership Responsibilities

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

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

The Divisional Medical Director with the assistant-director and professional leads will work in partnership to achieve the above objectives.

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

Appraisal and Revalidation

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

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

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

Job Planning

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

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

Implementation of HR policies for medical staff

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

Budgetary management

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

GENERAL REQUIREMENTS:

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.
4. Adhere at all times to all Trust policies including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct

5. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
6. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
7. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.
8. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.
9. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

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

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

SOUTHERN HEALTH & SOCIAL CARE TRUST**PERSONNEL SPECIFICATION**

JOB TITLE Divisional Medical Director

DIRECTORATE Surgery and Elective Care

Notes to applicants:

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

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

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

1. Applicants must be a permanent Consultant within the Southern Health and Social Care Trust.
2. Hold a medical qualification, GMC registration with License to Practice and specialist accreditation (CCT).
3. Experience of leadership within a team that led to successful service development and/or quality improvement.
4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

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

5. Excellent communication skills, both orally and in writing.
6. Be prepared to undertake clinical management and leadership development.

IMPORTANT NOTES REGARDING SELECTION PROCESS / INTERVIEW PREPARATION:

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

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

following shortlisting. To arrange a suitable appointment please contact Emma Campbell on

Personal information redacted by USh.

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

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

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

JOB DESCRIPTION

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

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Care

ACCOUNTABLE TO: Medical Director

COMMITMENT: 3 PAs

LOCATION: Trustwide

Context:

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

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

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

Job Purpose:

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

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

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.

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

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

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

Leadership Responsibilities

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

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

The Divisional Medical Director with the assistant-director and professional leads will work in partnership to achieve the above objectives.

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

Appraisal and Revalidation

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

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

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

Job Planning

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

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

Implementation of HR policies for medical staff

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

Budgetary management

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

GENERAL REQUIREMENTS:

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
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4. Adhere at all times to all Trust policies including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct

5. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
6. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
7. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.
8. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.
9. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

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

SOUTHERN HEALTH & SOCIAL CARE TRUST**PERSONNEL SPECIFICATION**

JOB TITLE Divisional Medical Director

DIRECTORATE Surgery and Elective Care

Notes to applicants:

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

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

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2. Hold a medical qualification, GMC registration with License to Practice and specialist accreditation (CCT).
3. Experience of leadership within a team that led to successful service development and/or quality improvement.
4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

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

5. Excellent communication skills, both orally and in writing.
6. Be prepared to undertake clinical management and leadership development.

IMPORTANT NOTES REGARDING SELECTION PROCESS / INTERVIEW PREPARATION:

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

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following shortlisting. To arrange a suitable appointment please contact Emma Campbell on

Personal information redacted by USh

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

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

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

JOB DESCRIPTION

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

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Care

ACCOUNTABLE TO: Medical Director

COMMITMENT: 3 PAs

LOCATION: Trustwide

Context:

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

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

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

Job Purpose:

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

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

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.

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

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

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

Leadership Responsibilities

- To provide assurance on the quality of the professional, clinical and patient safety / Multi-Disciplinary Team systems, processes and meetings within the division.
- To promote quality improvement and to grow and embed a culture of Collective Leadership within the Division.
- To manage the clinical quality of care within the Division, promoting a climate of continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.
- To promote and strengthen links with primary care services including communications and development of service pathway improvements
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- To strategically manage and develop the inter-relationships with primary care, the

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

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

The Divisional Medical Director with the assistant-director and professional leads will work in partnership to achieve the above objectives.

- To be a leader in the development of key quality and performance indicators for the Division and to ensure that effective performance management arrangements are in place.
- To ensure robust financial management of all medical staff across the Division
- To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
- To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.
- To model the HSC values.
- To act as an advocate for the Division.
- To represent the Division at the relevant senior Trust meetings.
- To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.
- To ensure that systems are in place so that all Health and Safety and other statutory requirements for patients, visitors, employees and contractors and the wider public are met.
- Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
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 - To provide quarterly updates on the progress of aspects of professional and social care governance
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Appraisal and Revalidation

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

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

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

Job Planning

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

- Monitor the completion of Job Plans within agreed timescales.
- Undertake Job Planning for Clinical Directors (and Lead Clinicians) and any other relevant medical staff.
- Advise and mediate in cases that cannot be resolved by Clinical Directors within existing job planning guidance.
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Implementation of HR policies for medical staff

- Co-ordinate and monitor implementation of all relevant policies including:
Annual Leave
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- Liaise with Human Resources for appropriate advice and support.
- Liaise with AMD for Education and Training and NIMDTA with regard to junior doctors in training for appropriate advice and support.

Budgetary management

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

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.
4. Adhere at all times to all Trust policies including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
5. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

6. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
7. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.
8. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.
9. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

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

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

SOUTHERN HEALTH & SOCIAL CARE TRUST**PERSONNEL SPECIFICATION**

JOB TITLE Divisional Medical Director

DIRECTORATE Surgery and Elective Care

Notes to applicants:

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

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

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

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

5. Excellent communication skills, both orally and in writing.
6. Be prepared to undertake clinical management and leadership development.

IMPORTANT NOTES REGARDING SELECTION PROCESS / INTERVIEW PREPARATION:

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

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

Personal information redacted by USI.

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

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

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

JOB DESCRIPTION

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

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Care

ACCOUNTABLE TO: Medical Director

COMMITMENT: 3 PAs

LOCATION: Trustwide

Context:

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

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

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

Job Purpose:

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

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

Main Duties / Responsibilities

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

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

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

Leadership Responsibilities

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

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

- To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full potential.
- To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:
 - (a) delivery of safe, high quality and effective person-centred care
 - (b) secures activity and performance
 - (c) maintains ongoing financial viability
 - (d) is aligned to corporate goals.

The Divisional Medical Director with the assistant-director and professional leads will work in partnership to achieve the above objectives.

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

Appraisal and Revalidation

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

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

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

Revalidation and Appraisal processes

Job Planning

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

Implementation of HR policies for medical staff

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

Budgetary management

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

GENERAL REQUIREMENTS:

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

4. Adhere at all times to all Trust policies including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
5. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.
6. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
7. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.
8. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.
9. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

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

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

SOUTHERN HEALTH & SOCIAL CARE TRUST**PERSONNEL SPECIFICATION**

JOB TITLE Divisional Medical Director

DIRECTORATE Surgery and Elective Care

Notes to applicants:

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

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER



What is Clinical Governance

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

What is Medical Professional Governance

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

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

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

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

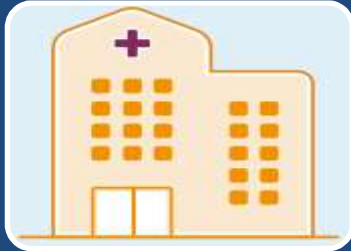
Safeguards are in place to ensure clinical governance arrangements for doctors are fair and free from bias and discrimination.

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

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

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

What this Means for.....



The Trust

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



Doctors

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



Regulators and quality improvement agencies

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

The Importance of Medical Leadership

‘Being a good doctor means more than simply being a good clinician’

(GMC, Leadership and management for all doctors)

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

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

Areas of Development to Date

Revision of Medical Leadership Structures

Introduction and Appointment of Deputy Medical Directors, Divisional Medical Directors and Clinical Directors

Newly developed individual structured accountability framework for Divisional Medical Directors

Strengthening Appraisal and Revalidation

Establishment of Medical Revalidation Oversight Group

Development of Medical Appraisal Mentoring Scheme

Additional Medical Appraisal and Revalidation Staffing

Improving Governance and Oversight of Medical Private Practice

Enhanced Declaration of Private Practice

Review of Private Practice Guidance -Revision of Change of Status form process

Private Practice Structured Reflective Template (Whole Practice Appraisal)

Private Practice Assurance Audits



Southern Health
and Social Care Trust

Revision of Medical Leadership Structures

Deputy Medical Directors

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

Divisional Medical Directors

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

Clinical Directors

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

Strengthening Professional Governance Roles

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

Revision of Medical Leadership Structures

Divisional Medical Director Key Professional and Clinical Governance Duties

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

Monthly DivMD Accountability Meetings

Professional Governance

Job Planning

Medical Appraisal

Revalidation

Professional Performance Management

Medical Workforce

Doctors and Dentists Oversight

Clinical and Social Care Governance

Adverse Incidents (Datix)

Serious Adverse Incidents

Litigation and Claims Management

Coronial Matters

Standards and Guidelines

Complaints

Morbidity and Mortality

Clinical Audit and Quality Improvement

Patient Safety

Other Relevant Areas

Medical Education

Research and Development



Southern Health
and Social Care Trust

What is Medical Appraisal

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

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

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

The appraisal process

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

What is Medical Revalidation

Medical Revalidation is a Quality Assurance Process

Revalidation is an evaluation of a doctors fitness to practise.

Supports doctors in regularly reflecting on how they can develop or improve their practice

Gives patients confidence doctors are up to date with their practice

Promotes improved quality of care by driving improvements in clinical governance.

Every licensed doctor who practises medicine in the UK must revalidate to show they are up to date and fit to practise.

Trust Revalidation Oversight Meeting

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

Medical Appraisal Mentoring Scheme

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

The purpose of the scheme will be to:

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

Medical Appraisal and Revalidation Augmentation

**Additional Medical Subject Matter
Experts**

Administrative and Systems Support



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

Policy for Shared Learning

Lead Policy Author & Job Title:	Stacey Hetherington, Corporate Clinical and Social Care Governance Co-Ordinator
Directorate responsible for document:	Medical Directorate
Issue Date:	28 July 2022
Review Date:	29 July 2024



Policy Checklist

Policy name:	Policy for Shared Learning
Lead Policy Author & Job Title:	Stacey Hetherington, Corporate Clinical and Social Care Governance Co-Ordinator
Director responsible for Policy:	Dr Damian Gormley, Interim Medical Director
Directorate responsible for Policy:	Medical Director
Equality Screened by:	Click here to enter text.
Trade Union consultation?	Yes ☒ No ☐
Policy Implementation Plan included?	Yes ☒ No ☐
Date approved by Policy Scrutiny Committee:	28 July 2022
Date approved by SMT:	
Policy circulated to:	Learning from Experience Forum, Interim Director for Clinical and Social Care Governance, Deputy Medical Director, Directorate Governance Co-Ordinators, Corporate Clinical and Social Care Governance Manager, Policy Scrutiny Committee, All Staff via SharePoint
Policy uploaded to:	SharePoint - Corporate Clinical and Social Care Governance

Version Control

Version:	V0_1		
Supersedes:	N/A – New Policy		
Version History			
Version	Notes on revisions/modifications and who document was circulated or presented to	Date	Lead Policy Author
Eg Version 1_0	Click here to enter text	Click here to enter a date.	Click here to enter text
Eg Version 2_0	Click here to enter text	Click here to enter a date.	Click here to enter text

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Introduction

The Southern Health and Social Care Trust (SHSCT) acknowledges the importance of assuring patient, service user and staff safety as a priority within the organisation. In order to achieve this assurance it is necessary to thoroughly investigate and extrapolate learning where opportunities to do this are presented, such as from incidents, all methods of service user feedback (complaints and compliments), audit, litigation (claims and coroners findings), mortality and morbidity meetings, professional fora, whistleblowing etc. (*this is not an exhaustive list*). Analysis of this information will contribute to facilitating pro-active risk management to help ensure the potential of similar events happening again is reduced.

This policy has been developed to demonstrate the SHSCT's commitment to continually improve from lessons learned and covers learning identified from internal sources and, in addition, learning obtained from external sources such as other HSC Trusts, NIAIC, regional learning shared by the Department of Health, particularly that shared from the Strategic Planning and Performance Group (SPPG).

This policy has been developed with the intention to capture and disseminate learning relating to SHSCT Corporate issues and not exclusively to Clinical and Social Care Governance issues only.

This policy and the formal process for sharing learning are intended to strengthen dissemination of identified learning and should not replace any form of direct communication or discussion that occurs in a one to one, team meeting or professional basis.

Safety Alerts issued on a regional or national level, will be issued and circulated separate to this policy and shared learning pathway.

Purpose and Aims

The purpose of this policy is to ensure that the safety lessons learnt, from internal and external sources, are appropriately and widely shared across the SHSCT. Any improvements required in response to lessons learnt will be implemented through an action plan and compliance audited.

Objectives of this Policy

- To ensure learning from internal and external sources is shared with all staff across SHSCT
- To make improvements in response to lessons learnt to reduce the potential of recurrence using a systematic and coordinated approach to solve a problem using specific methods and tools with the aim about bringing about measureable improvement
- To share best practice to enable continuous improvement

- To promote a culture of openness and transparency with findings in regards to incident and near miss reporting
- To promote a risk management ethos across the Trust
- To develop a central source of learning on SharePoint for staff to access as required

Policy Statement

Sources of Learning

Learning may be derived from a number of sources, internal and/or external to the organisation (*this is not an exhaustive list*):

- Corporate issues
- Adverse incidents
- Serious Adverse Incidents (SAI)
- Structured Judgement Reviews (SJR)
- Significant Event Audits (SEA)
- Near misses
- Complaints
- Ombudsman Case
- Compliments
- Standards and Guidelines
- Mortality and Morbidity review
- Litigation (including claims and coroners findings)
- Audits
- Case Management Reviews (child protection)
- Concerns raised by staff (whistleblowing)
- Professional fora
- Regional learning letters issued from:
 - events in other Trusts
 - NIAIC
 - Department of Health

Method for sharing learning

Shared Learning Template

The SHSCT Shared Learning Template (Appendix 2) will be used to disseminate learning, it is usually a one page document which can be easily read, displayed and filed. It should not name staff or the specific area where the event occurred. Information shared should be in accordance with the Data Protection Act 2018.

The template should be completed at the end of an investigation/review or in any instance where learning has been identified and appropriate dissemination of such learning is required.

Learning identified as being relevant to other Directorates and beyond should be discussed by the Director/Assistant Director at relevant

meetings, such as Weekly Governance Meeting, Governance Co-ordinators meeting, SAI Oversight Group, Complaints Group etc. or at the Learning from Experience Forum for a decision on the extent of dissemination required.

All Shared Learning Templates will be disseminated from the Corporate Governance Office to Directorate Governance Co-Ordinators for onward dissemination as identified. Confirmation that learning has been received by each Directorate and that the SHSCT Shared Learning Template has been disseminated will be sought by the Corporate CSCG team.

All SHSCT Shared Learning Templates will be available on the Corporate CSCG link on SharePoint. Additional methods for staff awareness of learning will be dictated by the applicability of learning identified within the template e.g. Southern-I, Global email etc.

Action Plans

Action plans will be generated for improvements required in response to lesson learnt. These actions should have an appropriate timeframe for completion, a named responsible individual and will be subject to audit by Corporate CSCG office.

Types of Learning

Local Learning (within service area, ward, department etc.)

Learning identified as only being relevant to the specific area/department where the incident, complaint, audit etc. occurred should be discussed on an individual basis where necessary and at the local staff/team meeting. Details of the learning and relevant meeting, along with any evidence such as meeting minutes, reflective practice notes etc. should be recorded on Datix. The Datix approver should ensure learning has been annotated, along with details of any investigation completed and actions taken prior to signing off.

Specific local learning is not required to be formally shared more widely, however a Shared Learning Template (Appendix 2) should be completed and sent to the Corporate Governance Office for upload onto Sharepoint.

Shared Learning within Directorates

Often learning identified will apply to other areas within the same Directorate. In this instance, learning should be shared via Directorate Governance Co-Ordinator, included on Directorate Governance meeting

agenda/minutes for audit purposes and also documented on Datix as above.

A Shared Learning template (Appendix 2) should be completed and sent to the Corporate Governance Office for dissemination to the relevant services within that Directorate.

Shared Learning beyond Directorates

Where learning has been identified as being relevant between Directorates, learning should be shared via the Directorate Governance Co-Ordinator, discussed and approved by the appropriate 'Group' within the Assurance Framework and reported to the Learning from Experience Forum which provides assurance that learning has been shared appropriately.

A Shared Learning template (Appendix 2) should be completed and sent to the Corporate Governance Office for dissemination to the relevant Directorates.

Shared Learning Template Trustwide

Where learning has been identified as being applicable across the organisation, learning should be shared via the Directorate Governance Co-Ordinator/Director, discussed and approved by the appropriate 'Group' within the Assurance Framework and reported to the Learning from Experience Forum which provides assurance that learning has been shared appropriately.

A Shared Learning template (Appendix 2) should be completed and sent to the Corporate Governance Office for dissemination across the Trust.

Regional shared learning

The SHSCT is required to address Learning Letters received from the DoH and/or findings from external/regional audit. Learning Letters/findings will be disseminated from the Corporate Governance Department to Directors/Directorate Governance Co-Ordinators for dissemination as appropriate.

If the SHSCT has identified learning that other Trusts across the region should be alerted to urgently, this should be directly shared as a matter of urgency between Trust's and communicated to the SPPG. Where regional learning has been identified through the investigation of an SAI,

this will be communicated by completion of the appropriate form held within the Procedure for the Reporting and Follow up of Serious Adverse Incidents.

Other methods of sharing learning within the Southern Health and Social Care Trust

Shared learning templates will inform and provide an assurance to Governance Committee, Trust Board, PCE etc. of the lessons learned and actions taken to improve patient safety across the organisation.

Learning to be shared Trustwide, from any source, will require oversight and sign-off by a Director.

Where Shared Learning identifies risk within a service area this should be escalated for inclusion on the appropriate Risk Register through the Directorate CSCG Co-Ordinator/Director and an appropriate time bound action plan put in place to minimise and/or mitigate the risk.

Coding of Learning

Shared Learning Templates will be categorised in accordance with the CCS2 codes on Datix, this will enable learning to be catalogued and themed as the resource expands. It is anticipated that this information will be used to develop dashboards and help identify areas of risk, quality improvement and staff training. Coding will also enable Shared Learning Templates to be re-issued as appropriate by way of a reminder should a trend in similar incidents, complaints etc. be identified prior to the review/investigation being fully completed.

Implementation of Policy

Dissemination

Following approval, the policy will be disseminated to all staff across the organisation. Implementation will begin immediately upon approval and issue of Policy and once Corporate CSCG department commence issuing and storing shared learning templates.

Exceptions

None

Monitoring

The process for monitoring the effectiveness of all of the above will be primarily monitored through the Learning from Experience Forum but will also be managed via the following arrangements:

- Controls Assurance Standards
- Governance Committee Meetings
- SAI Oversight Group
- Complaints Review Group
- Governance meetings
- Litigation meetings
- Morbidity & Mortality (M&M) Review Meetings
- Audit
- Professional Governance Structures
- SHSCT Education and Learning teams

Scope of Policy

This policy applies to all staff (permanent, temporary, locum, agency, bank, students, contractors and voluntary) in the SHSCT.

Responsibilities

Corporate Clinical and Social Care Governance (CSCG) will be responsible for receiving Trustwide learning from multiple sources and for disseminating the learning as indicated. The Corporate CSCG team will also be responsible for maintaining a central source of learning shared for staff to access as required on Sharepoint. As directed, Corporate CSCG team will be responsible for sharing awareness of learning e.g. Southern-I, Global email etc.

Directors and Directorate CSCG Co-Ordinators will be responsible for the onward dissemination to relevant staff and teams. It is important that where learning has been identified for specific teams/services that this is discussed at team meetings, through Supervision or at Directorate corporate/governance meetings and/or M&M review meetings, implementing safety improvements if necessary.

The Corporate CSCG team will monitor and report on shared learning activity, with particular focus on those which identified safety improvements required on a quarterly basis through the Governance Committee report. The team will also be responsible for auditing action plans generated from identified learning.

Legislative Compliance, Relevant Policies, Procedures and Guidance

HSCB Procedures for the Reporting and Follow up of Serious Adverse Incidents (November 2016)

Equality & Human Rights Considerations

In line with duties under the equality legislation (Section 75 of the Northern Ireland Act 1988), Targeting Social Need Initiative, Disability discrimination

and the Human Rights Act 1998, an initial screening exercise to ascertain if this policy should be subject to a full impact assessment has been carried out.

The outcome of the Equality screening for this policy is:

Major impact ☐

Minor impact ☐

No impact ☐

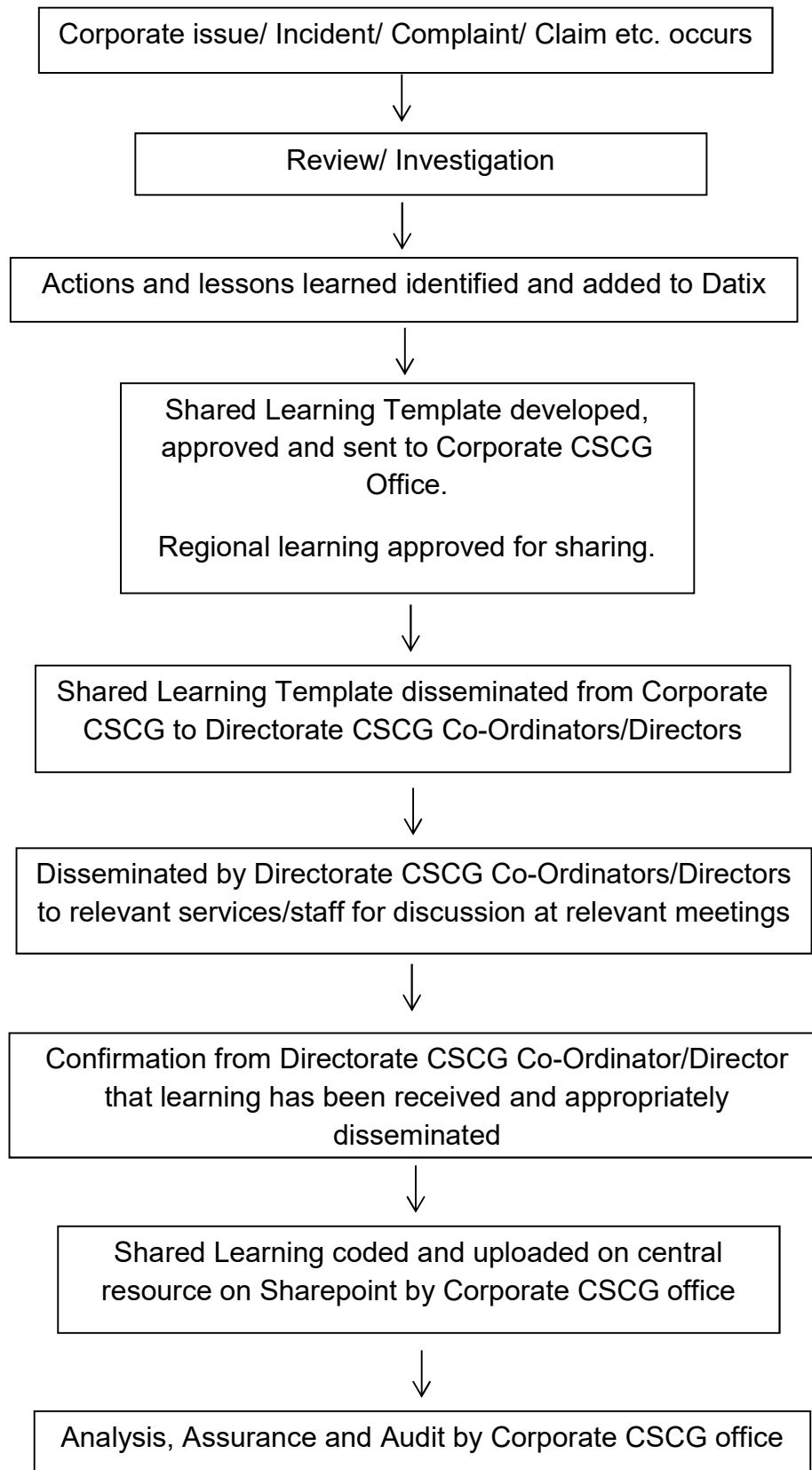
SIGNATORIES:

DATE:

Sources of Advice & Further Information

Appendix 1: Flowchart for Sharing Learning

Appendix 2: SHSCT Shared Learning Template

Appendix 1 – Flowchart for Sharing Learning

Appendix 2 – SHSCT Shared Learning Template

Shared Learning Template

Date issued:		Ref. No.	
Area learning identified: (Please highlight, in the case of 'Other' please identify source)	<i>Corporate Issue / Incident / SAI / SJR / SEA / Adverse Incident / Complaint / Compliment / Audit / Litigation / M&M / External Learning Letter / Other</i>		
Shared Learning Title:			
Summary – what happened?			
Please provide a brief, confidential summary of the event			
What went well?			
Please provide details of positive actions/outcomes			
What, if anything, could we improve?			
Please make any suggestions you think may improve this situation or prevent it from reoccurring			
What have we learned?			
In bullet form, please provide details of any immediate, urgent learning to be shared			
Shared Learning to be disseminated:			
Locally, where event occurred:	☐	To other services within Directorate: (Please specify)	☐
To other Directorate(s): (please specify)	☐	Trustwide:	☐
Regionally: (please complete HSCB form)	☐	Professional Specific Practice: (please specify)	☐
Other: (please specify)	☐		
Coding:			
Director Signature:			Date:

Initial call made to CMO Office (DoH) on 31.07.2020 DATE

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name Dr Maria O'Kane Organisation Southern Health and Social Care Trust
 Position Medical Director Telephone Personal Information redacted by USI

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. Urgent regional action
2. **Contacting patients/clients about possible harm**
3. Press release about harm
4. **Regional media interest**
5. Police involvement in investigation
6. Events involving children
7. Suspension of staff or breach of statutory duty

Brief summary of event being communicated: **If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.*

On 7th June 2020 the Trust became aware of potential concerns regarding delays of treatment of surgery patients who were under the care of a Trust employed Consultant Urologist. As a result of these potential patient safety concerns a lookback exercise of the Consultants work was conducted to ascertain if there were wider service impacts. The lookback which considered cases over a 17 month period (period 1st January 2019 - 31st May 2020), the following was found:

- The emergency lookback concentrated on whether the patients had a stent inserted during procedure and if this had been removed. 147 patients taken to theatre that was listed as being under the care of the Consultant during the lookback period with concerns identified in 46 of these cases.
- There were 334 elective-in patients reviewed where 120 of cases were found to have experienced a delay in dictation ranging from 2 weeks to 41 weeks, a further 36 patients who had no record of care noted on the regional NIECR system. To date one of the elective in-patient cases has been identified for screening for Serious Adverse Incident review.

In addition two recent cases managed by this consultant have been identified which are being screened as Serious Adverse Incidents involving two prostatic cancer patients that indicate potential deficiencies in care provided by the consultant in question where these deficiencies potentially had an impact on patient prognosis. The following actions have been taken:

- Discussions with the GMC employer liaison service have been conducted
- This case has been discussed with NHS Resolutions who have recommended restrictions of clinical practice including a request to the Consultant not to undertake private practice in his own home or other premises pending further exploration
- Restrictions have been placed by the Trust that they no longer to undertake clinical work and that they do not access or process patient information either in person or through others either in hard copy or electronically. A request has also been made they voluntarily undertake to refrain from seeing any private patients at their home or any other setting and confirm the same in writing.
- A preliminary discussion has been undertaken with the Royal College of Surgeons invited Review Service regarding the consultants practice and potential scope and scale of any lookback exercise

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Stephen Wallace / Zoe Parks

Contact details:

Email address (work or home) Personal Information redacted by USI

Mobile (work or home) Personal Information redacted by USI Telephone (work or home) Personal Information redacted by USI

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

FOR COMPLETION BY DoH:

Early Alert Communication received by: Office:

Forwarded for consideration and appropriate action to: Date:

Detail of follow-up action (if applicable)

Initial call made to Ryan Wilson

(DoH) on 15th October 2020 DATE**Follow-up Pro-forma for Early Alert Communication:****Details of Person making Notification:**

Name Dr Maria O'Kane Organisation Southern Health and Social Care Trust

Position Medical Director Telephone Personal Information redacted by USI

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. Urgent regional action
2. Contacting patients/clients about possible harm
3. Press release about harm
4. Regional media interest
5. Police involvement in investigation
6. Events involving children
7. Suspension of staff or breach of statutory duty

Brief summary of event being communicated: ** If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.*

Further to Early Alert dated 31st July 2020 (attached for ease of reference) relating to the provision of Trust Urology Services additional significant concerns have been brought to the attention of the Trust regarding prescribing practices regarding the medication Bicalutamide by the individual consultant who is no longer employed by Health and Social Care Services.

These additional concerns have been identified following an initial meeting of the Serious Adverse Incident review team which occurred this week. Concerns have been raised regarding the subject's prescribing practices which include use of unlicensed and sub-therapeutic dosages of Bicalutamide which we consider a significant and potentially wide patient safety risk requiring immediate action. Trust staff are working with the HSCB medications team to gain a better understanding of the implications of this latest development in terms of scale and scope and to identify patient groups that may be at risk. It is recognised that this prescribing issue involves medicines that are prescribed by primary care providers on advice from the secondary care team.

In addition to this early alert senior staff at HSCB, PHA and Department of Health have been briefed directly of this development. The Trust is continuing to liaise directly with colleagues in each organisation in order to take appropriate action.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Dr Maria O'Kane

Contact details:

Email address (work or home) Personal Information redacted by USI

Mobile (work or home) Personal Information redacted by USI Telephone (work or home)

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

FOR COMPLETION BY DoH:

Early Alert Communication received by: Office:

Forwarded for consideration and appropriate action to: Date:

Detail of follow-up action (if applicable)

CORPORATE RISK REGISTER

September 2022

INTRODUCTION

The SH&SCT Corporate Risk Register identifies corporate risks, all of which have been assessed using the HSC grading matrix, in line with Departmental guidance. This ensures a consistent and uniform approach is taken in categorizing risk in terms of their level of priority so that proportionate action can be taken at the appropriate level in the organization. The process for escalating and de-escalating risk at Team, Divisional and Directorate level, is set out in the Trust's Risk Management Strategy.

Each risk on the Register has been linked to the relevant Corporate Objectives which remain unchanged for 2022/23 as detailed below:-

Corporate Objectives

- 1: Promoting safe, high quality care.
- 2: Supporting people to live long, healthy active lives
3. Improving our services
4. Making the best use of our resources
5. Being a great place to work – supporting, developing and valuing our staff
6. Working in partnership

Where relevant, risks have also been linked to the **3 Corporate priorities** contained within the Corporate Plan 2022/23 as detailed below:-

1. Stablishing, Rebuilding and Growing
2. Improving access to planned services for our patients
3. Supporting unplanned, urgent and emergency services

Risk scoring is based on likelihood and impact as summarized in the Risk Assessment Matrix below.

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	Score	Frequency (How often might it/does it happen?)	Time framed Descriptions of Frequency
<i>Almost certain</i>	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
<i>Likely</i>	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
<i>Possible</i>	3	Might happen or recur occasionally	Expected to occur at least monthly
<i>Unlikely</i>	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
<i>Rare</i>	1	This will probably never happen/recur	Not expected to occur for years

Likelihood Scoring Descriptors	Impact (Consequence) Levels				
	Insignificant(1)	Minor (2)	Moderate (3)	Major (4)	Catastrophic (5)
Almost Certain (5)	Medium	Medium	High	Extreme	Extreme
Likely (4)	Low	Medium	Medium	High	Extreme
Possible (3)	Low	Low	Medium	High	Extreme
Unlikely (2)	Low	Low	Medium	High	High
Rare (1)	Low	Low	Medium	High	High

Risk Appetite: low (L); moderate (M); high (H) has also been included against each risk.

OVERVIEW OF CORPORATE RISKS AS AT SEPTEMBER 2022

The Corporate Risk Register remains a dynamic document which the Senior Management Team continually try and improve on. To that end, a deep dive into each corporate risk was undertaken by SMT during July and August 2022 with a view to populating a new streamlined Corporate Risk Register.

There are seven principal risk domains as follows:

1. People
2. Estates and Infrastructure
3. Access to Services
4. Technology Enablement
5. Finance
6. Infection, Prevention and Control
7. Urology Services Public Inquiry

Changes to the Register since August 2022**New risk**

On 22nd September 2022, SMT agreed the inclusion of Risk No. 1.7 'Risk to the consistent provision of high quality, safe care to children, young people and families due to shortages and vacancies across the Health Visiting service' on the Corporate Risk Register.

There are currently 32 corporate risks, the risk ratings of which are outlined below.

LOW	MEDIUM	HIGH	EXTREME	TOTAL
0	8	24	0	32

Risk No.	Risk Area/Description	Corporate Objective	Risk Rating	Page
1	People			
1.1	Risk to the consistent provision of high quality, safe medical care due to medical workforce shortages and vacancies within some specialties (exacerbated due to Covid-19)	1	HIGH	10
1.1a	Risk to the continuity of service provision within the Gillis Unit, St Luke's site, Armagh due to Consultant Psychiatry workforce shortages. Currently, there is only one permanent substantive Consultant Psychiatrist for the total Psychiatry of Old Age (POA) and Memory Service: three posts are vacant and one staff member remains on maternity leave until Autumn 2022	1	HIGH	13
1.2	Risk to safe, high quality care due to a high volume of medical locum engagements for different periods of time with varying levels of experience/training and often in hard to fill posts.	1	HIGH	14
1.3	Risk to the consistent provision of high quality, safe nursing care due to nursing and midwife shortages and vacancies across all Directorates and high nursing agency usage (exacerbated due to Covid-19)	1	HIGH	17
1.4	Risk to staff engagement, morale and health & wellbeing due to workforce capacity/demand pressures. (exacerbated due to Covid-19).	1 & 6	HIGH	19
1.5	Risk of potential harm to children due to Social Work vacancies impacting on the delivery of core Family Support & Safeguarding Services for children and families.	1	HIGH	21
1.6	Risk to the stability and effectiveness of Trust Board as a direct consequence of workforce vacancies at Senior Executive level and Non-Executive Director level.	1	MEDIUM	23
1.7	Risk to the consistent provision of high quality, safe care to children, young people and families due to shortages and vacancies across the Health Visiting service.	1	HIGH	24

Risk No.	Risk Area/Description	Corporate Objective	Risk Rating	Page
2	Estates and Infrastructure			
2.1	Insufficient capital to maintain and develop Trust Estates works (works under £1.5m) and maintenance programme this year	3 & 4	MEDIUM	26
2.2	Inability to complete Estates project by year end during to delay in availability of materials, delay with contractors or internal Estates capacity	3 & 4	MEDIUM	27
2.3	Risk of harm to visitor, staff and patients safety resulting from legionella, fire hazards and poor maintenance	1, 3 & 4	MEDIUM	28
2.4	Lack of controls over Health and Safety	1 & 4	MEDIUM	29
2.5	Risk that Trust does not achieve Year 2 Sustainability plan due to lack of resources and staffing	3 & 4	MEDIUM	30
2.6	Servicing of medical equipment not carried out in timely manner due to items not being sent to Estates for servicing or due to resourcing issues	1, & 4	HIGH	31

Risk No.	Risk Area/Description	Corporate Objective	Risk Rating	Page
3	Access to Services			
3.1	Risk to safe, high quality care due to delay in accessing elective services for assessment, diagnostics and treatment in accordance with clinical need due to a demand and capacity mismatch compounded by staffing constraints and previously reduced capacity due to the Covid 19 Pandemic	1	HIGH	32
3.2	If demand continues to outstrip supply and review appointments or planned assessment/ treatment are not completed in line with clinical timescales, due to demand and capacity mismatch compounded by staffing constraints and previously reduced capacity due to the Covid 19 Pandemic, then there is a risk of harm to individuals known to Trust services	1	HIGH	35
3.3	Clinical risk associated with delay in accessing inpatient beds in Acute, Mental Health, Beechcroft and Non Acute Hospitals	1	HIGH	37
3.4	Risk of deterioration of health and social functioning as a result of reduced access to a range of community services (examples include domiciliary care, day care centres, Carers Assessments etc.)	1	HIGH	40
3.5	Risk to the consistent provision of safe, high quality care due to reduced capacity in Out of Hours services (examples are GP OoH, Crisis Response and Emergency Department services)	1	HIGH	42
3.6	Risk to the ongoing supply of medicines due to EU Exit/NI Protocol when the grace period ends (currently extended), when NI will continue to follow EU rules and regulations for medicines and medical devices, whereas Great Britain will not, with implications for both the supply and regulation of medicines in N.I.	1	HIGH	44
3.7	Risk to the provision of food for patients and staff due to suppliers having difficulties sourcing and supplying some food produce.	1	HIGH	45
3.8	Risk to assuring compliance with agreed standards of care due to a reduced clinical audit capacity.	1	MEDIUM	46

4	Technology Enablement			
4.1	Risk to the HSC network availability in the event of a cyber attack on HSCNI or a supplier/partner organisation, resulting in the compromise of the HSC network and systems or the disablement of ICT connections and services to protect the HSC and its data. Risk associated with the reliance on digital technology to support service delivery, including information systems, clinical applications and data analysis tools such as Qlikview.	1	HIGH	47
4.2	Risk of achieving implementation of Regional Technology implementation due to the Trust not having the capacity to effect the change required to implement the digital initiatives.	1	HIGH	48
5.	Finance			
5.1	Risk of breach of statutory duty of break-even in year	4	HIGH	49
5.2	Risk of destabilization of services due to over reliance upon non-recurrent funding and the Trust's inability to secure sufficient recurrent investment	4	MEDIUM	51
6.	Infection, Prevention and Control			
6.1	Risk to patient, staff and visitor safety due to the potential to develop a healthcare acquired infection such as MRSA, C. difficile etc. In particular, the Covid-19 Pandemic with new and emerging variants poses unique challenges for IPC processes and there is a risk to the Trust's ability to respond adequately. (This risk is paired with the Trust's aging infrastructure risk and the People risk)	1	HIGH	52

Risk No.	Risk Area/Description	Corporate Objective	Risk Rating	Page
7.	Urology Services Public Inquiry (USI)			
7.1	Organisational capacity to manage the range, and complexity of information required to support the USI. This includes general discovery requests, which are wide in their scope and cover significant areas of the Trust and the support required to comply with S21 requests. Moving forward to subsequent phases of the USI, organisational capacity and readiness in relation to preparations for the Public Hearing process will remain a challenge Capacity of legal team (DLS and Barristers) to support the USI, particularly with a number of concurrent Public Inquiries on-going	1	HIGH	55
7.2	Risk to service continuity as a result of Section 21 notices response times and Public Hearing preparations.	1	HIGH	56
7.3	Risk to health and wellbeing of staff	5	HIGH	57
7.4	Reputational risk exists in the process of the Public Inquiry – the public release of information and the Public Hearings which are likely to attract media attention.	1	HIGH	58
7.5	No funding stream identified	4	HIGH	59

1. PEOPLE

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-23 : Stabilising, Rebuilding and Growing

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
1.1 Risk to the consistent provision of high quality, safe medical care due to medical workforce shortages and vacancies within some specialties (exacerbated due to Covid-19)	Organisational risk in being able to continue to deliver services Potential impact on patient / client safety and quality of care delivery Reputational – loss of public confidence Impact on staff health and wellbeing in areas of high vacancy rates	L	Director of HROD Medical Director	Monitoring of vacancy position through Medical Staffing and Directorates International recruitment and targeted advertising Monthly medical recruitment report, fill rates, unfilled posts. Analysis and improvement of recruitment and advertising strategies Collaborative working with other Trusts, when required Independent Sector contracts	Score 15 (5 x 3)	Rating High	Score 9 (3 x 3)	Rating Medium	Reports to Trust Board/Board Committees Performance Committee deep dives per Division/ Service Medical Director reports Reports Elsewhere Monthly recruitment report to Medical Director, Chief Executive & Director HROD, copies to Divisional MDs  JULY Monthly Recruitment Update	Demand comes from more than vacant posts – but also need to identify what additional posts are necessary Updated and agile workforce planning is needed	Review of international recruitment progress to date on the contract by December 2022 Bids for recurrent funding for ED & Medicine submitted to Strategic Investment Group in June 2022. Has been tabled at SPPG for funding potential. May need to consider invest to save proposals where no funding available. Review in September 2022. Plan to review if appointment of specialist posts would help where we are unable to recruit consultants. Review by Oct 2022

				Greater use of alternative roles through advanced practitioners – nursing and AHPs and Physician Associates Escalation of pressures to DOH/ SPPG e.g. an early Alert was issued on 25.7.22 to DOH due to the risk with medical staffing in Haematology. Adverts now include a sentence asking for expression of interest from doctors who would wish to apply for Consultant posts, but are not yet eligible. A formal log is being kept. Appointment of overseas doctors via the Medical Training Initiative scheme.				Business cases for additional investment. Social Media advertising / BMJ advertising package Adverts	No E rostering system in place for medics	Work with DMDs and LNC to consider promotion of flexible job planning and other initiatives to retain staff and avoid further retirements. By Mar 2023 Explore E rostering solutions for medics by March 2023
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				Consultant presence at Recruitment Fairs (e.g. Psychiatry Conference in Edinburgh June 22) Locum agencies to fill gaps.							
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CORPORATE OBJECTIVE: Promoting Safe, High Quality Care**CORPORATE PRIORITY: Stabilising, Rebuilding and Growing**

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
1.1a Risk to the continuity of service provision within the Gillis Unit, St Luke's site, Armagh due to consultant psychiatry workforce shortages. Currently, there is only one permanent substantive Consultant Psychiatrist for the total Psychiatry of Old Age (POA) and Memory Service: three posts are vacant and one staff member remains on maternity leave until Autumn 2022	Organisational risk in being able to continue to deliver services Reputational – loss of public confidence Human Resource impact – staff Potential impact on patient / client safety and quality of care delivery	L	Director of Mental Health and Disability	Co-location of Gillis and Willows Ward to allow the multi-disciplinary team to access on-site medical input and support. A review of Inpatient Memory Services is underway	Score 15 (5 x 3)	Rating High		Rating Medium	Reports to Trust Board/Board Committees Reported to Trust Board – May 2022 Reports Elsewhere SMT	Inpatient Memory Services review – what is optimum service for Southern Trust population?	Project Steering Group for Review of Inpatient Memory Services continues: public consultation planned for September/ October 2022 Recruitment campaign for Consultant Psychiatrist to be re-commenced September 2022.

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY: Stabilising, Rebuilding and Growing

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/metrics) Summary of reports	Current gaps in controls/assurance	Mitigating Actions with due dates
1.2 Risk to safe, high quality care due to a high volume of medical locum engagements for different periods of time with varying levels of experience/ training and often in hard to fill posts.	Organisational risk in being able to continue to deliver services Reputational – loss of public confidence Human Resource impact – staff Potential impact on patient / client safety and quality of care delivery	L	Director of HROD Medical Director	New Supporting Doctors in Difficulty Hub for Managers Monthly report of locum usage is issued to the service highlighting locum use, broken down in different data sets including expenditure. Centralised Medical Locum Team now part of Integrated Medical HR allows for streamlined oversight, identification of trends and consistent management of concerns.	Score 15 (5 x 3)	Rating High	Score 9	Rating Medium	https://view.pagetiger.com/Hub/doctors-in-difficulty-hub https://view.pagetiger.com/Medical-Staffing/shsct-locum-doctors Monthly locum reports issued to the service on their locum use and used for Monthly Oversight Committee.	Large volumes of Ad Hoc locums creates risk No Line managers for locums Locums have different RO's Induction of locums is not consistent	Development of the Page Tiger portal with videos to enhance induction materials available to locum doctors – by Dec 22 Requirement for longer term locum doctors to have Job Plans – by Mar 23 Engage with DOH for support and action in relation to regional paper relating to consistency in locum rates and enhancement of local medical banks. Ongoing ID Checks –To be reviewed with Deputy Medical Director to explore via Oversight Groups how this can be better managed. By Mar 23 Formal Supervision arrangements for locums to be reviewed and strengthened By Mar 23

				Specific signposting page for Locum Doctors working in the SHSCT Deputy Medical Director for workforce now in post alongside a new SAS lead for Locum Governance Southern Trust has taken lead in finalising proposal to encourage development of local banks as alternative to agency and consistency in medical locum rates. Now with DOH for consideration. Specific Guidance for management of concerns with locum doctors. First Trust in NI to develop which has been shared with GMC and other Trusts for implementation elsewhere.					Identification of Locum Champions – to help mentor and support all locums – By Mar 23
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				Protocol in place for engagement of Medical and Dental Agency Locums PALs oversight of current Medical and Dental Framework Monthly Oversight Committee for DMD to meet with AD for Service and AMD to review locum usage by specialty and identify plans for future.						
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CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Stabilising, Rebuilding and Growing

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
1.3 Risk to the consistent provision of high quality, safe nursing care due to nursing and midwife shortages and vacancies across all Directorates, and high nursing agency usage (exacerbated due to Covid-19)	Organisational risk in being able to continue to deliver services Reputational – loss of public confidence Human Resource impact – staff Potential impact on patient / client safety and quality of care delivery	L	Executive Director of Nursing, Midwifery and AHPs Director of HROD	Daily Senior Nurse oversight of staffing levels within Directorates at operational level supported by Safe Care to assess staffing levels on a daily basis in Acute Services. Directorate and other workforce analysis tools are in use for other Directorates to facilitate reporting status of Nursing and Midwifery Workforce Provision of Health roster workforce reports to operational teams to inform staff allocation.	Score 15 (5 x 3)	Rating High	Score 9	Rating Medium	Reports to Trust Board/ Board Committees Quarterly recording Workforce report to Performance Committee. Reports Elsewhere Monthly Health roster reports to Operational Directors. Monthly Nursing workforce reports to SMT.	Improvement required in Trust data reporting to drive agency reduction locally. Lack of capacity in Nurse Bank / Agency management	Complete ward-by-ward agency workforce exit plans to reduce off contract agency staff and occurrence of Trust own staff through off contract agency - by end of September 2022 Completion of Invest to Save proposal for separate Band 8a Nurse Bank / Agency Business Manager. Commencement of data scientist in September 2022 with focus on agency expenditure and patient data to drive improvement in workforce decision making Commence secondary International Recruitment September 2022 and maintain International recruitment from the regional contract.

				Use of Bank and Agency and enhanced rates of pay for trust staff. Recruitment actions including local recruitment And regional and secondary International recruitment campaigns.					Alignment of QUB and OU nursing graduates to Band 5 posts. Open recruitment for Band 5 ongoing. Trust wide nursing and midwifery recruitment event November 22. The second year of the SRC pre nursing programme commences in Sept 2022 and the same programme being offered to Trust own staff. Launch and commence work against key actions within the Nursing and Midwifery workforce action plan 2022-2024. This includes recommendations from the Regional Retention Implementation report (DoH,2022). The focus continues on minimising all band 2/3 nursing assistant vacancies- ongoing
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CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Stabilising, Rebuilding and Growing

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
1.4 Risk to staff engagement, morale and health & wellbeing due to workforce capacity/ demand pressures (exacerbated due to Covid-19).	Human Resource impact – staff	L	Director of HROD	People Framework Health and Wellbeing Framework and Steering Group Clinical Psychology staff support and wellbeing service Inspire Contract Occupational Health Wellbeing Service Ongoing recognition of staff and teams People management policies, systems, processes and training	Score 15 (5 x 3)	Rating High	Score 9	Rating Medium	 20220804 SHSCT  20220803 HWB  HWB Notes 6 Jun 2022.docx OHWS - Managers Support Service OH Psychology overview New.pdf  Occupational Heal and Well-Being ser  20220801 Dashboard Figures	People Framework requires to be launched. People & Culture Steering Group is required to drive People Framework Lack of support for staff with Long Covid New approach to appraisal needs rolled out. Lack of capacity for developing Raising Concerns programme	People Framework to be approved at September Trust Board 2022. People & Culture Steering Group to be established – October 2022. Long Covid Occupational Health Team recruitment ongoing. Team to be in place by mid October 2022. Roll out of new appraisal to be complete by March 2023. Development of F2SU Guardian roles and advertised in September. In place by November / December 2022.

				Raising Concerns Policy Management of organisational change policies and procedures Also – controls identified above in 1.1, 1.2. 1.3				 20220315 ToR Trust Corporate Recognition  22032022 Corp Recognition Steer Flexible Working - All Documents Staff Conduct  Your Appraisal Conversation - Pilc  Appraisal Conversation - Guid  CBH workshop slic - V5.ppt Creating a Great Place to Work  20220729 Your Right to Raise a Concern – V	Flexible working training / awareness for managers	Flexible working awareness raising for managers – by December 2022.
								Whistleblowing Management of Change  8b JD.pdf		

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Stabilising, Rebuilding and Growing

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/metrics) Summary of reports	Current gaps in controls/assurance	Mitigating Actions with due dates
1.5 Risk of potential harm to children due to Social Work vacancies impacting on the delivery of core Family Support & Safeguarding Services for children and families.	Organisational risk in being able to continue to deliver services Reputational – loss of public confidence Human Resource impact – staff Potential impact on patient / client safety and quality of care delivery	L	Director of Children and Young People's Services	Prioritisation of child protection and LAC cases, in particular safeguarding visits Prioritisation of work across the Directorate in line with action plan Skill mix Regional recruitment initiatives 12 Band 4 Social Work Assistants are in the process of being offered posts within FSSG. Recruitment of additional 3 Band 4 Social Work Assistants within Corporate Parenting division to support transfer pathway.	Score 15 (5 x 3)	Rating High	Score 9	Rating Medium	Reports to Trust Board/Board Committees Executive Director of Social Work report to Trust Board – March 2022 Delegated Statutory Functions report to Trust Board Reports Elsewhere DSF Report to Strategic Planning & Performance Group (SPPG)	Regional recruitment initiatives remain ongoing however these are unlikely to bring about substantive social work recruitment within Gateway and FIT service, given the limited pool of social work new entrants regionally	Regional recruitment initiatives - ongoing Ongoing engagement with the SPPG and DoH on a regional basis

				CYPS have revised and approved the child's pathway and transfer procedure to include an earlier transfer of LAC children to Corporate Parenting Division. Regional Children's Leadership Improvement work streams have been implemented to review the Delegation Framework for Children's Services.							
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CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Stabilising, Rebuilding and Growing

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
1.6 Risk to the stability and effectiveness of Trust Board as a direct consequence of workforce vacancies at Senior Executive level and Non-Executive Director level.	Human Resource impact – staff Reputational risk Organisational risk Potential impact on patient / client safety and quality of care delivery	M	Director of HROD	Senior Executive restructuring Medical Director now appointed and due to take up post in November 2022 3 Operational Directors already advertised and to be appointed by end of September 22. Chair continues to raise Non Executive Director vacancies with Public Appointments Unit	Score 12 (4 x 3)	Rating Medium	Score 6	Rating Low (3 x 2)	<u>Reports to Trust Board/Board Committees</u> Senior Executive Restructuring updates to Trust Board Senior Executive Job Descriptions to Remuneration Committee <u>Reports Elsewhere</u> Report of Phase 1 restructuring – to TU Side, Trust staff.	Currently 4 of 11 Directors permanent. Director of Performance & Reform, Director of CYPS and Executive Director of Social Work to be advertised and appointed. 2 Non-Executive Director vacancies	All Director posts to be advertised and appointed by December 2022. Non Executive Director positions Competition programme, including SH&SCT vacancies – to be advertised by PAU in October 2022.

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
					Score	Rating	Score	Rating			
1.7 Risk to the consistent provision of high quality, safe care to children, young people and families due to shortages and vacancies across the Health Visiting service.	Threat to compliance of the Regional Pre-School Child Health Promotion Programme (HCHF). Threat to compliance of pre-school vaccination programme. Reduced opportunities for early identification and intervention for infants/ children with underlying medical conditions or developmental delay. Threat to compliance with SBNI and Trust Safeguarding Children Policy & Procedure.	L	Director of CYPs Executive Director of Nursing	Implementation of step down model within the HV service, prioritising those families/children with the highest need. Systems in place to facilitate parents to be able to access the HV service when they have concerns. Within HV Service, a cross locality approach being undertaken to support HV teams with highest reduced staffing levels. Utilisation of Trust Bank and additional hours. Maintain referrals to Occupation Health in line with Trust policy and procedure.	15 (5 x 3)	High	9	Medium	Reports to Trust Board/Board Committees Monitoring and reporting of quarterly IoPs. Monthly staffing returns Reports Elsewhere	Regional lack of appropriately trained nurses available to recruit to undertake HV role. Regional gap in providing the number of HV training placement required to deliver full the Child Health Promotion Programme	Additional weekend clinics will be introduced. Communication Strategy will be developed. Influence the commissioning of additional regional HV training placements available. Avail of any regional opportunities to meet Normative Staffing levels within HV.

	Threat to compliance with Regional and Trust Health Visiting Policy & Procedures. Impact of long term deficits within HV on staff may contribute to further sick leave within the HV service and impact on morale			Proactive recruitment of additional HV. Maintain appropriate supports for staff including managerial and safeguarding children supervision. Recruitment of additional skill mix in the HV service. Escalation to PHA and DoH.						
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2. ESTATES AND INFRASTRUCTURE

CORPORATE OBJECTIVES: Improving our services; Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
2.1 Insufficient capital to maintain and develop Trust Estates works (works under £1.5m) and maintenance programme this year	Impact of physical safety to visitors/staff/ patients if Estates work is not undertaken. The Trust has a duty of care to protect those who use and enter its properties. Will lead to deterioration of Estate that if not adequately maintained, will further increase costs to public purse.	M	Director of Finance, Procurement and Estates	Capital funding of c£17m has been received for Estates work including invest to save in 22-23	Score 12 (4 x 3)	Rating Medium	Score 6 (3 x 2)	Rating Low	Reports to Trust Board/Board Committees Estates Services Annual Report to Trust Board Reports Elsewhere Monthly Estates report to SMT Quarterly Governance meeting External audit check year end accruals	IPT for IV work at DHH with the DOH for approval. If not approved promptly, there is a risk that this work will not be carried out within the financial year Globally construction costs for building materials and contractors are increasing which could increase or delay projects	IPT with Permanent Secretary for approval and approval is imminent. Estates have contractors in place to commence work once approval is sought. PALS are monitoring the increased costs of construction and further funding will be bid for if costs increase.

2. ESTATES AND INFRASTRUCTURE

CORPORATE OBJECTIVES: Improving our Services; Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
2.2 Inability to complete Estates project by year end due to delay in availability of materials, delay with contractors or internal Estates capacity.	Essential Estates work not being completed and consequently impacting on service and funding rescinded	M	Director of Finance, Procurement and Estates	Progress against projects is being monitored on monthly basis with report to SMT Action plan with timeframes in place for completion in place for all projects Experienced surveyors and architects employed in Trust to deliver projects PALS monitoring costs of building materials globally	Score 12 (4 x 3)	Rating Medium	Score 6 (3 x 2)	Rating Low	Reports to Trust Board/Board Committees Estates Services Annual Report to Trust Board Reports Elsewhere Monthly reports to SMT Quarterly Estates Governance meetings	Globally construction costs for building materials and contractors are increasing which could increase or delay projects outside of Trust control	PALS continue to monitor the increased costs of construction and further funding will be bid for if costs increase.

2. ESTATES AND INFRASTRUCTURE

CORPORATE OBJECTIVES: Promoting safe, high quality care; Improving our Services;
Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
2.3 Risk of harm to visitor, staff and patient safety resulting from legionella, fire hazards and poor maintenance	Safety of visitors/ patients/staff at risk	L	Director of Finance, Procurement and Estates	Cycle of water testing by trained staff in line with national policy and guidance Fire safety audits carried out by experienced fire officers in line with national policy and guidance	Score 12 (4 x 3)	Rating Medium	Score 6 (3 x 2)	Rating Low	Reports to Trust Board/ Board Committees Estates Services Report to Trust Board Reports Elsewhere Independent external annual assessment of water testing with report provided detailing areas for improvement NIFRS carry out annual review of fire procedures Internal audit review	Recommendations from external assessments being implemented (All low risk rating)	Actions plan in place to address recommendation with timeframes

2. ESTATES AND INFRASTRUCTURE

CORPORATE OBJECTIVE: Promoting safe, high quality care; Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
2.4 Lack of controls over Health and Safety	Risk of physical harm to staff/ patients and visitors	L	Director of Finance, Procurement and Estates	H&S Committee meeting quarterly H&S quarterly updates to DoFPE	Score 12 (4 x 3)	Rating Medium	Score 6 (3 x 2)	Rating Low	Reports to Trust Board/ Board Committees Annual H&S report to Governance Committee Reports Elsewhere Quarterly H&S Committee with Unions in attendance	Limited Assurance Audit in 2021-22 with 13 recommendations H&S Team are under resourced, staff off on Long Term Sick Leave/Maternity and not sufficient staff to appropriately carry out H&S function in organisation	Actions plan in place to address internal audit recommendations with expected implementation by 31 March 2023. H&S Committee oversight and monthly meetings with A/D and DoFPE oversight at quarterly Estates Governance meetings Two Agency staff in post and a review of staff is being undertaken.31/12/ 2022

2. ESTATES AND INFRASTRUCTURE

CORPORATE OBJECTIVE: Improving our Services; Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
2.5 Risk that Trust does not achieve Year 2 Sustainability plan due to lack of resources and staffing	Trust is not being as sustainable as it should be nor increases carbon footprint	M	Director of Finance, Procurement and Estates	5 Yr sustainability strategy commenced 21/22 Estates on target to achieve actions from plan Plans in place to install renewable energy (solar panels) in 2022-23 Programme of works in place to install LV DHH and electric car charging points Tree planting programme on target c£2m received from SIB in 22-23 for sustainability invest to save schemes.	Score 8 (4 x 2)	Rating Medium	Score 6 (3 x 2)	Rating Low	Reports to Trust Board/ Board Committees Annual sustainability report to Trust Board Reports Elsewhere Monitored at monthly sustainability meetings Monitored by DFPE at Quarterly Governance Meetings	Increased waste due to covid Further improvements to reduce energy consumption in hospital buildings is required	Revisit the Sustainability strategy to ensure that Trust is working towards reducing carbon footprint. Rolling out renewable energy schemes across Trust.31/3/2023 Keeping abreast of evolving renewable energy option for hospitals, more efficient boiler scheme 31/3/2023

2. ESTATES AND INFRASTRUCTURE

CORPORATE OBJECTIVE: Promoting safe, high quality care; Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
2.6 Servicing of medical equipment not carried out in timely manner due to items not being sent to Estates for servicing or due to resourcing issues	Medical equipment fails to operate correctly posing harm to patients	L	Director of Finance, Procurement and Estates	Servicing schedule in place Red risk items are given priority 3 additional service engineers appointed Monitored on weekly basis by DoFPE Global emails sent to trust staff as reminder to not use equipment unless it has been serviced Internal audit recommendation have been implemented with number of o/s items been reduced to those that are misplaced	Score 16 (4 x 4)	Rating High	Score 6 (3 X 2)	Rating Low	Reports to Trust Board/ Board Committees Internal Audit Report to Audit Committee Reports Elsewhere Monitored by Assistant Director, Estates and DoFPE on weekly basis through weekly servicing report Monitored by DFPE at Quarterly Governance Meetings Internal audit follow up	Many items cannot be found Staff still not sending in items in advance of servicing date Actions implemented following limited internal audit recommendation to be reviewed	Tracking system being explored 31/3/2023 Global reminders will continue with support from Directors (ongoing) Actions to be cleared by 30/9/2022

3. ACCESS T O SERVICES

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Improving Access to Planned Services for our patients

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
3.1 Risk to safe, high quality care due to delay in accessing elective services for assessment, diagnostics and treatment in accordance with clinical need due to demand and capacity mismatch compounded by staffing constraints and previously reduced capacity due to the Covid 19 Pandemic	There is a risk of secondary harm to the SHSCT population/ patients/ Service users and potential fatalities as a consequence of delays accessing safe, timely and appropriate care and treatment Unsatisfactory patient experience Loss of service user and stakeholder confidence	L	Director of Surgery and Elective Care	Regional clinical prioritisation of operative/ theatre capacity directed to those most in need on an equitable basis Mechanism in place to review service waiting lists to ensure those with greatest need are allocated capacity and routine users are offered access to available capacity on a chronological basis. Virtual consultations	Score 16 (4 x 4)	Rating High	Score 9	Rating Medium	Reports to Trust Board/Board Committees Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee Reports Elsewhere Monthly Acute cross Divisional Performance meeting for identification of risk Monthly Acute Directorate SMT Performance	Staffing constraints to maximise capacity including theatre capacity	Recruitment strategy and recruitment campaign to ensure staffing levels to provide timely, safe effective care Review of Nursing workforce etc. Review of Consultant Job Plans

				Effective booking of patients (IEAP guidance) Proactive pre appointment procedure triage/testing for Covid 19 to minimise cancellations Pre-operative assessment Effective discharge planning/ Enhanced recovery to reduce length of stay and ensure safe and effective discharge to maximise bed capacity Regular performance meetings Monitoring of outpatient clinics and elective procedures capacity Red flags reviewed weekly; other referrals reviewed monthly				and Governance meeting Monthly report on Rebuild/ Service Delivery Plan to SMT	Data on OPD and theatre utilisation is limited Data on e.g. triage, dictation, OPD outcomes etc. is limited Impact of emergency admissions and delayed discharges on bed availability risks cancelled activity	Review IT solutions to the management of PTLs and effective booking Review waiting list manager roles for consideration of implementation Review IT solutions to provide real time data to enable review of and maximisation of capacity Action plan including no more silos recommendations Given correlating delay within Cancer Pathways, there will be an increase in monitoring of sharing of reports to support improved compliance with 31/62 day targets
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				Independent Sector contracts to deliver OPD, diagnostic and treatment capacity						Opportunities continue to be identified to seek to increase capacity via sourcing of additional capacity, both internally & externally via Independent Sector Continue to scope innovative approaches/new ways of working to service delivery Development of Service Delivery Plans for core services
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CORPORATE OBJECTIVE: Promoting Safe, High Quality Care
CORPORATE PRIORITY 2022-2023: Improving Access to Planned Services for our patients

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
3.2 If demand continues to outstrip supply and review appointments or planned assessment/ treatment are not completed in line with clinical timescales, due to demand and capacity mismatch compounded by staffing constraints and previously reduced capacity due to the Covid 19 Pandemic, then there is a risk of harm to individuals known to Trust services	There is a risk of secondary harm to the SH&SCT population/ patients and potential fatalities as a consequence of delays accessing safe, timely and appropriate care and treatment Unsatisfactory patient experience Loss of service user and stakeholder confidence	L	Director of Surgery and Elective Care	Mechanisms are in place to categorise planned procedures and reviews into urgent and non urgent for assignment to appropriate waiting lists and to review service waiting lists to ensure those with greatest need are allocated capacity Effective booking of patients (IEAP guidance) Virtual consultations	Score 16 (4 x 4)	Rating High	Score 9	Rating Medium	Reports to Trust Board/Board Committees Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee Reports Elsewhere Monthly Monitoring information to assist with oversight and identify and escalate those requiring prioritisation	Staffing constraints to maximise capacity including theatre capacity Data on OPD and theatre utilisation is limited	Recruitment strategy and recruitment campaign to ensure staffing levels to provide timely, safe effective care Review of consultant job plans currently being undertaken to drive consistency Review IT solutions to the management of PTLs and effective booking Review waiting list manager roles

			Proactive pre appointment procedure triage/testing for Covid 19 to minimise cancellations Mechanisms in place for GPs to escalate change/ deterioration in condition Mechanisms in place for individuals to contact duty system for urgent review should there be a significant deterioration in clinical condition					Active monitoring of AHP output activity including monthly reporting against Rebuild/ Service Delivery Plan	Data on e.g. triage, dictation, OPD outcomes etc. is limited Impact of emergency admissions and delayed discharges on bed availability risks cancelled activity	Review IT solutions to provide real time data to enable review of and maximisation of capacity Action plan including no more silos recommendations Ongoing work by AHP Services to deliver increased levels of activity
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CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Supporting unplanned, urgent and emergency services

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/metrics) Summary of reports	Current gaps in controls/assurance	Mitigating Actions with due dates
3.3 Clinical risk associated with delay in accessing inpatient beds in Acute, Mental Health, Beechcroft and Non Acute Hospitals	Patient safety risk	L	Director of Surgery & Elective Care Director of Medicine and Unscheduled Care Director of OPPC	Acute and <u>OPPC</u> No More Silos Implementation Group Surgery contingency plan. Emergency & General Surgery on single site(CAH) Joint Directorate (Acute, MHD and OPPC) meeting up to three times daily to review inpatient delays and promote effective flow through both Acute and Non Acute Hospitals Care Home Information Hub plus Community Discharge Hub in place	Score 16 (4 x 4)	Rating High	Score 9	Rating Medium	Reports to Trust Board/Board Committees Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee Reports Elsewhere Activity levels reported through NMS	Staffing constraints to maximise capacity	Recruitment Strategy and recruitment campaign to ensure staffing levels to provide timely, safe effective care Review of Nursing workforce within Acute Wards – October 2022 Work ongoing to improve performance and increase the robustness of Winter Plans/Contingency

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Supporting unplanned, urgent and emergency services

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/metrics) Summary of reports	Current gaps in controls/assurance	Mitigating Actions with due dates
3.3 continued	Patient safety risk	L	Director of Mental Health and Disability	Mental Health Mental Health / Learning Disability Home Treatment/Crisis Response Teams Dorsy - fortnightly delayed discharge meeting. Bluestone Bed coordinator Daily Bluestone/Dorsy Ward rounds	Score 16 (4 x 4)	Rating High	Score 9	Rating Medium	Reports to Trust Board/Board Committees Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee Reports Elsewhere Mental Health & Disability - Early Alerts / RQIA updates	Inpatient beds levels impacted by frequent requests for out of Trust admissions due to regional bed pressures (Dorsy & Bluestone). Facilitation of early discharge for these admissions.	Ongoing Regional discussions. Early Alerts submitted. Clinical assessment.

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Supporting unplanned, urgent and emergency services

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/metrics) Summary of reports	Current gaps in controls/assurance	Mitigating Actions with due dates
3.3 continued	Patient safety risk	L	Director of Children & Young People's Services	Regional AD CAMHS Forum Community teams provide extensive on-site support to acute medical ward Admission Request Meeting (ARM) facility in place to request admission. Robust communication methods in place across CAMHS and appropriate stakeholders	Score 16 (4 x 4)	Rating High	Score 9	Rating Medium	Reports to Trust Board/ Board Committees Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee Reports Elsewhere Weekly status report from Beechcroft reported to Director/ Assistant Director/ Head of Service	Beechcroft's current inability to accept admissions. Waiting list currently (regionally). No contingency plan identified by Beechcroft Ongoing difficulties with access to acute assessment beds	Beechcroft are working to address capacity issues by expediting discharges where possible, where additional supports are being put in place in the community. CAMHS reviewing how they can increase the crisis response service to avoid admission to Beechcroft through intensive community support. DoH has commissioned a regional CAMHS workforce review, which will include Beechcroft. Report expected Autumn 2022.

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

CORPORATE PRIORITY 2022-2023: Improving Access to Planned Services for our patients

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/metrics) Summary of reports	Current gaps in controls/assurance	Mitigating Actions with due dates
3.4 Risk of deterioration of health and social functioning as a result of reduced access to a range of community services (examples include domiciliary care, day care centres, Carers Assessments etc.)	Patient safety risk	L	Director of Mental Health and Disability/ Director of Older People & Primary Care Services	<u>Day Care and Short Breaks</u> Local re-mobilisation pathways developed to support increased day care /short breaks attendances. Increase in offers of direct payments/SDS <u>Mental Health</u> Strategies for early intervention and prevention Implementation of IAPT (Improving access to psychological therapies) model of care	Score 16 (4 x 4)	Rating High	Score 9	Rating Medium	Reports to Trust Board/Board Committees Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee Reports Elsewhere Day Care remobilisation report to SPPG	The Trust is heavily dependent on the Independent Sector for provision of short break beds provision. This provision is impacted by covid rates as are Trust day care facilities.	The Trust continues to focus on care assessments and care planning to ensure needs are identified and met. Seek to increase capacity in IS for day centres Developing and strengthening partnerships for improving health and well being.

				Domiciliary Care Care Bureau working with Commissioning Teams to ensure outstanding Domiciliary Care list updated and outstanding packages highlighted to Providers daily Carers Assessments – Active monitoring of activity levels (Assessments offered and completed)				Active monitoring of outstanding Domiciliary Care cases Weekly Community Information reports	The Trust and Independent Sector Providers deliver domiciliary care through a partnership approach, however there are recruitment difficulties	Work ongoing to increase domiciliary care capacity by frequent review and potential downturn of existing packages, plus active recruitment of domiciliary care workers. Work ongoing to increase Carers Assessment levels by active championing of this activity against regionally agreed targets
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CORPORATE OBJECTIVE: Promoting Safe, High Quality Care**CORPORATE PRIORITY 2022-2023: Supporting unplanned, urgent and emergency services**

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
					Score	Rating	Score	Rating			
3.5 Risk to the consistent provision of safe, high quality care due to reduced capacity in Out of Hours services (examples are GP OoH, Crisis Response and Emergency Department services)	Patient safety risk	L	Director of Medicine and Unscheduled Care Services Director of OPPC	GP Out of Hours Temporary measures in place to increase the resilience of the service, including temporary consolidation of the model from 5 sites to 2	Score 16 (4 x 4)	Rating High	Score 9	Rating Medium	Reports to Trust Board/Board Committees		Review of current GP OoH provision with temporary consolidation of current bases to reflect current available resources, improving the ability of the services to recruit to vacant posts
				<u>ED</u> Phone First and Urgent Care Centres established to improve the provision of advice, guidance and triage of patients to ensure patients are dealt with in the right place Escalation and ED capacity plan					Performance Report to Performance Committee Corporate CPD Performance Scorecard to Performance Committee Reports Elsewhere Active monitoring of GP OoHs, Phone First and Urgent Care Centres NMS Performance Report		Development of Phone First, Urgent Care Centres and ambulatory services to reduce attendance/capacity within EDs

			Director of Mental Health and Disability	“Well Mind Hub” and Crisis Café development with PiPs Mental Health Integrated Liaison Service Operates 24/7 LD Crisis Response Service operates from 9am to 1am						Learning Disability – Development of Community Assessment and Rehabilitation Service (CARS) – proposed implementation March 2023.
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CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
3.6 Risk to the ongoing supply of medicines due to EU Exit/NI Protocol when the grace period ends (currently extended), when NI will continue to follow EU rules and regulations for medicines and medical devices, whereas Great Britain will not, with implications for both the supply and regulation of medicines in NI. Key issues include: Medicines licensing Medicines supply chain Medical Devices	Patient safety risk Organisational risk Reputational – loss of public confidence	L	Head of Pharmacy & Medicines Management	DoH led EU/ Northern Ireland Programme Board	Score 12 (3 x 4)	Rating High	Score 9	Rating Medium	Reports to Trust Board/ Board Committees Medicines Governance Report to Governance Committee Reports Elsewhere Updates from EU Exit/ Northern Ireland Protocol Programme Board Meeting	Medicines with a marketing authorisation valid only in GB (England, Wales and Scotland) labelled as PLGB, do not require a Unique Identifier and must not be supplied to Northern Ireland unless specifically approved by MHRA. Medicines Supply Pharmacist to be recruited to assist procurement team manage issues in relation to EU Exit/Ni protocol	From 1 st January 2022, a statutory instrument titled the Human Medicines (Amendment) (Supply to Northern Ireland) Regulations 2021 established the Northern Ireland MHRA Authorised Route (NIMAR). NIMAR provides a route for the lawful supply of prescription only medicines that are unlicensed in NI, where no licensed alternative is available. Pharmacist recruited on temporary secondment from 1 st Aug 2022 to 31 st March 2023. Approval now received to recruit permanently- post will be advertised at the end of this year.

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/metrics) Summary of reports	Current gaps in controls/assurance	Mitigating Actions with due dates
3.7 Risk to the provision of food for patients and staff due to suppliers having difficulties sourcing and supplying some food produce. Risk factors include: Procurement risks and need to increase frozen and storage space. Issues with the meats contracts due to EU Brexit standards and procedures. The same supplier supplied both raw and cooked meats leading to an increased reliance on one supplier. Other issues with contracts include minimum order values and minimum quantities and the bakery items contract ending before its expiry date.	Reputational risk – food supply issues impact on menu planning and there is the potential for increased complaints from service users due to limited menu choices Organisational risk in being able to continue to source and supply some food produce and impact on patients and staff	L	Executive Director of Nursing	Food procurement is managed by BSO PaLS either through EMM or E-Procurement. BSO PaLS have business contingency plans. The Trust has a Catering Contingency Plan in place which includes menu alterations as appropriate dependent on food availability. The Trust has a contact in place for the maintenance of refrigeration.	Score 12 (3 x 4)	Rating High	Score 9	Rating Medium	Reports to Trust Board/ Board Committees Functional Support Services Report to Governance Committee Reports Elsewhere SMT	BSO in conjunction with HSC Trusts need to develop a Food Procurement Strategy which is fit for purpose and meets the needs of all HSC customers.	Senior Managers have attended attend a workshop regarding Food Procurement Strategy and this was meant to be followed up with BSO completing a scoping exercise to assist in the development of a strategy but this has been delayed.

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
3.8 Risk to assuring compliance with agreed standards of care due to a reduced clinical audit capacity	Clinical / Reputational risk – failure to assure compliance with relevant local, regional or National Audit Recommendations Organisational risk in being able to fully deliver the Trust's clinical audit programme HR impact – staff capacity and morale	M	Medical Director	On-going support and delivery of limited clinical audit function, both locally at clinical lead level and corporately at facilitated support and assurance levels. Clinical Audit Strategy 2022 – 2024 sets out 9 key objectives to strengthen delivery and assurance over the next 3 year period.	Score 12 (4 x 3)	Rating Medium	Score 6 (3 x 2)	Rating Low	Reports to Trust Board/Board Committees National Audit Assurance Report to Governance Committee annually. This includes participation in annual audit programmes, key outcomes and progress on plans for improvement Reports Elsewhere Weekly SMT Governance paper	Whilst partial in year funds were approved by SMT on 14.7.2022 as the first phase to strengthen the assurance function in Q2/3 2022, resource implications to strengthen and improve the clinical audit function remain.	Critical Post paper 2022/23 approved July 2022 Funding paper for clinical lead and remaining corporate posts to be submitted during 22/23 for 23/24

4. TECHNOLOGY ENABLEMENT

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating	Target Risk Score and Rating	Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
4.1 Risk to the HSC network availability in the event of a cyber attack on HSCNI or a supplier/ partner organisation, resulting in the compromise of the HSC network and systems or the disablement of ICT connections and services to protect the HSC and its data. Risk associated with the reliance on digital technology to support service delivery, including information systems, clinical applications and data analysis tools such as Qlikview.	Organisational risk in being able to continue to deliver services and impact to service users associated with delays in care and treatment. Loss of personal and organisational information Reputational – loss of public confidence Service user safety risk in the event of digital records being unavailable	M	Director of Performance and Reform	Regional Cyber Security Programme Board (Director of P&R) Regional and Local Incident Management & Reporting Policies and Procedures Regional Cyber Incident Response Plan Trust level controls to Defend, Respond and Recover Trust Cyber Security Oversight Group Vulnerabilities software management (Tenable) Regional Cyber Security Policy Continued promotion of Operational Business Continuity Plans at Cyber Oversight Group and reference on Team Risk Registers	Score 16 (4 x 4) Rating High	Score 9 (3 x3) Rating Medium	Reports to Trust Board/Board Committees Internal audits Regional cyber security programme papers, minutes Monthly cyber dashboard and cyber oversight group (including KPI for cyber awareness training) Monthly desktop message Monthly staff update Range of monitoring software and monthly meetings Individual Directorate/Divisional/Team Business Continuity Plans with ICT preparedness reviewed	Regional delays continue. Regional security group has not yet been established. Whilst the Trust has made good progress in local cyber security Internal Audit recommendations, the regional recommendations remain outstanding. Cyber Awareness Training KPI Individual Directorate /Divisional/ Team Business Continuity Plans with ICT preparedness are in place in some services, but not all. Need for assimilated cyber event to test plans and apply learning	Deloitte has been commissioned to review ICT Business Continuity Plans and test Disaster Recovery Plans - Report March 2023 Advice will be sought from Deloitte as part of the commission on testing BCPs – March 2023 Consideration of ward based simulation for multiple-system downtime to be discussed at next Local Cyber Security Group – December 2022

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
4.2 Risk of achieving implementation of Regional Technology implementation. There are a range of complex high risk Regional programmes including: • Encompass (Single care record) • Labs (Pathology Blueprint), • HRPTS replacement EQUIP • NI Picture Archiving system NIPACS upgrade • Digital shared services. The agenda is very large and diverse with limited additional resources in either the IT team or to help front line services with the business change. The risk is fundamentally that the Trust will not have the capacity to effect the change required to implement the digital initiatives. Ongoing risk associated with multi-system implementation ongoing in parallel	Delay in implementation of new digital improvements with ongoing reliance on systems with limited lifespan; reduced resilience to cyber attack; inability to perform functions Staff morale and impact on sickness & absenteeism in the event that they don't feel supported and trained on use of new technology will impact on the ability to deliver services	M	Director of Performance & Reform	Encompass Strategic Assurance Group (regional) Encompass Readiness Group (Internal) Transformational Board with SMT monthly for escalations & updates Encompass programme board at Chief Executive level EQUIP Programme Group (Regional) Pathology Blueprint Programme Group (Regional)	Score 16 (4 x 4)	Rating High	Score 9	Rating Medium	Reports to Transformational Board (Encompass) Regional Digital (DHCNI) Programme Board DHCNI Portfolio Programme Board	Gaps in resources, both operational and IT, to lead and implement digital transformation across the Trust associated with workforce challenges and funding	Transformation Programme Board has highlighted resource risks to Encompass Regional SRO. Paper outlining gaps and risks prepared by DOP's and presented to Encompass SRO Resource Challenges with Regional portfolio shared by DOP's at DHCNI Programme Board Internal Shared Services Readiness Group to be established – December 2022

5. FINANCE

CORPORATE OBJECTIVE: Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ Assurance	Mitigating Actions with due dates
5.1 Risk of breach of statutory duty of break-even in year	Failure to meet DOH target Breach of Accounting Officer responsibilities Risk of qualification of Annual Accounts by external audit	M	Director of Finance, Procurement and Estates	Budgets have been allocated to budget holders and regular scheduled monthly reporting to all budget managers in Trust Regular scheduled budget meetings with all budget managers when deviations to budget are addressed to ensure breakeven	Score 15 (5 x 3)	Rating High	Score 6 (3 x 2)	Rating Low	<u>Reports to Trust Board/Board Committees</u> Monthly Financial Position report to SMT/Trust Board Reporting to Chief Executive Accountability Meetings <u>Reports Elsewhere</u> Monthly monitoring returns to SPPG/DoH	Current agreed Budget for 2022/23 remains outstanding Trust in a deficit position with risk of funding not being secured, particularly in absence of a functioning NI Executive Significant turnover of senior personnel in Trust has potential to lead to some instability in budget management Significant pressures remain across all services, with managers having many operational challenges to oversee, reducing capacity to keep close control on finances	• Indicative allocations for the financial year 2022/23 have been released to Trusts, however, work continues with SPPG and DoH to understand the potential implications of the budget settlement on Trusts, in particular due to political landscape. Once further clarity is received in relation to the final agreed budget for the Trust, DoF will prepare an updated briefing for SMT and Trust Board. It is expected that this will be in September/ October 2022.

				Continual support to budget managers on use of Collaborative Planning Budget and Reporting system including targeted one on one training for new budget managers and regular monthly refresher training via zoom Trust works closely with SPPG and DoH to secure funding to address deficits and pressures to enable the Trust to breakeven at year end				Reports Elsewhere (cont'd) Report to those charged with Governance by NIAO following year end audit. Internal Audit of Budgetary Control on regular cycle		Finance will complete a mid-year hard close, the purpose of which is to inform the finance strategy for the remaining months of the financial year. This is good practice. The hard close will be as at September 2022. Results from this will be known in November 2022 and findings from this will inform forecasts for the remainder of the financial year.
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CORPORATE OBJECTIVE: Making best use of resources

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/metrics) Summary of reports	Current gaps in controls/assurance	Mitigating Actions with due dates
5.2 Risk of destabilisation of services due to over reliance upon non-recurrent funding and the Trust's inability to secure sufficient recurrent investment.	Risk to medium to longer term planning of Trust Services to meet Corporate Objectives Risk of committing recurrent resources on the back of non-recurrent funding therefore with potential to increasing future financial deficit	L	Director of Finance, Procurement & Estates	Review and approval of Revenue IPTs and Capital Business Cases at Strategic Investment Committee Regular meetings with SPPG on financial plan and equity gap and early alerts to SPPG on pressures via Performance meetings with Commissioners	Score 12 (4 x 3)	Rating Medium	Score 6 (3 x 2)	Rating Low	<u>Reports to Trust Board/Board Committees</u> Monthly Financial Position report to SMT/Trust Board Reporting to Chief Executive Accountability Meetings <u>Reports Elsewhere</u> Monthly monitoring returns to SPPG/ Reporting on Equity Gap to SPPG	There is still a significant element of the Trust budget provided on a non-recurrent basis each year. The impact of the current political instability is impacting on the DoH ability to agree budgets, particularly on a recurrent basis	Director of Finance is continuing to closely work with SPPG and Department of Health in relation to the capitation inequity gap. To date this work has been successful in ensuring that an element of budget previously non-recurrent has been made recurrent and SHSCT savings are less than that of other Trusts. There is now a full acceptance and recognition of the gap at commissioner level.

6. INFECTION, PREVENTION AND CONTROL

CORPORATE OBJECTIVE: Promoting safe, high quality care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
					Score 12 (3 x 4)	Rating High	Score 6 (2 x 3)	Rating Medium			
6.1 Risk to patient, staff and visitor safety due to the potential to develop a healthcare acquired infection such as MRSA, C. difficile etc. In particular, the Covid-19 Pandemic with new and emerging variants poses unique challenges for IPC processes and there is a risk to the Trust's ability to respond adequately. (This risk is paired with the Trust's aging infrastructure risk and the People risk)	May result in serious harm or death to a patient, prolonged Length of Stay, unsatisfactory patient experience Risk of HCAI for visitors Organisational risk in being able to fully deliver Trust services HR impact – staff capacity and morale Reputational risk – loss of public and stakeholder confidence Significant financial loss	L	Medical Director	IPC and microbiologist team IPC Strategy and IPC guidance including HH, PPE etc. Staff training Bronze SMT Bronze Operational Group Strategic and Clinical Forum meetings Augmented care group Laboratory testing and Surveillance and monitoring					Reports to Trust Board/ Board Committees Progress update report to Performance Committee Reports Elsewhere Reports to strategic forum Reports to AMS oversight committee Reports to the ventilation, water, environmental and decontamination committees	Increased workload of the IPC/ microbiology/ clinical/ Functional support services staff with the management of Covid-19 surges and outbreaks-limited ability to comply with the full remit of the IPC team, including outbreak report writing, updating strategy and GNB work streams	Develop a case to further develop an Multi-Disciplinary Team infection service Develop audit team to provide assurance on all aspects of IPC

				Patient and risk assessment for placement for both emergency, elective admission and OPD Isolation of patients with transmittable infections and those who are immuno-compromised Outbreak management groups Post infection reviews for learning and action Environmental Controls: Environmental decontamination programme and standards, segregation and safe disposal of waste process, programme of water safety and IPC design incorporated into refurbishments and new builds.						IPC strategy needs updated Absence of Regional IPC Strategy Compliance with mandatory training Limited face to face training due to pandemic Laboratory testing capacity for respiratory viruses is limited locally The IPC/ microbiology team have no access to IPC management /surveillance and epidemiology IT systems	Review and update of IPC/AMS Strategy Improve staff update of mandatory training Further develop videos to support on line mandatory training Further develop diagnostic capacity to facilitate early diagnosis to facilitate isolation and timely appropriate treatment to prevent AMR Continue to influence regionally for IPC management/ surveillance and epidemiology IT systems
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				Antimicrobial Stewardship: Policies and Standards, and ward round							The aged Trust estates does not comply with HTM & HBN. Lack of ensuite isolation facilities, storage and ventilation. Poor finishes that inhibit the ability to clean Continue to bid for funding to improve trust facilities including ensuite side room provision, ventilation, ED and ICU facilities. Improved environmental provision for day care etc. CAH and DHH site wide redevelopment Case for VHP and annual deep clean programme
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7. UROLOGY SERVICES PUBLIC INQUIRY

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
7.1 Organisational capacity to manage the range, and complexity of information required to support the USI. This includes general discovery requests, which are wide in their scope and cover significant areas of the Trust and the support required to comply with S21 requests. Moving forward to subsequent phases of the USI, organisational capacity and readiness in relation to preparations for the Public Hearing process will remain a challenge Capacity of legal team (DLS and Barristers) to support the USI, particularly with a number of concurrent Public Inquiries on-going	Reputational Organisational HR impact	L	Programme Director of the Public Inquiry	Trust Public Inquiry Team Regular liaison with Trust legal advisors Lookback Group Quality Assurance Group DOH Urology Assurance Group SPPG/formerly HSCB Urology oversight group	Score 16 (4 x 4)	Rating High	Score 6 (2 x 3)	Rating Medium	Reports to Trust Board/ Board Committees Progress updates at each confidential Trust Board meeting Reports Elsewhere SMT Chief Executive regular reporting to Department of Health	Programme Board co-chaired by Chief Executive and Independent member has not yet met Clarity around the Public Hearing schedule awaited - Early clarity will assist in planning and preparing the Trust. Resource implications	First meeting of Programme Board scheduled for October 2022 The Trust will continue to use the experience gained by the UPI during the discovery and S21 response process which will add to its ability to deliver on USI requests. Identification of key resource requirements informed by experience of UPI to date. Staff recruitment in key support functions underway Completion mid-September. Additional legal cover to be sourced – completion September 2022

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/ metrics) Summary of reports	Current gaps in controls/ assurance	Mitigating Actions with due dates
7.2 Risk to service continuity as a result of Section 21 notices response times and Public Hearing preparations.	Organisational risk – service delivery Reputational risk – loss of public confidence	L	Programme Director of the Public Inquiry	Liaison with USI in respect of projected timeframes for hearings Information shared with SMT to allow for service planning to accommodate S21 response timeframes	Score 16 (4 x 4)	Rating High	Score 6 (2 x 3)	Rating Medium	Reports to Trust Board/ Board Committees Progress updates at each confidential Trust Board meeting Reports Elsewhere SMT	Lack of confirmed timetable around schedule of Public Hearings limits Trust's ability to manage staff workloads accordingly. Uncertainty in relation to time that staff may be unavailable; witness may be required to give evidence more than once; need to identify level of preparation/ debrief required likely to vary between staff	The Trust continues to liaise with the USI to achieve a workable timeframe for response of S21s, and has highlighted the operational impact of the on-going discovery process - managing on a case-by-case basis in conjunction with legal team Ongoing proactive engagement with USI continues in relation to S21 response deadlines and has been generally positively received Proactive identification of staffing impact and preparation of business contingency plans..

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/metrics) Summary of reports	Current gaps in controls/assurance	Mitigating Actions with due dates
7.3 Risk to health and wellbeing of staff	HR impact – staff capacity and morale. Potential impact on staff sickness Impact on family life for staff involved in the UPI	L	Programme Director of the Public Inquiry	Occupational Health Support Psychologist is available for staff support Proactive regular check in sessions for PI Team and others as required is available Information in relation to psychological support is made available to all staff Inspire Line management support	Score 16 (4 x 4)	Rating High	Score 6 (2 x 3)	Rating Medium	Reports to Trust Board/ Board Committees Progress updates at each confidential Trust Board meeting Reports Elsewhere SMT	Lack of clarity around timeframe for public hearings limits timely engagement of key staff.	Consider need to allocate defined psychological support for public hearing process. Develop plans to pro-actively support staff engaged in public hearing process. This includes: Timing information; Briefing on what to expect ie attendance of observers; live-streaming; media coverage potential; website coverage. Arrangements to de-brief and follow up

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/metrics) Summary of reports	Current gaps in controls/assurance	Mitigating Actions with due dates
7.4 Reputational risk exists in the process of the Public Inquiry – the public release of information and the Public Hearings which are likely to attract media attention.	Reputational – loss of public confidence	L	Programme Director of the Public Inquiry	Lookback Group Quality Assurance Group DOH Urology Assurance Group SPPG/formerly HSCB oversight group	Score 16 (4 x 4)	Rating High	Score 6 (2 x 3)	Rating Medium	Reports to Trust Board/ Board Committees Progress updates at each confidential Trust Board meeting Reports Elsewhere SMT Department of Health	Not all discovery process complete, therefore not all issues surfaced. Discovery relating to other participants not yet available to the Trust.	Consultations with staff and review of discovery information Full open and transparent discovery to ensure the Trust is aware of issues prior to publication. Ongoing process of assurance and learning

CORPORATE OBJECTIVE: Promoting Safe, High Quality Care

Risk Description linked to strategic objective alignment	Impact of the Risk (implications)	Risk Appetite	Executive Risk Owner	Existing Controls (reflecting current risk rating)	Current Risk Score and Rating		Target Risk Score and Rating		Assurance from What? (papers/metrics) Summary of reports	Current gaps in controls/assurance	Mitigating Actions with due dates
7.5 No funding stream identified	Potential Trust wide impact	M	Programme Director of the Public Inquiry	Monthly financial reporting	Score 16 (4 x 4)	Rating High	Score 6 (2 x 3)	Rating Medium	Reports to Trust Board/ Board Committees Progress updates at each confidential Trust Board meeting Reports Elsewhere SMT		Funding requirements shared with DoH.

Weekly Governance Meeting – Terms of Reference

Approved 28th October 2021

Background

The Trust is committed to delivering high quality, safe and effective services. To achieve this there must be a fast and responsive mechanism to:

- (i) de-brief on newly emerging issues e.g. SAIs, Never Events, Complaints, Adult Safeguarding referrals, complex Adult Protection cases where the risk is high to the individual or the organisation, Medicines management, Litigation etc;
- (ii) brief staff on newly issued Standards & Guidelines, Safety alerts etc; and
- (iii) report the above to Trust SMT, as part of the integrated governance arrangements of the Trust's assurance and accountability framework.

The Weekly Governance meeting, Chaired by the Medical Director, is a multi-disciplinary, cross Directorate vehicle through which this is achieved.

Purpose / Role of the Group

- To promote incident reporting safety culture across the organisation in order to reduce avoidable harm
- To review Directorate patient safety concerns which emerged in the week prior to the meeting of the group
- To identify learning from the events surrounding these concerns
- To identify opportunities for improvement based on a thorough understanding of the issue which caused the concern; ensuring the application of systematic quality improvement tools and methods
- To provide a Weekly Governance paper to SMT detailing the issues/concerns of the previous week.

Membership

- Medical Director (Chair)
- Executive Director of Nursing
- Head of Nursing , Patient Safety and Quality
- Deputy Medical Director Governance, Safety and Quality (Alternate Chair)
- Deputy Medical Director of Education and Workforce
- Assistant Director Clinical and Social Care Governance and Infection Prevention & Control

- Assistant Director Clinical and Social Care Governance
- Corporate Clinical and Social Care Governance Coordinator
- Operational Directorate Governance Coordinators
- Governance Officer, Corporate Clinical and Social Care Governance
- Complaints Manager
- Datix Risk Manager
- Head of Patient Safety Data and Improvement
- Senior Manager of Standards, Risk & Learning
- Litigation Manager
- Medicines Governance Pharmacist
- Head of Service – Adult Safeguarding
- Head of Information Governance
- Liaison Officers
- Assistant Director Quality Improvement / Head of Quality Improvement
- Corporate CSCG Admin staff member

When a member of the meeting group is unable to attend, an alternative nominee from his/her service area is required to attend. In cases where this is not possible, a comprehensive narrative report is required to be submitted clearly describing any issues which ought to be brought to the attention of the group.

Meeting Format

- Meetings held on a weekly basis
- Chaired by Medical Director or Deputy Medical Director
- Papers will be circulated the day before the meeting via email
- Additional members or presenters will be invited as agreed with the Chair

Review

- Terms of reference for the group will be reviewed on a 6 monthly basis

Confidentiality

- Information included in meeting papers will be anonymised and the discussions of the meeting will be treated as strictly confidential

Reporting

- The Weekly Governance Meeting will report weekly to the Trust SMT



Southern Health
and Social Care Trust

Quality Care - for you, with you

CORPORATE CLINICAL SOCIAL CARE GOVERNANCE FUNCTIONS AND STRUCTURES PROPOSAL

September 2020



CORPORATE CLINICAL SOCIAL CARE GOVERNANCE FUNCTIONS AND STRUCTURES PROPOSAL

1st September 2020

PURPOSE OF PAPER

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

INTRODUCTION

1. Clinical governance is “a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.” (Scully and Donaldson 1998). Within public healthcare services in Northern Ireland we can expand this definition to include social care governance.
2. Clinical and Social Care governance is an umbrella term. It describes activities that not only sustain and continuously improve high standards of patient care, but also provide quality assurance.

3. Healthcare providers that have effective Clinical Governance and Leadership structures which consider learning, communication and safety as defined goals have been shown as high-performing healthcare organisations (NHS Scotland, Quality Improvement Hub, 2017).
4. All Health and Social Care (HSC) organisations now have a duty to the communities they serve for maintaining the quality and safety of care. Whatever structures, systems and processes an organisation puts in place, it must be able to show evidence that standards are upheld.
5. The Department of Health (UK) and Social Care identified the core elements of Clinical Governance in the 1999 publication 'Quality in the new NHS'. The framework was designed to specify the elements of clinical governance systems that could both assure and improve quality. The results, known as the seven pillars of clinical governance, are:
 - People who use services, carer and public involvement
 - Clinical effectiveness
 - Clinical audit
 - Risk management
 - Training and personal/professional development
 - Use of information
 - Staffing and staff management.
6. The Department of Health (Northern Ireland) Quality standards for Health and Social Care - Supporting Good Governance and Best Practice in the HPSS (2006) outlines the requirements for Health and Social Care organisation governance. Theme One of these standards outline the following requirements:
 - ***The organisation has a coherent and integrated organisational and governance strategy, appropriate to the needs, size and complexity of the organisation with clear leadership, through lines of professional and corporate accountability.***
 - ***The organisation has structures and processes to support, review and action its governance arrangements including, for example, corporate, financial, clinical and social care, information and research governance.***

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



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

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

Learning from Recent Experiences

9. **The Francis Inquiry Report (2013)** into the failures in leadership and governance present at Mid-Staffordshire NHS Foundation Trust highlights what amounts to a 'perfect storm' of systematic failures which included:

- 'Somebody Else's Problem' attitude
- an institutional culture that cared more about the needs of the hospital staff than the patients
- an unacceptable willingness to tolerate poor standards of patient care
- a failure to accept and respond to legitimate complaints
- a failure of leadership

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

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

Trust Clinical and Social Care Governance Review 2019

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

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

Table 1 – Breakdown of 2019 Governance Review Recommendations

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

Clinical and Social Care Governance Scoping Exercise August 2020

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

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

Table 2 – Breakdown of 2020 Governance Scoping Exercise

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

Proposals to Strengthen Trust Clinical and Social Care Governance Functions

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

Considerations and Exclusions in this Document

17. The following considerations and exclusions are noted:

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

PROPOSAL 1 – REALIGNMENT CLINICAL AND SOCIAL CARE GOVERNANCE STRUCTURES

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

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

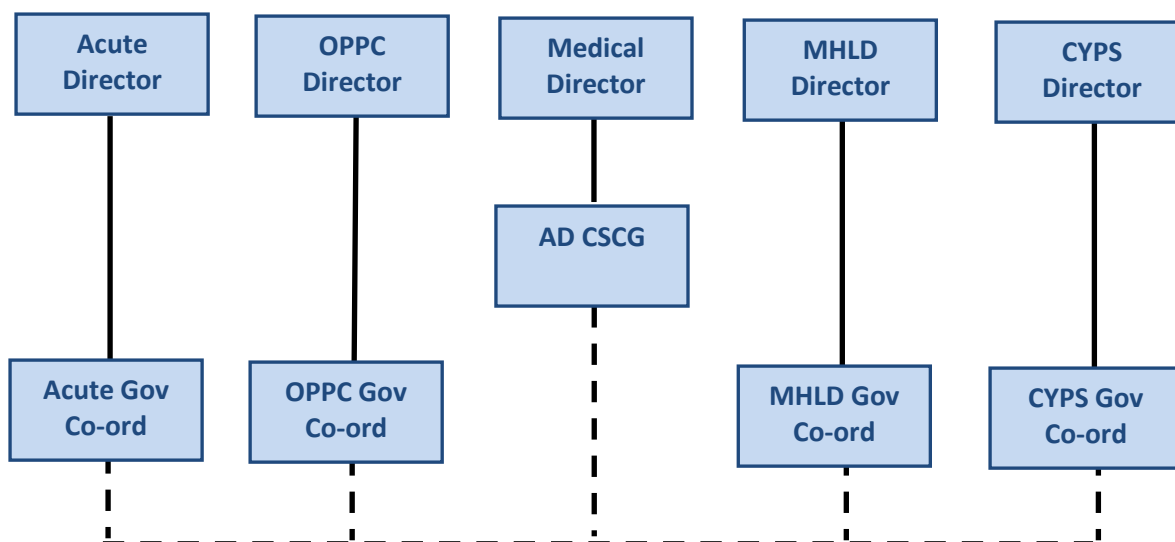


Figure 1 – Current Clinical and Social Care Governance Structure within the Trust

Challenges with a distributed Clinical and Social Care Governance Structure

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

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

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

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

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

21. The benefits of a corporate lead service include:

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

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

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

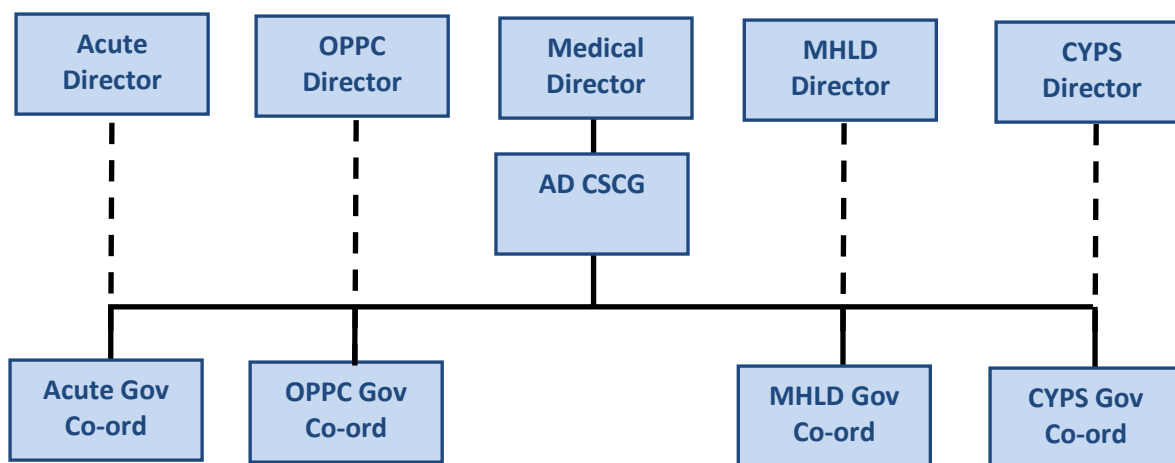


Figure 2 – Proposed Clinical and Social Care Governance Structure

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

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

Options Appraisal

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

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

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

Option 2 – Realignment Clinical and Social Care Governance Structures

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

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

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

Staffing Comparison with Analogous Corporate Functions

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

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

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

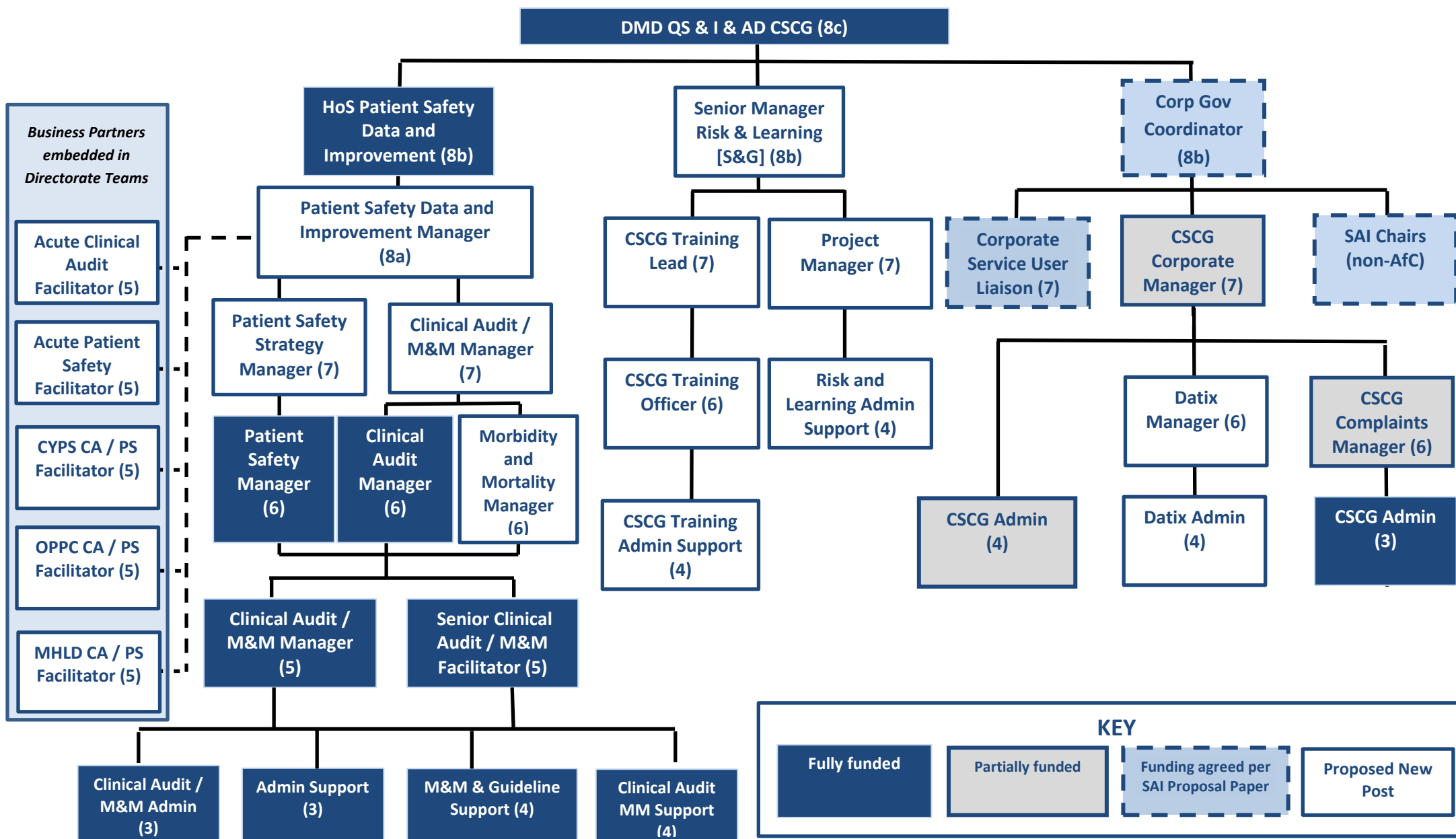
**Excluding Estate Services

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

****Informatics includes IT staffing complement

27. Based on the findings of the 2019 Governance Review and the suggested structure the following page outlines the proposed staffing model including posts that are currently funded, those which have partial funding and those which are new, unfunded positions within the corporate team.
28. As stated in the introduction a separate paper detailing the requirements of directorate clinical and social care governance teams will be required when full scoping is complete.
29. The medical directorate acknowledges that this is a high value funding proposal and suggest that a phased approach to team growth is adapted to allow new team members to embed in their roles and functions and ensure that the model as designed is delivering its objectives. The phased implementation can be found on page 20 of this document.

PROPOSED REVISED CORPORATE CLINICAL AND SOCIAL CARE GOVERNANCE STRUCTURE



FUNCTIONS AND BENEFITS OF THE REVISED STRUCTURE

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

31. The following functions and benefits have been identified:

Workplan Element	Overview of Elements
Management of Standard and Guidelines	• Development of a standardised, robust framework for the management of standards and guidelines within the Trust • Develop a mechanism to link standard and guideline assurance formally to clinical audit activity • Develop dynamic oversight reporting and risk analysis of standard and guideline compliance
Development of a Trustwide Patient Safety Strategy	Development of a structured patient safety strategy for the Trust that will: • Improve understanding of safety by drawing intelligence from multiple sources of patient safety information • Equip patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system • Allow for the design and support of programmes that deliver effective and sustainable change in the most important areas
Support for Morbidity and Mortality Processes	• Further increase administrative support and facilitation for Morbidity and Mortality processes • Provide support for multidisciplinary and specialty input and increase the range of Patient Safety inputs available for each meeting • Ensure the Trust Morbidity and Mortality structure fully benefits from the Learning from Experience programme
Strengthening Response to Serious Adverse Incidents	• Provide corporate team involvement in oversight of reviews in progress • Provide availability of corporate team support for teams conducting reviews to advise on review technical issues • Provision of resource to provide bespoke training / guidance to local teams in the conduct of review elements

	• Provision corporate support available to assist with the coordination of cross directorate / cross Trust or interagency reviews • Provide corporate support available to assist with improving the process of learning • Provide corporate support for developing recommendations and embedding learning in response to incident review findings • Provide corporate support to assist with the consolidation of themed recommendations across services and directorates
Development of Trust Risk Management Systems	• Implementation of the organisation wide Risk Management Strategy • Trust level coordination of work relating to the risk management and Risk Appetite aspects of the Health Care • Development of an action plan to ensure achievement and continuous maintenance of required standards including the development and implementation of an effective risk identification and management process. • Development and maintenance of effective incident reporting systems across the Trust, ensuring that structures and process are in place to facilitate lessons learned and integration with complaints and claims • Provision of advice to Trust services on any necessary changes/developments required to meet the Risk Management Standards
Improving our Service User Complaints Processes	• Development of a Trustwide customer service training programme including support for construction of responses to service users • Improve our complaints trend analysis programme using complaints to better inform service improvements • Develop processes to support the management of Independent Sector Providers
Supporting Trust Learning from Experience Processes	• Oversight and management of the Trust Learning from Experience programme • Identify and coordinate sources of learning both internal and external into standardised communication channels • Link learning from experience into clinical audit and other assurance processes to ensure learning and improvement is embedded in services.

32. The following new and revised role high level descriptions are provided below:

Role Title	Band	Details
Senior Manager of Risk and Learning	8b	• Oversight and responsibility for Corporate Risk Register • Oversight and responsibility for Trust Standard & Guidelines process • With operational change leads develop action plans to direct operational Standard & Guidelines implementation including the review and update of legacy Standard & Guidelines • Support the creation and provision of an education and learning programme which integrates learning between SAI's/M&M/Litigation/Datix Trust-wide • Support the creation and implementation of governance e-learning packages • Support the implementation of the Datix system upgrade and adaptation of modules
Patient Safety Data and Improvement Manager	8a	• Lead for the implementation, coordination, management and delivery of Trustwide monitoring and improvement programmes for patient safety initiatives • Production of patient safety performance data & reports, to identify areas for increasing collaborative, multidisciplinary working and to inform new ways of working. • Responsible for monitoring Trust patient safety performance metrics interpretation and benchmarking of Process & Outcome data with other participating Trusts on Interventions • Reporting to the Trust Governance Forums through monitoring of the Patient/Client Safety Quality Improvement Plan on behalf of the Trust, identifying deviations from the plan's goals & objectives and taking corrective action where appropriate.
Patient Safety Strategy Manager	7	• Lead on the development and implementation of a Trustwide Patient Safety Strategy • Monitor clinical process and outcomes and system issues related to quality of patient care and provide and monitor written communication for performance improvement activities • Where appropriate assist in the development of clinical practice guidelines

		• Identify and investigate performance improvement events, opportunities, trends and sentinel events • Help operational teams outline remedial actions in response to patient safety improvement programmes • Participate in performance improvement committees and provide staff education on performance improvement topics
Corporate Clinical Audit and M&M Manager	7	• Responsible for line management of the M&M and Clinical Audit Team • Integration of M&M outcomes and the Clinical Audit programmes. • Facilitate and manage an annual programme of clinical audits, ensuring programmes meets local and national requirements for assigned specialities. • Liaising and communicate with all levels of healthcare professionals including managers ensuring opportunities for clinical audit are identified, pursued and supported. • Facilitating multi-disciplinary groups within specialities to plan and oversee clinical audit projects. To analyse and interpret a range of complex data and facts and report the findings in a variety of formats suitable for the particular audience associated with the individual audit projects. • Demonstrating the ability to employ a range of alternative methods, including the use of modern technology, to deliver well planned and effective clinical audit projects • Assisting assigned specialities to identify improvements to patient care through the clinical audit programme
CSCG Training Manager and Training Officer	7 and 6	• Create and sustain an education and learning programme which integrates learning from SAI's/M&M/Litigation/Complaints/Datix Incidents Trust-wide • Support the creation and implementation of governance e-learning packages • Support the implementation of the Datix System upgrade and adaptation of modules • Line Manage the Risk and Learning Admin support
Corporate Service User	7	• Create interfaces with services user/family and staff involved in

Liaison Officer (CSULO)		incidents/sudden death/complaints, SAI's, Coroner Inquests, GMC/NMC hearings • Create and maintain interfaces with PCC, NIPSO, PSNI, Coroner's Office, Litigation, DLS, Bereavement Coordinator • Support the extraction and circulation of learning from case management to all SHSCT streams of learning education while working the premise of Being Open
CSCG Corporate Manager	7	• Responsible for the line management of Datix Manager, Corporate Complaints Manager, Datix admin support, and 2 CSCG Admin • Support the Compilation, updates and assurance in relation to all Governance Reports for audit and submission Regionally, Trust Board and Trust Senior Management Team • Compile and provide SHSCT Patient Safety Data and Complaints data regionally for audit including DoH, HSCB along with Trust Board and Trust Senior Management Team • Support the creation and maintenance of Datix patient safety dashboards Trust-wide • Support the implementation of Trust-wide education & learning programme in-conjunction with the CSCG Training Officer and CSULO • Support the Datix Manager to implement the Datix system upgrade and customise all relevant modules for use. Provide interface with IT and IT systems to ensure Datix sustainability • Oversee the creation and management of Trust-wide SAI recommendations and action plans for each Trust Directorate • Provide support and oversight of the dissemination of Standards & Guidelines coming in to the Trust for the Senior Manager of Risk and Learning • Oversee and monitor the screening and recording of Trust-wide complaints using the Health Care Analysis Tool
Morbidity and Mortality Manager	6	• Coordination and support for the Trust M&M Function • Management of the RMMRs function • Provision of reporting and analysis of RMMRs performance in support of M&M monthly meetings review of case discussion and completion

		• Develop processes of learning from M&M Outcomes that link to safety improvement initiatives and clinical audit.
Datix Manager	6	• Lead the Trust-wide upgrade of the Datix System • Adapt and secure Datix web modules in relation to Morbidity & Mortality, SAI Management, Litigation, Complaints • Maintain interface with IT systems team to ensure maintenance of the Datix System • Lead and support the education and learning in relation to incident reporting on the Datix system across the trust • Support the CSCG Training Office to create and update e-learning in relation to incident management • Support any CSCG patient safety or programmes of audit with data available from Datix system or create the ability to access same where possible • Manage and monitor and Datix system access and accounts Trust wide
Corporate Complaints Manager	6	• Responsible for the initial screening, management (and escalation as appropriate) of all complaints submitted to the SHSCT inc informal/formal complaints, MLA queries, Ombudsman queries, Freedom of Information requests, queries from DoH • Responsible for the screening of all complaints to ensure rapid escalation of any high-risk complaints • Responsible for overseeing the implementation and application of the Health Care Analysis Tool to every Trust complaint • Responsible for the gathering of data, learning and themes of complaints to support all SHSCT reports and Regional guidance as relevant • Responsible for ensuring local resolution of complaints is made when at all possible and follow up with written correspondence to service user and Specialty Teams involved • Responsible for providing timely and appropriate acknowledgement of all Trust complaints

Patient Safety / Clinical Audit Facilitators	5	• Provide support to directorate teams to undertake quality and safety data analysis, reporting and audit activities and plans for safety improvement. • Support processes for monthly Patient Safety Meetings providing an effective process of mortality and morbidity assurance which will meet regionally developed standards, supporting the use of the regional RMMRS system and producing relevant supporting documentation
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REVISED STRUCTURE COSTING

33. The following costing table outlines the costs for the corporate service

Role Title	Band	No. of Posts	Funded	Currently Funded (Mid-Point of Scale with Goods and Services)	Additional Cost (Mid-Point of Scale with Goods and Services)
Assistant Director CSCG	8c	1	Yes	£94,106	
HoS Patient Safety Data and Improvement	8b	1	Yes	£80,188	
Corporate CSCG Coordinator*	8b	1	Yes	£80,188	
Senior Manager of Risk and Learning [S&G]	8b	1	No		£80,188
Patient Safety Data and Improvement Manager	8a	1	No		£67,076
Patient Safety Strategy Manager	7	1	No		£60,037
Project Manager	7	1	No		£60,037
M&M and Clinical Audit Manager	7	1	No		£60,037
CSCG Training Lead	7	1	No		£60,037
Corporate Service User Liaison Officer*	7	1	Yes	£60,037	
CSCG Corporate Manager	7	1	Partial	£39,034	£21,003
Datix Manager	6	1	No		£48,375
Morbidity and Mortality Manager	6	1	No		£48,375
CSCG Training Officer	6	1	No		£48,375
Corporate Complaints Manager	6	1	Partial	£39,034	£9,341
Patient Safety Manager	6	1	Yes	£48,375	
Clinical Audit Manager	6	1	Yes	£48,375	
M&M and Clinical Audit Facilitator	5	2	Yes	£39,034	
Clinical Audit Support	4	1	Yes	£34,250	
Audit and Guidelines Administrator	4	1	Yes	£35,250	
Risk & Learning and Support Administrator	4	1	No		£35,250
CSCG Training Support Administrator	4	1	No		£35,250
CSCG Administrator (Adverse Incidents and SAls)	4	1	Partial	£29,824	£4,426
Datix Administrator	4	1	No		£35,250
Clinical Audit Administrator	3	2	Yes	£59,648	
CSCG Administrator (Complaints)	3	1	Yes	£29,824	
SAI Chairpersons [Medical]*	NA	2	Yes	£55,000	
SAI Chairpersons [Non-Medical]*	8b	0.4	Yes	£32,075	
Total Cost				£804,242	£673,057

*Funding previously agreed by Trust Senior Management Team as part of Serious Adverse Incident proposal paper

34. The following costing table outlines the costs for the business partner posts

Role Title	Band	No. of Posts	Funded	Currently Funded (Mid-Point of Scale in Goods and Services)	Additional Cost (Mid-Point of Scale in Goods and Services)
Acute Clinical Audit Facilitator	5	1	No		£39,034
Acute Patient Safety Facilitator	5	1	No		£39,034
CYPS CA / PS Facilitator	5	1	No		£39,034
MHLD CA / PS Facilitator	5	1	No		£39,034
OPPC CA / PS Facilitator	5	1	No		£39,034
Total Cost					£195,170

35. The following costing table outlines the costs for directorate teams (work in due for completion October 2020).

Directorate	Role Title	Funded	Currently Funded (Mid-Point of Scale in Goods and Services)	Additional Cost (Mid-Point of Scale in Goods and Services)
Acute	Governance Officer Band 7	No		£60,037
	Governance Admin Support Band 2	No		£39,034
OPPC	ISP Governance Officer 8a	No		£23,075
	Governance Officer Band 7	No		£60,037
CYPS TBC				
MHLD TBC				
Total Cost *				£182,183

Phased Implementation Proposal

36. In order to ensure the most effective use of resource, the Cooperate and Clinical Social Care Governance division purposes a phased implementation approach, which we believe supports greatest value. A phased approach will provide time for transitional learning and training in a controlled environment which would maximise value for money for the Trust and a stabilised skilled workforce.

Phase	Action	Timescales
Phase 1	• Patient Safety Data and Improvement Manager, Band 8a • Senior Manager Risk & Learning, Band 8b • Datix Manager Band 6 • Patient Safety Strategy Manager, Band 7 • Project Manager Band 7	In post within 3 months of proposal acceptance and investment
Phase 2	• Corporate Clinical Audit Manager, Band 7 • CSCG Training Officer Band 7 • Morbidity and Mortality Manager Band 6 • Directorate Clinical audit and patient safety posts Band 5	Within 3-6 months of proposal acceptance and investment
Phase 3	• Datix Admin, Band 4 • Risk and Learning Admin Support Band 4 • Training admin Support Band 4 • Business Partner posts Band 5	Within 9-12 months of proposal acceptance and investment

Options Appraisal

Option 1 – Do Nothing – No Investment in Additional Resourcing

Resourcing remains static, the Trust is unable to deliver on the recommendations of the 2019 Governance Review or 2020 Governance Scoping Exercise and will be unable to deliver in a timely manner on specific governance actions such as supporting the implementations of recommendations into hyponatraemia related deaths.

Option 2 – Funding for Resourcing is Agreed

The Trust will be able to commence developing functions that can meet the requirements of 2019 Governance Review and 2020 Governance Scoping Exercise and deliver on governance actions a timely and robust fashion commencing with Phase 1 of the proposal.

Corporate Liaison Officer



Quality Care - for you, with you

JOB DESCRIPTION

JOB TITLE	Corporate Liaison Officer
BAND	7
DIRECTORATE	Medical Directorate
INITIAL LOCATION	Beechfield House, CAH
REPORTS TO	Corporate Clinical and Social Care Governance (CSCG) Co-Ordinator
ACCOUNTABLE TO	Assistant Director of CSCG (ADCSCG)

JOB SUMMARY

The post holder will have responsibility for management of the proactive liaison service for service users, relatives and carers who have had involvement in a serious adverse incident and/or structured judgement review process or submitted a complaint to the Trust regarding service user safety. The post holder will be the key central point of contact between the affected service users, relatives¹ and carers and will ensure they remain fully supported, including pastoral and tangible supports where required, throughout and following any Trust review processes.

The post holder will ensure the Trust maintains a responsive liaison service for patients, relatives, carers at all times. This will include liaising with internal Trust services and external agencies to ensure that appropriate supports are provided to service users and families who may require access.

The post holder will provide advice and support to SHSCT staff who have had involvement in a serious adverse incident and/or structured judgement review process or a complaint submitted to the Trust regarding service user safety.

¹ The definition of family includes any person(s) who may be affected as a result of a healthcare related incident regardless of their personal connection to the services provided



KEY DUTIES / RESPONSIBILITIES

1. Provide a central point of contact for service users, relatives and carers who have had contact with a serious adverse incident and/or structured judgement review or submitted a complaint to the Trust regarding service user safety. The contact may be in person, by telephone, e-mail or written correspondence.
2. Facilitate meetings with service users, relatives and carers who have had involvement in a serious adverse incident and/or structured judgement review process or submitted a complaint to the Trust regarding service user safety. This will include dealing with situations which are highly emotive and challenging where information may be of a sensitive and complex clinical nature.
3. Where necessary, advise and support service users to access alternative sources of information, including advocacy services, other healthcare organisations, or voluntary sector services suited to their needs.
4. Keep service users, relatives and carers who have had involvement in a serious adverse incident and/or structured judgement review process or submitted a complaint to the Trust regarding service user safety continuously informed of Trust review processes and expected timescales for completion.
5. In cases where service users, families or carers require on-going help and support to regarding their involvement in a serious adverse incident and/or structured judgement review process or complaint, chair liaison meetings between Trust staff and service users, families or carers to discuss any concerns they have.
6. With the consent of service users, families or carers, provide links to Trust services, General Practitioner services or external counselling agencies.
7. Lead on communication with service users, families or carers when sharing sensitive and complex information and with input from clinical subject matter experts the factors that led to adverse events affected them.
8. With operational directorate teams, make objective analysis and assessment of concerns that may be complex and/or sensitive, make judgements and through liaison with chair / reviewer to ensure the appropriate level of reviews are carried out and if required, facilitate negotiations with all concerned to find solutions.
9. With operational directorate teams, communicate the outcome of any review to individuals in response to concerns or feedback raised, either verbally and/or in writing.



10. Keep accurate and contemporaneous records of all communications with service users, relatives and carers including outcomes and actions and input data onto the Datix system.
11. Work collaboratively with directorates to monitor the progress of action plans as a result of concerns and patient feedback and ensure that lessons are learned and shared with affected service users, relatives and carers.
12. Work closely with directorates to embed a culture which views adverse events, complaints, concerns and service user feedback as opportunities for learning and support services to ensure adequately supported and empowered to deal with complaints quickly, effectively and objectively at local level.
13. Represent the Trust at regional meetings and forums including the patient and client council regional working group.
14. Lead and manage multidisciplinary service improvement projects designed to create improved systems and processes for the identification and dissemination of learning from adverse events and complaints.
15. Provide guidance to the Chief Executive, operational directors, senior managers and clinicians on the management of communications with patients, relatives and carers.
16. Using evidence based approaches, design and deliver specialist training for multiprofessional staff to support them when communicating with patients, families and carers.
17. Lead on the local development of guidance in respect of service user, relative and carer engagement processes by leading on the assessment, interpretation and implementation of national and regional guidance and policies.
18. Lead and oversee an ongoing review of organisational engagement processes with regard to patients, relatives and carers and lead on the development of appropriate levels of staff, public and service user consultations.
19. Lead on the development of quality metrics and targets based on national and regional policies and provide action plan and monitoring information to the Medical Director.
20. Have input in the governance agenda by highlighting patient safety issues raised through concerns, complaints and service user feedback to both the



Corporate Clinical and Social Care Governance (CSCG) Co-Ordinator and Assistant Director for Clinical and Social Care Governance (ADCSCG).

21. Assist the Corporate CSCG Co-Ordinator, ADCSCG and Head of Patient Safety Data with improvement analysing trends and themes arising from concerns/complaints or feedback and assist in the production of reports to Care Groups and departments.
22. Work to undertake surveys, audits and other projects relevant to the department.
23. Ensure that members of the public know how to raise concerns and complaints and that any barriers preventing this are addressed.
24. Provide assistance to the Corporate CSCG Coordinator and ADCSCG in collating and presenting data in preparation for external audits.
25. Contribute to Trust-wide training on customer services including; staff supporting service users; relatives and carers; frontline resolution of concerns and complaints, in order to ensure that staff are supported and enabled to meet patients' needs in practice.
26. Provide advice and support to SHSCT staff who have had involvement in a serious adverse incident and/or structured judgement review process or a complaint submitted to the Trust regarding service user safety.
27. Responsible for maintaining own professional development and to be aware of current practices and developments within the Trust and the Health and Social Care in order to fulfil the role effectively.

ORGANISATIONAL RESPONSIBILITIES

1. Support the development of processes which provide corporate assurance that both the operational and professional aspects of CSCG are of a sufficiently high standard.
2. Support the development, implementation and audit of organisational wide CSCG policies and procedures.
3. Work collaboratively and effectively with the SHSCT Corporate CSCG Co-Ordinator and ADCSCG to ensure there is a clear, two-way line of communication from each operational Director, SMT Governance teams and Trust Governance Committees.



4. Support the Corporate CSCG Co-Ordinator and ADCSCG in the planning and implementation of Trust wide policies and procedures as required and actively bring forward strategic plans for driving forward the CSCG agenda within the Southern Trust, influencing and shaping this agenda regionally.
5. Support robust monitoring arrangements, to ensure that at all times the Directorates are complying with and operating within the CSCG policies, procedures and standards that the Trust has agreed. Where monitoring indicates any exception or deviation, this must first be brought to the attention of the Corporate CSCG Co-Ordinator for escalation as required to the ADCSCG and then the Medical Director.

INFORMATION MANAGEMENT

1. Ensure the effective implementation of all Trust information management policies and procedures.
2. Ensure the systems and procedures for the management and storage of information by the post holder meet internal and external reporting requirements.

HUMAN RESOURCE MANAGEMENT RESPONSIBILITIES

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

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



RAISING CONCERNS - RESPONSIBILITIES

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

PERSONAL AND PUBLIC INVOLVEMENT RESPONSIBILITIES (PPI)

- Promote and support the implementation of the Trust's PPI Strategy and ensure all staff are aware of their responsibilities as appropriate to their job role.

GENERAL REQUIREMENTS

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.
2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.
3. Adhere at all times to all Trust policies/codes of conduct, including for example:
 - Smoke Free policy
 - IT Security Policy and Code of Conduct
 - standards of attendance, appearance and behaviour
4. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.



5. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.
6. All employees of the Trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000 the Environmental Information Regulations 2004, the General Data Protection Regulations (GDPR) and the Data Protection Act 2018. Employees are required to be conversant with the [org name] policy and procedures on records management and to seek advice if in doubt.
7. Take responsibility for his/her own ongoing learning and development, in order to maximise his/her potential and continue to meet the demands of the post.
8. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

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

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

<January 2022>





Quality Care - for you, with you

PERSONNEL SPECIFICATION

JOB TITLE AND BAND	Corporate Liaison Officer, Band 7
DEPARTMENT / DIRECTORATE	Corporate CSCG/Medical Directorate
SALARY	£40,057 - £45,839
HOURS	Full-Time (37.5 hours)

Ref No: <to be inserted by HR>

January 2022

Notes to applicants:

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

ESSENTIAL CRITERIA

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

Factor	Criteria	Method of Assessment
Experience/Qualifications/Registration	1. Relevant professional clinical qualification ² 2. Current professional registration ² 3. Worked for at least 2 years in a Band 6 or above role in a major complex organisation ³	Shortlisting by Application Form



	4. Experience of providing direct liaison support to service users, families or carers 5. Expert knowledge of health and social care delivery, legislative, professional and statutory requirements of clinical and social care governance, demonstrated by achieving successful outcomes for at least 2 years 6. Possess a qualification in Counselling (or an undertaking to complete an appropriate course of study within 2 years of taking up post) ² A relevant Professional Clinical Qualification and registration with a recognised professional body is considered to be: • a full, current registration with the General Medical Council (UK) with Licence to Practice • a full, current registration with the Nursing and Midwifery Council (UK), • current registration with the Northern Ireland Social Care Council on the social work part of the register • current registration with British Psychological Society as a registered Psychologist • Allied Health Professional with current registration with the Health and Care Professions Council (HCPC) ³ 'major complex organisation' is defined as one with at least 200 staff or an annual budget of at least £50 million and involving having to meet a wide range of objectives requiring a high degree of co-ordination with a range of stakeholders	
Other	Hold a current full driving licence which is valid for use in the UK and have access to a car on appointment. <i>This criteria will be waived in the case of applicants whose disability prohibits driving but who have access to a form of transport approved by the Trust which will permit them to carry out the duties of the post.</i>	Shortlisting by Application Form
SECTION 2: The following are ESSENTIAL criteria which will be measured during the interview/ selection stage:		
Skills / Abilities / Knowledge	1. Excellent communication skills (written, oral, presentational and interpersonal) with the ability to communicate effectively with service users, families, carers and all levels of staff with a positive and caring attitude 2. Evidence of highly effective planning	Interview



	and organisational skills 3. Demonstrate the ability to assess risk and problem-solve based on excellent analytical skills 4. Ability to work effectively as part of a multiprofessional team 5. Ability to work flexibly to meet the needs of the service 6. A good level of computer literacy 7. Demonstrate the ability to write clear and concise reports related to complex subject matter 8. Demonstrate a working knowledge of Governance structures within the SHSCT and across the region	
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DESIRABLE CRITERIA

SECTION 3: these will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these criteria. Failure to do so may result in you not being shortlisted

Factor	Criteria	Method of Assessment
Experience	1. At least 1 year's experience in a role directly supporting service users, families or carers during/following trauma and/or bereavement related to and not exclusive to sudden death or serious adverse incident	Shortlisting by Application Form

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

Successful applicants may be required to attend for a Health Assessment

THE TRUST IS AN EQUAL OPPORTUNITIES EMPLOYER



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

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



Wallace, Stephen

From: Cassells, Carol
Sent: 26 July 2022 20:15
To: Wallace, Stephen; Gillespie, Michael
Cc: Doyle, Caroline; Davidson, Fiona; McConville, JoanneE; Gormley, Damian
Subject: RE: Prioritised Posts for Patient Safety and Clinical Audit

Thanks Stephen

Accepted as SMT decision and we will approve ereqs as soon as submitted

Carol

Carol Cassells
Asst Director of Finance – Financial Management
SHSCT, Lurgan Hospital

DDL: [Personal Information redacted by USI]
Mobile: [Personal Information redacted by USI]
E-mail: [Personal Information redacted by USI]

From: Wallace, Stephen [Personal Information redacted by USI]
Sent: 18 July 2022 10:03
To: Gillespie, Michael [Personal Information redacted by USI]
Cc: Doyle, Caroline [Personal Information redacted by USI]; Cassells, Carol
[Personal Information redacted by USI]; Davidson, Fiona [Personal Information redacted by USI]; McConville,
JoanneE [Personal Information redacted by USI]; Gormley, Damian
[Personal Information redacted by USI]
Subject: Prioritised Posts for Patient Safety and Clinical Audit

Hi Michael,

At SMT on 14th July 2022 the attached funding proposal was agreed for 2022/23, Carol was in attendance from Finance. The eight specific posts are as follows

- 1 X Band 8a Assurance & Improvement Mgr.
- 1 x Band 8a Patient Safety Improvement
- 1 x Band 7 Clinical Audit Manager
- 1 x Band 6 Senior Audit Facilitator
- 2 x Band 5 Patient Safety (M&M) Facilitators
- 1 x Band 5 Patient Safety Co-ordinator
- 1 x Band 4 Patient Safety Co-ordinator

Fiona and Joanne will be commencing creating position numbers and recruitment shortly. I would be grateful if you could accept this as confirmation of the SMT decision.

Thanks
Stephen

Stephen Wallace

Assistant Director Systems Assurance

Craigavon Area Hospital
Portadown

Personal information redacted by USI



Quality Care - for you, with you



Serious Adverse Incident Management

ID	Element	Description	Actions Required	Responsible	Date for Completion	Comment
AI01	Review of all written communication used with patients and families	Ensure all written communication provided by Directorates is standardised where possible and are written to reflect 'Being Open'	Manual scoping of all SAI related governance written communication with Governance Coordinators. Create focus group to provide feedback in relation to patient experience and view of language, communication process and timing of communication. Create Directorate SOP's regarding SAI communication. Consider populating Sharepoint with agreed SAI processes. Create link on Trust Web for family FAQ re SAI Review process.	Connie Connolly, Nicole O'Neill, Suzanne Barr	01/11/2020	
AI02	Establish a dedicated SAI Chair resource for Level 2 Reviews	Establish a dedicated SAI Chair resource for Level 2 Reviews that includes both Clinical and Senior Health professionals	Complete Non clinical JD for submission to HR and AFC. Recruit x2 to post upon processsing	Connie with Nicole	01/08/2020	
AI03	Standardise SAI methodology across all Directorates	Standarise SAI methodology across all Directorates including recommendation management and learning	Create a comprehensive suite of SOP which reflects Corporate SAI standarisation with speciality nuances. Formal screening of incidents to be standardised in all Directorates.Engage training which reinforces Trust-wide SAI management via elearning and F2F. Create specialist support network in Corporate Governance for Divisions and Directorates to engage during review process and recommendation mananagement.	Connie with Nicole	01/10/2020	
AI04	Corporate oversight of all SAI and SAI related activity	Create SAI management pathway which includes the joint circulation of all SAI activity with Directorates via Corporate team and provide assurance through validation of reports by Directoate and Corporate office prior to submission to HSCB	Creation of corporate process which requires Directorates to submit outcomes of all incident screening weekly. SAI Chair support Pathway to be validated by Directorates which will designate Corporate leadership for Level 2 & 3 investigations. Agree monthly interface meeting with Governance coordinators relating to the monitoring of recommendation Action Plans and implementation. Corporate to oversee management of legacy SAI Action Plans.	Connie and Governance Coordinators	01/10/2020	
AI05	Establish regular communication with DRO/NIPSO/PCE/DLS/PSNI	This will require quarterly individual meetings with DRO/NIPSO/PCE/DLS/PSNI. Will include CSULO and Corp rep	Agendas and meetings to be established to maintain dialogue to provide feedback in relation to production of SAI reports(DRO), complaint responses (NIPSO/PCE), Litigation activity involving staff who will be supporting inquests, testimony ect and PSNI in relation to any investigation which have crossover interest via SAI or criminal activity by staff or SHSCT patients	Connie and Nicole	01/11/2020	

AI06	Lead the introduction of the CSULO across all Directorates	Ensure that CSULO resource is allocated to the areas of highest risk	Create a portal for requests for CSULO support- criteria for support priorities to be set. Corp to set workplan for CUSLO which will inc representing SHSCT at interface mtngs, support staff via immediate trauma debrief and in support of coroner/legal testimony. CUSLO to workload to be cognisant of bereavement coordinators and Preserve Life officer.	Stephen & Connie with Governance Coordinators	01/09/2020	
AI07	Establish Learning from experience forum	Establish Learning from experience forum and process which binds all learning inc from other workstreams- SAI recommendations/M&M/Incidents/Complaints/Patient Safety Strategy inc utilisation of live streaming, learning via simulation,elearning and sharepoint	Map out all current processes with all Directorates cascade learning from SAI recommendations/M&M/Incidents/Complaints. Create focus group with ward managers/AHP leads and line managers to map out the preferred method and vehicle of sharing learning. Interface will be need to be create to supply clear succinct learning outcomes from all systems capturing learning prior to leading quarterly forum. Forum will need to be accessed by streaming, and then posted in learning library. Presentations to be given at forum with specified theme.	Connie, Fiona, Damien, Ashling, Suzanne ,Heather Trouton and teams	01/03/2021	
AI08	Rapid notification of all staff involved in SAI's notified to HSCB/ coronor/legal queries	Notification of all relevant staff to be formally notified of involvement in SAI's notified to HSCB/ coronor/legal queries at the time of HSCB notification	Standardisation of SAI process will ensure that a Staff inventory will be established in advance of incident screening or immediately after. SOP to be created to ensure all relevant staff (with relevant AMD/Clinical Supervisors) are notified, provided details of contact and SAI Chair as well as the support of CSULO/OHD. All Notifications will be provided in writing simultaneously at commencement of SAI Review. SOP will ensure that all persons recieving notifications will be provided opportunity to check for factual accuracy and recieve final report.	Connie Nicole CSULO and Governance Coordinators	01/10/2020	
AI09	Create formal and accessible support for patients/family and staff via the CSULO and timely debrief support as needed	Create formal and accessible support for patients/family and staff via the CSULO and timely debrief support as needed	Proforma to be created for all all Heads of Service and directors in the event of sudden or traumatic event to ensure rapid referral and response from CSULO. CSULO to be integrated into communication SOP regarding the escalation of sudden or traumatic event involving family, staff or patients.	Connie	01/10/2020	
AI10	Written literature supporting patients, families and staff involved in SAI process	Creation of written literature providing information and support for patients, families and staff involved in SAI process	Create short life working group to combine needs and views of staff, past and present service users past	Connie and Nicole	01/10/2020	

AI11	Corpoate assurance in relation to the standards and formats of all SAI reports submitted to the HSCB from the SHSCT	Complete benchmarking exercise in relation to quality and value of current SAI review reports across directorates and agree modifications where needed- incorporating feedback from DRO's	Complete benchmarking exercise in relation to quality and value of current SAI review reports and agree modifications where needed incorporating feedback from DRO's. Establish Directorate position of their individual templates. Source regional examples of speciality report templates for benchmarking. Review training inrelation to SAI report writing considering that Directorates will only be responsible for Level 1 reviews. SHSCT Chair pool to have formal process and template agreed as part of role induction.	Connie	01/03/2021	
AI12	Introduce/pilot 'Rapid Review' model for patients completing suicide.	Establish an appropriate 'Rapid Review' model for patients completing suicide. Will include HSCB/PCE/Litigation/DRO as well as Regional counterparts	Create focus group to provide feedback in relation to current SAI process and report for families of suicide. Benchmark UK Suicide SAI processes and reports. Engage CSULO, bereavement coordinator, Protect Life officer, DRO's, Coroner (?PSNI) and PIPS to consider improvements in communication from the Trust and SAI reports submitted to HSCB and presented to families.	Nicole and Suzanne with Connie	01/03/2021	
AI14	Corporate oversight of the management of adverse incidents should be strengthened to include a quality assurance component which will be dependent upon the resources and skills available within the Clinical and Social Care department					
AI15	The Trust should constitute an SAI Review Group and/or SAI Rapid Review Group [or similar] which should provide independent scrutiny and challenge to the SAI process including review of level of investigation, independence of review panel and approval of terms of reference when SAIs are initiated. In addition, the Review Group should oversee completed reports before submission to the HSCB. The Review Group should be chaired by the MD or his/her Deputy and will report to a Trust Board Sub Committee. The Review Group should meet on a four weekly basis initially.					

AI16	The Trust should develop a database of SAI Review Panel Chairs who have undertaken SAI/Systems Analysis Training.					
AI17	The Trust should develop an SAI RCA/Systems Analysis toolkit					

Complaints Management

ID	Element	Description	Actions Required	Responsible	Date for Completion	Comment
CM01	Introduction of Corporate Portal of Trust Wide complaints which includes MLA/Ombudsman/Freedom of Information queries	Streamling all sources of compliants or queries directed to Trust which will be screened, locally resolved if possible, and analysed- then circulated to Directorates	Agreement and negotiation of what can be managed via local resolution. Ensure approach is supported Regionally, NIPSO & PCE. Secure training to support the screening management (inc HCAT)and analysis of complaints or queries. SOP to be developed to support new process. Create new suite of complaints data which has been approved by Governance and SMT.	Connie & Nicole	01/10/2020	
CM02	Review Complaints structure and assurance feedback with ISP	Create a transparent and robust Complaints feedback mechanism regarding ISP activity.	Scope ISP complaint policy/processess for 46 homes Establish interface re compliance Audit of complaints management Establish literature availability Scope RQIA support re complaints activity	Suzanne & Connie	01/01/2021	
CM03	Create PCE/PPI and NIPSO interface to benchmark performance and effectivity	Compliant Manager to engage formal interface with Ombudsman and PCE/PPI groups	Support Complaints Manager to create interfaces with NIPSO/PPI/PCE. Review all Complaints written communication and engage NIPSO and PPI for feedback. Benchmark Regional complaints literature. Ammend Complaints literature after review.	Complaints Manager	01/10/2020	
CM04	Support Trust structure in relation to Learning from experience	Create a standardise process which provides learning from experience to Trust staff which joins outcomes from incidents, complaints, HCAT, SAI, M&M and litigation	This project will require the creation of a Learning from Experience Forum which sets out who will provide learning from each stream. All events to include MDT. Templates to be created to standardise the format of presentation of elements of learning. Devolop case studies to support simulation teaching and learning. Learning presentations to be shared via electronic platform	All Directorate Leads and nominations from all professions ,PCE lead, NIPSO rep, Patient Safety Lead, AMDO x2, Simulated learning lead	01/12/2020	

CM05	Trust-wide Customer Care/Complaints management training	Develop and support Trust-wide Customer Care/Complaints management training F2F and elearning	Create customer care/complaints training with a focus on 'Being Open' & early resolution. Develop elearning platform and provide F2F Trust-Wide training. Create audit cycle reviewing complaints management and customer satisfaction <i>Dear all,</i> <i>Further to discussion at the meeting earlier today, here is the link for the Page Tiger Complaints Awareness training:</i> <i>https://view.pagetiger.com/ciwlrod/1</i> <i>This is the Trust's first version of the training which has only just gone live for use in our Nursing Induction programmes. The package will be revised subject to feedback, so your views would be most welcome.</i>	Corporate Complaints officer supported by Connie and Nicole	01/11/2020	
CM06	Support the quarterly Governance Committee reporting structure with clear and meaningful data using HCAT	Develop HCAT performance Dashboard for all Divisions	Create SOP for staff recording complaints to standardise management and HCAT outcomes Create electronic report recording on a monthly bases providing quantifiable data and themes of complaints		01/10/2020	
CM07	The remit of the Corporate Complaints Officer should be reviewed in line with the extant Trust Complaints Management policy.	Review of Complaints Officer Role	Complete	Stephen and Connie	01/07/2020	Complete
CM08	The current process of screening of complaints should be reviewed and parameters for alerts to be clearly defined to include alerts to professional Executive Directors					
CM09	It is recommended that the Trust constitutes a Director's Oversight Complaints Review Group as a task and finish group to focus on reviewing Policy and Procedure and improving the management of complaints and experience of the service user. Membership should include a Non-Executive Director and/or a Service User(s).					

Complaints Regional

ID	Element	Description	Actions Required	Responsible	Date for Completion	Comment
CR01	ACCOUNTABILITY HSC organisations will ensure that there are clear lines of accountability for the handling and consideration of complaints.	Managerial accountability for complaints within HSC organisations rests with the Chief Executive (or Clinical Governance Lead in FPS settings);				
CR02	ACCOUNTABILITY HSC organisations will ensure that there are clear lines of accountability for the handling and consideration of complaints.	HSC organisations must designate a senior person to take responsibility for complaints handling and responsiveness locally;				
CR03	ACCOUNTABILITY HSC organisations will ensure that there are clear lines of accountability for the handling and consideration of complaints.	HSC organisations must ensure that complaints are integrated into clinical and social care governance and risk management arrangements;				
CR04	ACCOUNTABILITY HSC organisations will ensure that there are clear lines of accountability for the handling and consideration of complaints.	HSC organisations will include complaints handling within its performance management framework and corporate objectives;				
CR05	ACCOUNTABILITY HSC organisations will ensure that there are clear lines of accountability for the handling and consideration of complaints.	Each HSC organisation must ensure that the operational Complaints Manager is of appropriate authority and standing and has appropriate support;	Governance Review			
CR06	ACCOUNTABILITY HSC organisations will ensure that there are clear lines of accountability for the handling and consideration of complaints.	All staff must be aware of, and comply with, the requirements of the complaints procedure within their area of responsibility;				
CR07	ACCOUNTABILITY HSC organisations will ensure that there are clear lines of accountability for the handling and consideration of complaints.	Where applicable, HSC organisations will ensure that independent provider contracts include compliance with the requirements of the HSC Complaints Procedure; and				
CR08	ACCOUNTABILITY HSC organisations will ensure that there are clear lines of accountability for the handling and consideration of complaints.	Each HSC organisation is responsible for quality assuring its complaints handling arrangements.				

CR09	ACCESSIBILITY All service users will have open and easy access to the HSC Complaints Procedure and the information required to enable them to complain about any aspect of service.	Arrangements about how to make a complaint are widely publicised, simple and clear and made available in all areas throughout the service;				Leaflets and posters are displayed within departments and communal areas throughout the Trust. Details of how to make a complaint are also provided on our external website. We also have great relationships with organisations such as the Patient Client Council who can provide advice to the general public on our process for making a complaint.
CR10	ACCESSIBILITY All service users will have open and easy access to the HSC Complaints Procedure and the information required to enable them to complain about any aspect of service.	Arrangements for making a complaint are open, flexible and easily accessible to all service users, no matter what their personal situation or ability;				Complaints can be made via telephone, email, letter, feedback form, online feedback form attached to our external website, in person, advocate. Guidance on how to make a complaint is available in several different languages and also in easy read version. Complainants can opt to give details of their concerns anonymously if they so wish.
CR11	ACCESSIBILITY All service users will have open and easy access to the HSC Complaints Procedure and the information required to enable them to complain about any aspect of service.	Flexible arrangements are in place in order that individual complainants may be suitably accommodated in an environment where they feel comfortable; and				Meeting rooms are available on request which provide a confidential, comfortable environment to discuss concerns.
CR12	ACCESSIBILITY All service users will have open and easy access to the HSC Complaints Procedure and the information required to enable them to complain about any aspect of service.	All staff have appropriate training about the needs of service users, including mental health, disability and equality awareness training.	Additional training required for staff within all areas of the Trust in relation to mental health and disability and equality			Staff within the Corporate Office have availed of Sage and Thyme Training; Managing Difficult Conversations; Bereavement Training.

CR13	RECEIVING COMPLAINTS All complaints received will be dealt with appropriately and the process and options for pursuing a complaint will be explained to the complainant.	Flexible arrangements are in place so that complaints can be raised in a variety of ways (e.g. verbally or in writing), and in a way in which the complainant feels comfortable;				Complaints can be made via telephone, email, letter, feedback form, online feedback form attached to our external website, in person, advocate. Guidance on how to make a complaint is available in several different languages and also in easy read version. Complainants can opt to give details of their concerns anonymously if they so wish.
CR14	RECEIVING COMPLAINTS All complaints received will be dealt with appropriately and the process and options for pursuing a complaint will be explained to the complainant.	Complaints from a third party must, where possible, have the written consent of the individual concerned;				In the case of a complaint from a third party, consent will be obtained from the person on behalf of whom the complaint is being made before any records are accessed. If the person making the complaint has power of attorney, proof of such will be sought. MLA's are also required to provide a signed consent form from their constituent to provide permission for them to act on their behalf. If a person lacks capacity to provide consent, confirmation of this will be sought from their practionner.
CR15	RECEIVING COMPLAINTS All complaints received will be dealt with appropriately and the process and options for pursuing a complaint will be explained to the complainant.	HSC staff are aware of their legal and ethical duty to protect the confidentiality of service user information;				All Trust staff are required to complete Information Governance E-Learning.
CR16	RECEIVING COMPLAINTS All complaints received will be dealt with appropriately and the process and options for pursuing a complaint will be explained to the complainant.	Attempts to resolve complaints are as near to the point of contact as possible,	Additional training required to give front line staff the confidence to address concerns at the point of service delivery. A new method of training is currently being considered whereby staff can receive training in modular form which is specific to their role in the complaints process.			Complaints at Point of Service Delivery option available. Operational Support Leads provide a service whereby they arrange for patients to speak to someone directly involved in their care about any concerns they may have before they reach the formal complaints process.

CR17	SUPPORTING COMPLAINANTS AND STAFF HSC organisations will support complainants and staff throughout the complaints process.	HSC organisations will ensure the provision of readily available advice and information on how to access support services appropriate to the complainant's needs;				
CR18	SUPPORTING COMPLAINANTS AND STAFF HSC organisations will support complainants and staff throughout the complaints process.	The HSC organisation's Complaints Manager will offer assistance in the				
CR19	SUPPORTING COMPLAINANTS AND STAFF HSC organisations will support complainants and staff throughout the complaints process.	HSC organisations will promote the use of independent advice and advocacy services;				
CR20	SUPPORTING COMPLAINANTS AND STAFF HSC organisations will support complainants and staff throughout the complaints process.	HSC organisations will facilitate, where appropriate, the use of conciliation;				
CR21	SUPPORTING COMPLAINANTS AND STAFF HSC organisations will support complainants and staff throughout the complaints process.	HSC organisations will adopt a consistent approach in the application of DOH guidance on responding to unreasonable or abusive complainants;				
CR22	SUPPORTING COMPLAINANTS AND STAFF HSC organisations will support complainants and staff throughout the complaints process.	HSC organisations will ensure that staff receive training on complaints, appropriate to their needs	Additional training required to give front line staff the confidence to address concerns at the point of service delivery. A new method of training is currently being considered whereby staff can receive training in modular form which is specific to their role in the complaints process.			
CR23	SUPPORTING COMPLAINANTS AND STAFF HSC organisations will support complainants and staff throughout the complaints process.	HSC organisations will ensure that mechanisms are in place to support staff throughout the complaints process.				
CR24	INVESTIGATION OF COMPLAINTS All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.	Investigations are conducted in line with agreed governance arrangements;				
CR25	INVESTIGATION OF COMPLAINTS All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.	Investigations are robust and proportionate and the findings are supported by the evidence;				

CR26	INVESTIGATION OF COMPLAINTS All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.	A variety of flexible techniques are used to investigate complaints, dependent on the nature and complexity of the complaint and the needs of the complainant;				
CR27	INVESTIGATION OF COMPLAINTS All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.	Independent experts or lay people are involved during the investigation, where identified as being necessary or potentially beneficial and with the complainant's consent;				
CR28	INVESTIGATION OF COMPLAINTS All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.	People with appropriate skills, expertise and seniority are involved in the investigation of complaints, according to the substance of the complaint;				
CR29	INVESTIGATION OF COMPLAINTS All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.	All HSC providers/commissioners and regulatory bodies will co-operate, where necessary, in the investigation of complaints;				
CR30	INVESTIGATION OF COMPLAINTS All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.	The HSC organisation will investigate and take necessary action, regardless of consent, where a patient/client safety issue is raised; and				
CR31	INVESTIGATION OF COMPLAINTS All investigations will be conducted promptly, thoroughly, openly, honestly and objectively.	All correspondence and evidence relating to the investigation will be retained in line with relevant information governance requirements;				
CR32	RESPONDING TO COMPLAINTS All complaints will be responded to as promptly as possible and all issues raised will be addressed.	The timescales for acknowledging and responding to complaints are in line with statutory requirements;	Additional resources would enable a quicker turnaround of responses			The Corporate Complaints office now acknowledges complaints received directly into their office by email or letter. They also acknowledge any telephone complaints where an email address can be obtained. This has positively affected the Trust acknowledgement figures. Any correspondence received through the Chief Executive's office is formally acknowledged by that office.
CR33	RESPONDING TO COMPLAINTS All complaints will be responded to as promptly as possible and all issues raised will be addressed.	Where any delays are anticipated or further time required the HSC organisation will advise the complainant of the reasons and keep them informed of progress;				

CR34	RESPONDING TO COMPLAINTS All complaints will be responded to as promptly as possible and all issues raised will be addressed.	HSC organisations must consider alternative methods of responding to complaints;				
CR35	RESPONDING TO COMPLAINTS All complaints will be responded to as promptly as possible and all issues raised will be addressed.	Responses will be clear, accurate, balanced, simple, fair and easy to understand. All the issues raised in the complaint will be addressed and, where appropriate, the response will contain an apology;				
CR36	RESPONDING TO COMPLAINTS All complaints will be responded to as promptly as possible and all issues raised will be addressed.	The Chief Executive may delegate responsibility for responding to a complaint where, in the interests of a prompt reply, a designated senior person may undertake this task (or a clinical governance lead in FPS settings);				
CR37	RESPONDING TO COMPLAINTS All complaints will be responded to as promptly as possible and all issues raised will be addressed.	Complainants should be informed, as appropriate, of any change in system or of practice that has resulted from their complaint; and				
CR38	RESPONDING TO COMPLAINTS All complaints will be responded to as promptly as possible and all issues raised will be addressed.	Where a complainant remains dissatisfied, he/she should be clearly advised of the options that remain open to them.				
CR39	MONITORING HSC organisations will monitor the effectiveness of complaints handling and responsiveness.	HSC organisations should ensure the regular and adequate reporting on complaints in accordance with agreed governance arrangements;				
CR40	MONITORING HSC organisations will monitor the effectiveness of complaints handling and responsiveness.	HSC organisations must produce and disseminate, where appropriate, an Annual Report on Complaints;				
CR41	MONITORING HSC organisations will monitor the effectiveness of complaints handling and responsiveness.	HSC organisations must ensure that they have in place the necessary technology/information system to record and monitor all complaints and outcomes;				
CR42	MONITORING HSC organisations will monitor the effectiveness of complaints handling and responsiveness.	HSC organisations should have a mechanism to routinely request feedback from service users and staff on the operation of the complaints process;				
CR43	MONITORING HSC organisations will monitor the effectiveness of complaints handling and responsiveness.	HSC organisations must review the arrangements for complaints handling and responsiveness; and				

CR44	MONITORING HSC organisations will monitor the effectiveness of complaints handling and responsiveness.	HSC organisations must be assured, that ISPs with which they contract have appropriate governance arrangements in place for the effective handling, management and monitoring of all complaints.				
CR45	LEARNING HSC organisations will promote a culture of learning from complaints so that, where necessary, services can be improved when complaints are raised.	HSC organisations will monitor the nature and volume of complaints so that trends can be identified and acted upon;				
CR46	LEARNING HSC organisations will promote a culture of learning from complaints so that, where necessary, services can be improved when complaints are raised.	HSC organisations will ensure there are provisions made within governance arrangements for the identification of learning from complaints and the sharing of learning locally and regionally;				
CR47	LEARNING HSC organisations will promote a culture of learning from complaints so that, where necessary, services can be improved when complaints are raised.	Learning will take place at different levels within the HSC (individual, team and organisational);				
CR48	LEARNING HSC organisations will promote a culture of learning from complaints so that, where necessary, services can be improved when complaints are raised.	HSC organisations will ensure that they have adequate mechanisms in place for reporting on progress with the implementation of action plans arising from complaints;				
CR49	LEARNING HSC organisations will promote a culture of learning from complaints so that, where necessary, services can be improved when complaints are raised.	HSC organisations will incorporate learning arising from any review of findings of an investigation;				
CR50	LEARNING HSC organisations will promote a culture of learning from complaints so that, where necessary, services can be improved when complaints are raised.	HSC organisations will contribute to, and learn from, regional, national and international quality improvement and patient safety initiatives				

CR51	LEARNING HSC organisations will promote a culture of learning from complaints so that, where necessary, services can be improved when complaints are raised.	HSC organisations will include learning from complaints within its Annual Report on Complaints				
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Risk Management

ID	Element	Description	Actions Required	Responsible	Date for Completion	Comment
RM01	Corporate lead training and education regarding Risk & Incident Management and learning for all bands and professions					
RM02	Datix upgrade and development of module re M&M/Complaint/Litigation					
RM03	Develop elearning package for Datix reporting with supporting hardcopy manual					
RM04	The Draft Risk Management Strategy should be submitted for approval as a matter of urgency.					
RM05	The Trust Board should consider the application of the Risk Appetite Matrix in respect of the organisation's Corporate Objectives and associated Board Assurance Framework and Corporate Risk Register.					
RM06	A risk management training programme should be developed and delivered to underpin the publication of the approved Risk Management Strategy and the training should include risk appetite, risk assessment/evaluation and management of risk registers					
RM07	The management of the Board Assurance Framework and Corporate Risk Register should be delegated to the Executive Medical Director in line with the Risk Management Strategy.					
RM08	A standardised Directorate risk register template should be considered when Datix risk register module is implemented.					

RM09	To ensure that the Trust maximises the potential for the use of patient safety software it is vital that a dedicated Datix systems administrator is appointed who can ensure the quality of data provided as this has been identified as a gap at present					
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Hyponatraemia Oversight Group

ID	Element	Description	Actions Required	Responsible	Date for Completion	Comment
HY01	Hyponatraemia Oversight Group	The group is an oversight group with reporting responsibility to SMT and Trust Board - Medical Director is Co-Chair alongwith the Director of Nursing	• Perform a gap analysis of current position with regard to all 96 Report recommendations of the O'Hara report • Create an action plan with action leads and timescales • Have an overview of the implementation of all required actions and regional input where required • The Oversight Group will create a Risk Register when considering the Inquiry recommendations. Areas of risk will be communicated to SMT by the Oversight Group Chair. • The Oversight Group have identified a key risk for the Trust as failure of the Trust to implement actions in response to the recommendations into the Inquiry into Hyponatraemia. The Oversight Group have identified a project management approach to address this risk. • The group initially a task and finish group • Meetings are currently 6 weekly. • The Oversight Group will report to Trust SMT monthly and produce Progress Reports for Trust Board as requested.	TBA	On-going	
HY02	2020/2021 Work Programme Areas	HSS(MD)2/2020 Publication of a New Regional Policy for the Administration of Intravenous Fluids to Children Aged from Birth (term) until their 16th Birthday: Reducing the risk of Harm due to Hyponatremia (Oct 2019)	Short life working group established.	TBA	TBA	

HY03	2020/2021 Work Programme Areas	Internal Audit Report Management of Children in Adult Wards 2019/20 - Limited assurance. The nine key internal audit recommendations to be taken forward will be overseen and reported through to the Oversight Group	1. Hyponatremia Training 2. Mandatory Safeguarding Training 3. Trust Policy on Caring for and Safeguarding Children and Young People 4. Completion of Documentation when children are treated in adult wards. 5. O'Hara Report Recommendations and IHRD Oversight within the Trust. 6. Paediatric Intravenous Infusion Policy 7. Regional Fluid Balance & Prescription (RFB&P) Chart and PIVFAIT 8. Display of 'Parental Fluid Therapy Children & Young People' Wall Charts. 9. Reporting by Trust IHRD Oversight Steering Group to SMT and Trust Board	TBA	TBA (Sign-off meeting on 16/06/2020 agreed timescales	
HY04	2020/2021 Work Programme Areas	Current oversight action plan items at May 2020. To be taken forward using a project management and working group structure to progress between Oversight Group Mtgs	1. Arrangements for 14-16 year olds requiring cardiac monitoring in with representation from Cardiology and Paediatrics. Discussion to include telemetry equipment. 2. To receive draft Regional Protocol. SOP needed and a review of the protocol on maintaining responsibility. 3. Communication pathway/ escalation process when a child is admitted to each department (Obs and Gynae, Paediatric A&E, Surgery, CDU, F-bay etc) 4. Audits for recommendations 10-30 - to be carried out in ED, Obs and Gynae, Surgery and Paeds. 5. Short life working group set up. Work in progress around PEWS, safeguarding, medical kardex, diabetes management and Paediatric/ Nursing admin documentation. 6. Separate action point in relation to Safeguarding Training has been included within this action to be taken forward by Working Group. 7. Protocol on children with challenging behaviours being admitted. Set up of interface group and reinstatement of wider group on both sites. 8. Interface meeting/ workshop to be arranged between Paediatrics and Surgeons. 9. On-going review of cases – children admitted to adult wards (outside protocol) 10. Sub groups to be set up to progress non clinical recommendations including HR; Education and Learning; SAI's; and CSCG.	TBA	On-going with 6 weekly update to Oversight Group	
HY05	Hyponatraemia Secretariat Support	Provision of Secretariat and Central Repository (Sharepoint) Maintenance and Update	The Corporate Clinical and Social Care Governance Team provide the secretariat support to the Hyponatraemia Oversight Group	TBA	On-going	

HY06	IV Fluid Management and Prevention of Harm from Hyponatraemia	Safety and Quality Reminder SQR-SAI-2020-068	Oversight Group is the nominated Change Lead for this S&G process	TBA	Sep-20	
HY07	Regional PIVFAIT Audit Programme	PIVFAIT Charts updated with compliance / non compliance	Weekly Collation of Paediatric and Adult Acute PIVFAIT audit results Maintain database of weekly results Results shared at weekly governance de-brief Support to QI project - indicator identification	Clinical Audit Dept		
HY08	Nice Guideline NG29	NG29 mapping exercise detailed 32 recommendations of which 8 audited as part of the PIVFAIT audit tool. An annual Surveillance audit prototype has been developed and project funding bid to the RQIA 20/21 programme secured and deferred to Oct-2020	Comprehensive Audit Tool Development Project Team and Plan confirmation Tool Sign-Off Monitoring Template sign-off Pilot Test (5 Cases) Amend for Full Study Auditor Team Confirmed Training Schedule Developed Full Audit Chart Review (30 cases) Input to automated data collection tool Submitted data analysed for compliance against each NG29 recommendation First Draft for Review Finalised for Oversight Group Sign-off	TBA	Oct 2020 - Mar 2021	
HY09	SHSCT participation in Regional IHRD Work streams and Sub Groups	Hyponatraemia Oversight Group and Secretariat role to ensure nomination / representation and shared repository of communications	Workstream 1 Duty of Candour – Being Open Subgroup – (Geraldine Donaghy and Tracey Boyce) Workstream 2 Death Certification Implementation Working Group - Stakeholder Group for Preparing for Inquests Workstream 3 Duty of Quality – CSCG & RQIA Sub group – (Stephen Wallace) Workstream 3 Duty of Quality – ALB Board Effectiveness Subgroup – (Vivienne Toal/Martin McDonald) Workstream 4 Paediatric Clinical Collaborative – (Dr Aljarad/Bernie McGibbon/Eileen Mullan) - Regional Trust Oversight Committee – (Stephen Wallace)	TBA	On-going	

Learning from Experience

ID	Element	Description	Actions Required	Responsible	Date for Completion	Comment
LE01	Lead the development and implementation of the Learning from Experience Framework					
LE02	Establish Learning from experience forum and process which binds all learning inc from other workstreams- M&M/Incidents/Complaints					From the CGSC Review - Review the Terms of Reference, including membership, and strengthen the purpose of the Lessons Learned Forum.
LE03	Lead the development of a learning repository that integrates and shares learning from experience from SAI/Complaints/Datix/M&M, Litigation and Incidents					
LE04	Work integration between quality improvement and the integrated governance function is reviewed to ensure optimum connectivity.					

Morbidity and Mortality

ID	Element	Description	Actions Required	Responsible	Date for Completion	Comment
MM01	Lead on the development of the SHSCT Mortality and Morbidity Processes	Develop an interim process to govern M&M progression	- Decoupling Morbidity and Mortality Case Presentation & Learning - Selection of Cases for Presentation - Multi-Disciplinary Patient Safety Inputs - Inclusion of RAMI and SHMI Mortality Indicators to Inform Case Selection - Developing Improved Models for Learning from Experience and Management of Risk - Pilot of Structured Judgment Review Methodology	D Gormley / S Wallace / F Davidson	01/03/2021	
MM02	Maintain, grow and improve the facilitated support to M&M Specialty & Sub-Specialty Meetings	Use of Standardised agenda, real-time mortality reporting, patient safety and mortality data inputs	- The RMMR process should be adequately resourced and supported to ensure optimum outputs and clinical engagement. This includes the resources required within the team to ensure the development of administrative systems for the central suppository of M&M information - Establish M&M structure in MHD along side Patient Safety Data team	M&M Chairs & M&M Facilitation Team	On-going to Mar 2021	
MM03	Support the succession planning and appointment of M&M Chairs	Requirement to appoint Medical M&M chairperson with potential deputy chair	- Replacement M&M chair nomination required - Additional deputy chair funding to be sought	Acute AMD MUSC / Director Acute Services with D Gormley / S Wallace / F Davidson	01/10/2020	
MM04	Establish a reference Group for Covid-19 Mortality	Reference Group to review the Laboratory confirmed and clinical case mortalities associated with the C19 pandemic for wider aspects of organisational learning	- Establish Membership & ToR - Agree high level methodology to be used - Schedule meeting dates and identify administrative support - Undertake case review, identify learning and report to M&M oversight group	D Gormley / S Wallace / F Davidson	01/12/2020	
MM05	Quantitative Mortality Reporting	Quarterly Mortality Monitoring Reports - Trust and Clinical Speciality Level	- Quarterly Mortality Monitoring Trustwide (RAMI and SHMI) - Development of Quarterly Mortality Monitoring Trustwide (RAMI and SHMI)	D Gormley / S Wallace / F Davidson	On-going	
MM06	Completion of the Action Plan for Internal Audit Report - Mortality & Morbidity - 2018/2019	M&M Internal Audit Report (18/19) - Limited Assurance and 15 recommendations were made (10 priority 2 and 5 priority 3)	- IA Action Plan on Timescales on IRD (24 hrs), Consultant Review Task (48hrs) and M&M discussion (6 - 8 weeks) - IA Action plan on limited learning from M&M, use of shared learning template and inadequate audit trail on the implementation of learning	D Gormley / S Wallace / F Davidson	01/09/2020	

MM07	Improve the Review and Sign off of Deaths on RMR&MRS	Backlog of mortality proformas require consultant completion for Consultant Review Task	• Monthly aide memoire process for identifying outstanding consultant review task to M&M Chair, AMD, CD • Escalate Outstanding CRT to MDO for issue of standardised memo • Schedule review mtgs after 10 days if non compliance with completion remains • Non compliance link to annual appraisal and re-validation	D Gormley / S Wallace / F Davidson	01/07/2020	
MM08	Development SJR Methodology	Implementation of review methodology to provide second line assurance on review of and learning from deaths.	• Feasibility work on the potential to introduce RCP SJR methodology in SHSCT • Undertake initial discussion with RCP on training delivery and costs and Datix on the RCP reporting platform / SHSCT Datix upgrade • Regional position on SJR methodology - pilot in BHSCT	D Gormley / S Wallace / F Davidson	01/09/2020	
MM09	Maintenance of the all deaths database	Weekday updates to maintain internal recording of mortality alongside RMMRS necessary to produce aide memoire lists, additional team review status and dashboard reports as no reporting functionality on RMMRs	• Pandemic period running of daily mortality reports now results in daily / weekly update of the mortality database • Monthly update process has changed to daily / weekly with improved access to real-time position on status of deaths being reviewed, further development of Business Intelligence solution to improve dashboard reporting • Will require the on-going daily reporting going forward and the re-configuration of team resources required to support this.	M&M Team	ongoing	
MM10	Daily Mortality Surveillance (COVID-19)	PHA / DoH Daily Reporting of Reportable deaths and internal reporting of Clinical C19 deaths to Chief Executive 7 / 7	• Process has been developed to undertake this daily monitoring from 9am - 9am • Daily confirmation of position to C/Ex @ 9.15am	M&M Team	ongoing	
MM11	Theming and Sharing of Learning from M&M	See Learning from Experience Section	See Learning from Experience Section	See Learning from Experience Section	See Learning from Experience Section	
MM12	The resource implications for the delivery of the RMMR should be considered in line with the proposals for the Medical Leadership model.	Medical leadership model to incorporate M&M requirements	Medical leadership proposal to be updated	D Gormley / A Diamond / S Wallace	01/09/2020	

Patient Safety

ID	Element	Description	Actions Required	Responsible	Date for Completion	Comment
PSUS01	Lead the development of the SHSCT Patient and Service User (PSU) Safety Processes	Initial scope of process required to govern PSU development	- Establish a PSU Safety Oversight Group / Committee - Review current indicators of safety, quality and performance and their reporting and commission additional indicators and their measurement - Participation in regional safety initiatives - Co-ordination of agreed PSU safety priority projects and monitoring systems - Patient safety reports to SMT / CG / TB	D Gormley / S Wallace / F Davidson	TBA	?Work to encompass the broader remit of service user safety, outside hospital care setting.
PSUS02	Lead development of Patient and Service User Safety Strategy	Framework for the oversight of safety measure implementation, monitoring and assurance	- Strategy Project Structure - Strategy Project Plan - Culture of Safety Baseline Assessment - Safety Measures and Monitoring Framework - Patient safety reports to SMT / CG / TB	D Gormley / S Wallace / F Davidson	TBA	
PSUS03	Development of PSU Safety BI Dashboard	Underpinning informatic platform to support PSU data triangulation and reporting	- BI scoping exercise to be completed - Strategic Patient Safety Analytic Forum established	D Gormley / S Wallace / F Davidson	TBA	
PSUS04	Maintenance of Current Patient Safety Measures (MDO & NDO)	Comprehensive portfolio of longterm PS and QI data	Current Monthly and Quarterly reporting Small team with lack of cross cover / succession planning Total reliance on manual processes	F Davidson / Patient Safety Manager	On-going	
PSUS05	Deteriorating Patient / NEWS	Line graph - % Compliance with Sepsis 6 bundle		F Davidson / Patient Safety Manager	On-going	
PSUS06	Regional QI Sepsis Work	Line graph % compliance with 1hr to first antibiotic target	Potential Sepsis cases identified from ED Coders Forward on to Clinician & review cases via phone Where possible follow-up with cases, which require additional information via patient's Med Records Maintain monthly table of cases & time to first Ax. Monthly results shared with Acute Gov. via Patient Safety Report	F Davidson / Patient Safety Manager	On-going	
PSUS07	WHO Surgical Checklist	Line graph - % Compliance with SSCL against 95% goal	Monthly data shared with Acute Gov. QI work suspended due to Covid-19	F Davidson / Patient Safety Manager	On-going	
PSUS08	VTE (Pt Safety Dept)	Data Table - compliance by ward and RAG status and Line graph with acute / non acute compliance	Validate weekly VTE Audits from Wards across the Trust with Ward Managers/Auditors (24) Maintain database of weekly results Monthly results shared with Acute Gov. via Patient Safety Report	F Davidson / Patient Safety Manager	On-going	

PSUS09	Ventilator Associated Pneumonia (VAP) (Pt Safety Dept)	Days between run chart with target	Monthly data shared with acute Governance	F Davidson / Patient Safety Manager	On-going	
PSUS10	Crash Calls (Pt Safety Dept)	Line Graph with Monthly CAH and DHH rate per 1000 D&Ds	Receive data on Crash Calls from Resus Officers (CAH & DHH) Validate with Resus Officers Receive data on Deaths/Discharges from P&R Directorate Post results on IHI Extranet Provide data on Crash Calls/per to Kay Carroll Monthly results shared with Acute Gov. via Patient Safety Report	F Davidson / Patient Safety Manager	On-going	
PSUS11	Surgical Site Infection - C Section (Pt Safety Dept)	Run chart with CAH / DHH / NI data and SHSCT Rate	Undertake quarterly SSI C/S Audit CAH (March/June/Sept/Oct), audit tool issued in advance on quarterly Audit Collate a list of potential cases (Emergency/Elective) via Delivery Suite Receive completed Audit from DHH Validate Audits with Ward Managers/Auditors Obtain & supply PHA with quarterly numbers of C/Sections Receive, action & follow-up on PHA SSI Validation Report Extract SSI Rates from PHA Regional Database Results shared via Patient Safety Dashboard (quarterly) Quarterly results shared with Acute Gov. via Patient Safety Report	F Davidson / Patient Safety Manager	On-going	
PSUS12	Surgical Site Infection Ortho (Pt Safety Dept)	Run chart with CAH / NI data and SHSCT Rate	Quarterly data shared with Acute Gov. & Annual Audit	F Davidson / Patient Safety Manager	On-going	
PSUS13	Central Line	Line graph with ICU & ward compliance and 95% Target	Access ICU Intellispace Critical Care & Anaesthesia Database on a daily basis to identify suitable patients for the Central Line Audit Maintain a monthly table of patients Undertake monthly Audit (Ward-based Audit, CAH has been suspended due to Covid-19) Results shared with Clinical Lead, Ward Manager, Project Managers & Lead Nurses Monthly results shared with Acute Gov. via Patient Safety Report	F Davidson / Patient Safety Manager	On-going	

PSUS14	Stroke Collaborative	Data Table and Line graph on Lysis Rate	Receive Audit from Stroke Specialist Nurse – Audit DHH has been suspended due to Covid-19 Validate Audit with Stroke Specialist Nurse as and when required Maintain monthly table of Stroke lysis numbers & rate Review & Quality Assure monthly P&R data Issue Patient Safety Dashboards & Run Chart to Team Join Monthly Team Meeting to review data/discuss issues of non/low compliance Monthly results shared with Acute Gov. via Patient Safety Report	F Davidson / Patient Safety Manager	On-going	
PSUS15	Regional Delirium	Data Table - Cases audited by nursing and bundle compliance	Receive audits from Pilot Wards across the Trust (13), some Wards suspended the Audit due to Covid-19 Validate Audits with Ward Managers/Auditors Post results on IHI Extranet Attendance & share results at Delirium Steering Group meetings (suspended due to Covid-19) Monthly results shared with Acute Gov. via Patient Safety Report	F Davidson / Patient Safety Manager	On-going	
PSUS16	NEWS (Nursing Independent Audit)	Data Table - Cases audited by nursing and bundle compliance		F Davidson / Patient Safety Manager	On-going	
PSUS17	Falls (Nursing Independent Audit)	Data Table - Cases audited by ward and Line graph on rate of all Falls, injurious & rate	Validate previous month's data via datix/Ward Managers Post results on IHI Extranet Generate monthly Patient Falls Walking Stick for Wards across Trust (27, ICU excluded).....these are issued at end of each month Monthly results shared with Acute Gov. via Patient Safety Report	F Davidson / Patient Safety Manager	On-going	
PSUS18	Pressure Ulcers (Nursing Independent Audit)	Data Table - Cases audited by ward and Line graph on rate of all PU and Grade 3/4 HA and NA	Daily Review of Reported WAPU's via datix, maintain table, liaise with TVNs & Ward Managers if any immediate actions required Validate previous month's data via datix/TVN/Ward Managers Post results on IHI Extranet Generate monthly Pressure Ulcer Safety Crosses for Wards across Trust (28) these are issued at end of each month Monthly results shared with Acute Gov. via Patient Safety Report	F Davidson / Patient Safety Manager	On-going	

PSUS19	MUST Screening (Nursing Independent Audit)	Data Table - Cases audited by nursing and bundle compliance	quarterly data shared with Acute Gov. & PHA	F Davidson / Patient Safety Manager	On-going	
PSUS20	Omitted Medicines (Nursing Independent Audit)	Data Table - Cases audited by nursing and bundle compliance	quarterly data shared with Acute Gov. & PHA	F Davidson / Patient Safety Manager	On-going	
PSUS21	Nursing Documentation (Nursing Independent Audit)			F Davidson / Patient Safety Manager	On-going	
PSUS22	Mental Health QI Work		quarterly data shared with Acute Gov. & PHA	F Davidson / Patient Safety Manager	On-going	
PSUS23	Directorate Monthly Mtgs / Qtrly Mtgs PSM		Patient Safety Manager submits monthly reports to Acute Governance meeting and attends on a quarterly basis	F Davidson / Patient Safety Manager	On-going	
PSUS24	PHA / HSCB QIP Report (annual PU, SKIN, Falls, Fallsafe, NEWS, Mixed Gender Accom (NGA - safeguarding)			F Davidson / Patient Safety Manager	On-going	
PSUS25	Annual Quality Report		Contribution of Patient Safety information to AQR led by Quality Improvement Dept.	F Davidson / Patient Safety Manager	Annual	

Standards and Guidelines

ID	Element	Description	Actions Required	Responsible	Date for Completion	Comment
SG01	The Trust should explore the options for an electronic policy and procedure management system that is accessible, easy to navigate, contains a search facility and includes the capacity for email notification of new/changed policy and automates a review/revise reminder.					
SG02	The Corporate oversight of the management of Standards and Guidelines should be reinstated and the former Accountability (Compliance) reporting arrangements are also reinstated.					
SG03	The Trust should further develop the Standards and Guidelines model developed within Acute Services and provide a central management system within the Corporate Clinical and Social Care Team under the leadership of the Medical Director.					
SG04	The Trust should review the Sub Committee Structure to include an oversight committee for the management of Standards and Guidelines either a full time committee or a Task and Finish Sub Committee					

Clinical Audit

ID	Element	Description	Actions Required	Responsible	Date for Completion	Comment
CA01	On-going implementation of the Clinical Audit Strategy	The current clinical audit strategy was approved in June 2018 and contained an 12 point action plan.	1. Directorates should ensure clinical audit structures exist to support the promotion, development, monitoring, reporting and quality assurance of clinical audit activity at operational level 2. The NHS England Quality Accounts List of national audits should be forwarded to operational directorates in February, for their review in developing a draft annual clinical audit work programme 3. Operational directorates should develop and deliver their annual clinical audit work programme, in line with the prioritisation criteria in the clinical audit strategy. 4. The Medical Director will present the Trust's consolidated annual clinical audit work programme to the Executive Quality Improvement Steering Group / SMT for assurance and approval 5. The arrangements for seeking approval of clinical audits should be agreed within operational directorate structures 6. Clinical audit projects agreed within year should be highlighted to the Executive Quality Improvement Steering Group / SMT, and registered with clinical.audit@southerntrust.hscni.net 7. Following corporate approval, the clinical audit strategy should be launched within operational directorates 8. Operational Directorates should encourage the registration of all approved clinical audit activity. 9. Operational level: Audit findings should be discussed within the appropriate operational directorate structures.	D Gormley / S Wallace / F Davidson	On-Going	The Corporate clinical audit team and Directorate Capacity for clinical audit is described as inadequate to deliver the 18/19 audit programme
CA02	Oversight of Clinical Audit within the Clinical Governance Structure	Formation of a Clinical Audit Committee	Recommendation of the Clinical & Social Care Governance Review - The Clinical Audit Committee should be reinstated and the reporting arrangements considered in the review of the Trust Board Committee Structure	D Gormley / S Wallace / F Davidson		

CA03	National Audit Assurance Report	Annual / Biannual Report to Governance Committee on SHSCT Clinical Audit Programme	An annual collation of audit programme updates and outcomes is undertaken each autumn Clinical audit NAAT lead liaises with all clinical audit leads and issues standardised audit template for completion. A) Identification of the 3 most important performance indicators in SHSCT, as identified by the clinical audit lead for that area, B) areas for improvement and actions taken c) Priority to raise awareness - an area of concern / unidentified risk / good practice or barrier to improvement • Provides assurance on participation in the NHS England Quality Accounts List(1) 2018/19 national clinical audits. • Highlights compliance with key performance indicators, together with recommendations and actions to achieve further improvement. • Outlines the SHSCT 2019/20 Clinical Audit work programme, including the rationale for non-participation in selected national audit. • Need to ensure that all audits (international, national, regional and local) are reported and monitored on a regular basis within operational directorate governance arrangements. • Requirement for clarity in relation to strategic direction for clinical audit and the interface with quality improvement • Requirement for additional resources to support the Trust's proposed clinical audit work programme and implement the clinical audit strategy 2019/20	D Gormley / S Wallace / F Davidson	Annually Nov 2020	
CA04	Dissemination of National Audit Studies	Maintain current system of dissemination	National Studies received are disseminated to the relevant Director(s), ADs and AMDs and CC'd to Corporate Directorates as per process communicated in Jul-19. This is for information and to inform improvement plans going forward. There is no monitoring of implementation of recommendations e.g a change lead process as per S&G	D Gormley / S Wallace / F Davidson	On-Going	
CA05	Introduce a system for monitoring of implementation of national clinical audit studies e.g. HQIP, NCEPOD, NHS Benchmarking, Royal College & Society Audits and GAIN.	Assurance process that audit recommendations / learning has been shared and improvements implemented	A corporate process, structure and plan to support this function would be for discussion and agreement to ensure that infrastructure and resources could be secured to develop this function and underpin the assurance process.	TBA	TBA	
CA06	NCEPOD - Ambassador and Local Reporter Roles	Clinical lead for NCEPOD Ambassador Required	Currently senior audit facilitator fulfils the role of NCEPOD local reporter. Ambassador role is a clinical lead role and requires recruitment / EOI along with requisite job planning / resourcing	TBA	TBA	

Clinical Guidelines

ID	Element	Description	Actions Required	Responsible	Date for Completion	Comment
CG01	On-Going Management of Clinical Guidelines Database	Clinical Guidelines is a bespoke respository for internal SHSCT Guidelines since 2014 and is publicly available on the SHSCT Website	• Assignment of CG ID tags and upload to GC portal • On-going issue of reminders (30 and 60 day) to authors for Guidelines for review and the archive of previous versions.	D Gormley / S Wallace / F Davidson	On-Going	
CG02	Batch update exercise by author for Guidelines that currently require review	Clinical Guidelines review dates are monitored	Author notification of expired guidelines to be undertaken routinely to ensure timely review. Once out of the review period authors, AMDs and CDs will be notified of 'batch review' processes to advise of extended review dates or guideline rmoval	D Gormley / S Wallace / F Davidson	On-Going	Currently awaiting MD / AMD discussion
CG03	Notification of new Clinical Guidelines published	Notification / Dissemination of new Guidelines	New clinical guidelines that are uploaded to the site to be disseminated through agreed dissemination routes similar to compliment Standards and guidelines process.	D Gormley / S Wallace / F Davidson	TBA	
CG04	Directorate Governance Forum reports	Provide oversight of Clinical Guideline status on a weekly and monthly basis	Monitoring reports of Guideline status to be provided to monthly Directorte governance meetings and weekly governance de-brief.	D Gormley / S Wallace / F Davidson	TBA	
CG05	SHSCT Intranet Portal Policies and Procedure Transfer	Process required to ensure final transfer of and removal of previous	Transfer or removal of guidelines from the Trust Intranet to Clinical Guidelines repository on Sharepoint	D Gormley / S Wallace / F Davidson	TBA	? Responsibility of Authors but not taking place

Deteriorating Patient - Based on The Scottish Patient Safety Programme Approach

ID	Element	Description	Actions Required	Responsible	Date for Completion	Comment
DP01	People with physiological deterioration in acute care will have a structured response and person centred care plan	Development of a structured response to the deteriorating patient in acute and non-acute hospitals in SHSCT	TBA	TBA	TBA	
DP02	Early, anticipatory planning and person centred care	1. Anticipatory care planning in Community Care 2. Patient and family at the centre of decisions and planning 3. Reliable communication across care pathways 4. Assessment of functional ability, health trajectory and detection of limited reversibility 5. Reliable implementation of national DNACPR policy	TBA	TBA	TBA	
DP03	Structured response to acute deterioration	1. Accurate observations using NEWS 2. Observations are performed at correct frequency 3. Healthcare staff are trained in recording of observations and escalation process. 4. Healthcare staff use NEWS as an adjunct to clinical knowledge in recognition of acute deterioration	TBA	TBA	TBA	
DP04	Structured review of acute deterioration	1. Risk of deterioration is considered with appropriate care plan documented 2. Limited reversibility is considered and documented in people at risk of acute deterioration 3. Treatment escalation plan is reviewed and updated, including DNACPR where appropriate 4. Communication with patient and family on management plan	TBA	TBA	TBA	
DP05	Reliable communication within and across multidisciplinary teams	1. Hospital huddles and ward safety briefs highlight deteriorating patients & describe plan 2. Structured rounds in acute care – reliable review of treatment escalation plan 3. Reliable ongoing patient and family communication that informs treatment escalation plan 4. Use SBAR to handover across MDT and care teams	TBA	TBA	TBA	
DP06	Create a learning system	1. Mortality and morbidity reviews that inform improvement plans 2. Review of cardiac arrests/2222 calls to inform improvement plans 3. Involve resuscitation officers in education and improvement 4. Organisational priority: Executive Sponsorship, Clinical Leadership, Executive Lead for Palliative Care and QI support 5. Consider use of electronic track and trigger tools to actively measure and manage at risk patients across the organisation	TBA	TBA	TBA	

Supporting Tasks

ID	Element	Description	Actions Required	Responsible	Date for Completion	Comment
ST01	Restructuring of Corporate Induction	Create 2-tier model of overarching Corporate induction which combines elearning and F2F presentation	Create Corporate training model which includes Risk& Incident Management. Integrate 'Being Open' training into all elements. Coordinate induction to include case study learning. Undertake audit of staff who have attended induction since 2018. Develop elearning modules that includes a wide range of subjects, IPC, Insulin management, POCT, Falls management, introduction of Governance, Risk & Incident management (inc SAls), role of morbidity & Mortality, customer care, Datix reporting, minimum standards for documentation. Ability to complete applicable mandatory modules in advance of formal induction.	Connie	01/01/2021	This will require scoping all current contributors and teams which support induction across the Trust. Negotiation will be required to create 1 portal to which all induction elements are managed and organised. Any new programme will need to have SMT and Trust Board validation.
ST02	Implentation of Trust Being Open Policy	Integration of 'Being Open' ethos into Trust Policy and Culture	Create forum (task& finish) which includes membership from Governance, Education, HR, Trade Unions, Communications to amment Trust policy and proceedure to reflect 'Being Open' culture. All Trust Policies and Procedures to be ammended to reflect change.	Connie	01/10/2020	
ST03	Trust staff perception & understanding of re Governance & Risk Management	Create bespoke education and Governance and Risk Management training for all Trust staff	Create formal Governance and Risk Management portal for all staff divided into role specific 'tiles'. Education via interactive and case study examples. Portal to provide wide-ranging support to all staff electronically providing links, resources, signposting to Trust support services	Connie & Nicole	01/12/2020	
ST04	Datix upgrade	Install Datix upgrade to Regional Standard	Appoint Datix Manager to support Trust wide implementation of upgrade, training, maintenance, creating bespoke pages and modules and ensuring the system remains in line with Regional standard. Datix modules regarding M&M management, Litigation and complaints to be secured and then made bespoke to individual processes.	Stephen and Connie	01/12/2020	SHSCT is the only Trust Regionally not to have an up to date Datix system (V14). Lack of dedicated resource and training continues to directly impact the quality of reporting and the ability to identify staff involved in incidents. The Datix Dashboard capability is not maximised due to lack of dedicated resource resulting in the loss of live data so support the Patient Safety agenda. Governance teams are not currently able to timely patient safety data as there is no resource dedicated to this element of datix

ST05	Develop elearning package for Datix reporting with supporting hardcopy manual	Create Datix elearning package with supporting documentation that includes bespoke specialist modules	Datix elearning package to be created for both new and advanced user. The learning packages will be modelled to reflect each Directorate's specialist issues Work to include the creation of focus groups to review Datix layout and language across all division and specialties	Connie & Nicole	01/12/2020	Elearning package will be mandatory in advance of attending Corporate Induction. Introduction to 'Being Open' policy and Risk Management will be included. Advanced package will support line managers in investigating incidents and ensure standardisation of review.
ST06	SHSCT Corporate Service Liaison Officer (CSULO) to create a Trust resource for learning and supporting staff	CSULO to create and Chair network which includes PSNI/DLS/SAI Chairs/ DRO/NIPSO/PCE/OHD and supporting community teams (Mental Health in particular)	CSULO outreach to interface agencies to share learning from incidents and gain awareness of regional issues/trends.	Connie	01/10/2020	Creation of this network will establish regional links for the CSULO and facilitate support as needed for both Senior Line Managers and any staff needing guidance and support
ST07	Full implementation of all Regional Templates	Oversee the implementation of Regional Templates for: Being Open, Supporting Staff, Early Alerts, Memorandum of Understanding PSNI/HSENI, RIDDOR, Reporting of Adverse Incidents.	Complete the integration of Regional Templates to in all SHSCT Policy and Procedures. Comms work to be done for the 'Being Open' ethos within all external/web facing information. Sharepoint to be updated with all of the new amended policy across all divisions and directorates.	Connie	01/10/2020	
ST08	Establish robust and transparent Cross-division M&M structure in MHD	Establish robust and transparent Cross-division M&M structure in MHD along side Patient Safety Data team	Corporate to support complete mapping of governance structure, communication and SAI/incident management in MHD. Learning from experience forum to be established for Directorate tying incident/SAI/complaints/litigation together and presenting in both electronic and F2F formats. Will need to be tailored to divisions and specialties.	Connie Tony and David	01/12/2020	
ST09	The Trust should consider the training implications of implementing the 'Being Open' framework which includes compliance with IHRD Recommendation 69 (i) ~ Trusts should appoint and train Executive Directors with specific responsibility for 'Issues of Candour'.					

ST10	The Integrated Governance Framework should be reviewed as a matter of urgency to ensure it provides clear descriptions of the roles and responsibilities of key stakeholders. It is also recommended that the Framework provides electronic links to key corporate Trust Strategies and Policies and extant guidance where applicable.					
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