Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 2 of 2023

Date of Notice: 24th March 2023

Note: An addendum amending this statement was received by the Urology Services Inquiry on 02 June 2023 and can be found at WIT-96809 to WIT-96827. Annotated by the Urology Services Inquiry.

Statement of: Mrs Patricia Kingsnorth

I, Patricia Kingsnorth, say as follows:-

1. **Having regard to the Terms of Reference of the Inquiry, please provide a narrative account of your involvement in or knowledge of all matters falling within the scope of those Terms. This should include:**

(i) an explanation of your role, responsibilities and duties, and

1.1 I qualified as a General Nurse in June 1986 and as a Registered Midwife in February 1991.

1.2 I began working as a Midwife (Band 6) in the Southern Health and Social Care Trust (Legacy Newry and Mourne Trust) in November 1997.

1.3 I was appointed as a Clinical Risk Midwife (Band 7) in May 2011.

a. This was a new Role within the Trust and I was tasked with developing the Governance processes within the Integrated Maternity and Women's Health Division (IMWH).

b. I was provided with training in Serious Adverse Incident Reviews using a Root Cause Analysis process. I attended training in Human Factors and Risk Management and medico-legal issues in Women's Health Care. I also attended online courses regarding Risk Management and Patient Safety.

c. I worked with two Consultant Obstetricians from the Craigavon Site and two Consultant Obstetricians from the Daisy Hill Site. Together

23.2 I found it to be one of the most robust and worthwhile SAI reviews I have ever been involved in. I thought Dr Hughes was an excellent Chair and that he endeavoured to create a fair review for the patients (and/or their families) and staff. Meeting the patients and families and hearing their stories was truly moving and some of them really wanted to be involved in sharing the learning from this Review, which was inspirational. I would like to add in this particular regard that I appreciate how stressful this Inquiry must be for the patients and their families and my thoughts and prayers are with them all during this process.

NOTE:

By virtue of section 43(1) of the Inquiries Act 2005, "document" in this context has a very wide interpretation and includes information recorded in any form. This will include, for instance, correspondence, handwritten or typed notes, diary entries and minutes and memoranda. It will also include electronic documents such as emails, text communications and recordings. In turn, this will also include relevant email and text communications sent to or from personal email accounts or telephone numbers, as well as those sent from official or business accounts or numbers. By virtue of section 21(6) of the Inquiries Act 2005, a thing is under a person's control if it is in his possession or if he has a right to possession of it.

Statement of Truth

Signed: Patricia Kingsnorth (Signature attached)

Dated: 3rd May 2023

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice Number 2 of 2023

Date of Notice: 24th March 2023

Addendum Witness Statement of: Patricia Kingsnorth

I, Patricia Kingsnorth, will say as follows:-

I wish to make the following amendments to my existing response, dated 3rd May 2023, to Section 21 Notice number 2 of 2023.

1. At paragraph 1.5(v) (IWT-92019), I have stated '*There was never any indication of which I was aware that there were concerns regarding Mr O'Brien's clinical practice until he retired in approximately June 2020.*' This should state '*There was never any indication of which I was aware that there were concerns regarding Mr O'Brien's clinical practice until* ***after he*** *retired in approximately June 2020.'*

2. At paragraph 1.8 (WIT-92026), I have stated '*I did escalate to my Director (Mrs Gishkori) and my line manager (Dr Boyce) my concerns regarding adequate resources, especially in relation to the resources my counterparts had in their Directorates which I believed were proportionately greater than what I, with a larger service, had*.' This should state '*I did escalate to my Director (Mrs Gishkori) and my line manager (Dr Boyce) my concerns regarding* ***inadequate*** *resources, especially in relation to the resources my counterparts had in their Directorates which I believed were proportionately greater than what I, with a larger service, had*.'

3. At paragraph 4.2 (WIT-92033), I have stated '*Any serious concerns would have been escalated to the Director immediately and an Early Alert generated and sent to the HSCB and Department of Health*.' This should state '*Any serious concerns would have been escalated to the Director* ***of Acute Services*** *immediately and an Early Alert generated and sent to the HSCB and Department of Health*.'

Urology Services Inquiry

4. At paragraph 9.2 (WIT-92045), I have stated '*This was the reason the Deputy Medical Director, Dr Gormley, wanted the 2 July 2020 Datix (mentioned above) shared at the screening meeting so as to raise awareness within the Division of SEC that these issues had been discovered*.' This should state '*This was the reason the Deputy Medical Director, Dr Gormley, wanted the **two** July 2020 Datix (mentioned above) shared at the screening meeting so as to raise awareness within the Division of SEC that these issues had been discovered*.'

5. At paragraph 13.1 (WIT-92048), I have stated '*As previously indicated in my answer to Question 1(i) above, I was aware that the Trust had escalated concerns regarding the practices of Mr O'Brien following his retirement in July 2020*.' This should state '*As previously indicated in my answer to Question 1(i) above, I was aware that the Trust had escalated concerns regarding the practices of Mr O'Brien following his retirement in **June** 2020*.'

6. I would also like to attach additional documents:-

1. *SAI Urology review email dated 25 January 2021*
2. *MDT staff for meeting with chair email dated 18 January 2021*
3. *Email from Patricia Kingsnorth to Patricia Thompson dated 30 November 2020*
4. *Email from Patricia Kingsnorth to Darren Mitchell dated 23 February 2021*
5. *SAI Urology review MC 1st draft*
6. *Email from Martina Corrigan to Patricia Kingsnorth dated 25 January 2021*

Statement of Truth

I believe that the facts stated in this witness statement are true.

P Kingsnorth.

Signed:

Date: 2 June 2023

Southern Health and Social Care Trust

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JOB DESCRIPTION

JOB TITLE	**Acute Directorate Clinical & Social Care Governance (CSCG) Co-ordinator**
BAND	8B
DIRECTORATE	ACUTE
INITIAL LOCATION	Craigavon Area Hospital
REPORTS TO	Director of Acute Services
ACCOUNTABLE TO	Director of Acute Services

JOB SUMMARY

The post holder will have responsibility for driving forward and coordinating all aspects of the Trust CSCG agenda within the Acute Directorate with and on behalf of, the Service Director and the Assistant Director with responsibility for Governance. They will provide an internal and external Directorate focus for the prioritisation, linking, implementation and review and monitoring of both the operational and professional governance agenda for the Directorate.

The post holder will, on behalf of the Director, provide a key challenge function to the service teams within the Directorate to ensure that areas where performance improvement in relation to CSCG is required are identified and addressed. They will contribute to developing corporate and operational strategy, policy and decision making within the Trust with respect to the CSCG agenda within the Directorate and as an integral part of the Trust CSCG Working Body and through close collaboration with the Trust's Corporate Assistant Director for CSCG. They will be responsible for advising on and actively participating in planning, delivering, reviewing and monitoring both Directorate and Corporate CSCG plans and will act as a focal point for the Director of Acute Services and the Trust's Corporate Assistant Director for CSCG in respect of any issues relating to the development, implementation, performance management and assurance of CSCG plans, systems and procedures and their associated improvement plans.

patients in 5 geographical locations within the Trust and this involved the development and improvement of Maternity / Obstetric community clinics in accordance with the recommendations for the Northern Ireland Maternity Strategy (2012-2020). I managed 65 staff members including two Band 7 Team Leaders and Community Midwives and Maternity Support Workers. My role also involved the oversight and development of the home birth services and providing obstetric emergency training for midwives attending home births.

1.5 I was appointed Acting Clinical and Social Care Governance Coordinator (Band 8b) and took up post on 21st January 2019.

a. I believe this to be the role I occupied that may be of direct relevance to the Inquiry's Terms of Reference. Please see:

   1a. Acute Governance Coordinator Job Description

b. My role was to provide clinical and social care governance within the Acute setting. This included Medicine and Unscheduled Care, Emergency Department, Surgery and Elective Care (including Urology), Maternity and Women's Health, Diagnostics, and Cancer Care. This was a vast remit which included management of complaints, incident reporting, SAIs, equipment management, and Standards and Guidelines within all of Acute Services (some of which Standards and Guidelines were relevant for the whole Trust).

c. I had a number of teams to manage. There was a Complaints Team comprising a Band 6 Complaints Manager, a Band 5 Complaints Officer, a Band 3 Complaints Assistant and a Band 2 Administrative Assistant. I was also responsible for a Band 7 Standards and Guidelines (S&G) Manager, a Band 5 Governance Officer for Standards and Guidelines, and a Band 7 Equipment Manager. There was also the SAI Team which initially included a Band 6 Governance Nurse and Band 5 Governance Officer (administrative support) and

myself until two recently recruited Band 7 Governance Managers came into post in March and May 2019.

d. My general role encompassed general oversight of incident reporting, complaints, Ombudsman complaints and action plans. It included the development of Trust Guidelines following recommendations from adverse incidents, for example, the "Conscious Sedation Guideline". I was responsible for maintaining and updating the Directorate and Divisional Risk Registers (the Corporate Risk Registers were managed at Trust Board level). A report of the Risk Registers was included in monthly governance papers for the Acute Clinical Governance Meeting and for the Acute Governance Meeting for each Assistant Director and their relevant Divisions. Within these governance papers, a report on current complaints, including Ombudsman complaints and any outstanding complaints, was provided to ensure that the Divisional Assistant Directors were aware of any delays or backlogs in complaints responses.

e. I was also involved in providing responses to the HSCB and RQIA as part of my assurance role.

f. Compliance audits were carried out, for example, on surgical site infections and hand washing. Reports of these audits were presented bimonthly.

g. Reports were generated for the monthly Acute Governance Meeting to advise of the complaints position, the number of Datix, and the themes of incidents including the number of moderate to catastrophic incidents.

h. Regarding incident reporting, I had oversight of all Datix submissions. These Datix submissions were graded from minor to catastrophic. All

management of Standards and Guidelines (S&G) and there were two meetings a fortnight to ensure that the Acute Assistant Directors and Acute Director were aware of the Trust's responsibilities and responses required regarding S&G. I also oversaw the equipment management of medical devices within the Trust.

3.4 There was a separate team within the Trust responsible for Clinical Audit, M&M and Quality Improvement that were not under my remit.

3.5 I kept the Director of Acute appraised of any outstanding issues regarding screening, for example, when screening didn't occur and the reasons for this. This was an issue with surgical screening and the lack of attendance of the Associate Medical Director and Clinical Director as they had competing clinical priorities which made it difficult for them to attend most screening meetings. This was addressed and there was good improvement from April 2020. This may have been related to the Covid pandemic response in that all meetings became accessible remotely, which made attendance for medical managers (who were also busy clinicians) easier.

3.6 There was a separate process followed through Human Resources when issues were identified regarding a staff member's competences. As stated above at Question 1(i), the operational teams are responsible for the competency of, or professional issue with, any registrant and any issues of such a nature would be addressed through this route. Usually, the Medical Director's Office or Executive Director of Nursing would be made aware of any such issues. They would not be shared at my level in view of the confidential nature of them. Of course, the problem with that is that it prevents one from having all the information when an SAI Review is conducted. Practices have now changed somewhat so that any staff member mentioned in an SAI has to discuss this at revalidation.

3.7 As both a Lead Midwife and Risk Midwife, I was aware of midwives being referred for Supervisor of Midwives Investigations or to the NMC. These were robust investigations and could often result in sanctions. Therefore, it was not unusual for these processes to be kept confidential amongst a select number of people. However, as a Band 7 Risk Midwife I would have been made aware that a process had commenced in respect of a named individual, even though

Southern Health and Social Care Trust

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REPORT SUMMARY SHEET

Meeting	Governance Committee 6th December 2018
Title:	Management of Trust Standards & Guidelines
Lead Director:	Dr Ahmed Khan Interim Medical Director
Corporate Objective:	Safe, high quality care
Purpose:	The purpose of this paper to provide a report to Governance Committee which sets out the Trusts position on implementation and compliance to Standards Guidelines received from 1st September 2016 to the 24th October 2018.

Summary of Key Issues for Governance Committee

High level context:

The volume of standards and guidelines has become increasingly challenging for providers and commissioners to manage within existing risk management and clinical governance arrangements. In August 2016 SMT agreed to revise processes to manage Standards and Guidelines and strengthen systems by introducing:

- Risk stratification of each standard and guideline by operational teams
- Multi-level standard and guideline compliance reporting
- Identification of barriers to compliance
- Modernisation of the corporate standard and guideline database to facilitate corporate reporting; ensure the consistency of information captured and to free up administrative time.

Key issues/risks for discussion:

- Resource and capacity to undertake evaluation/and or audit of Standards and Guidelines
- Links to Trust Audit Strategy (2018)
- The Current corporate logging system is limited in its functionality.
- Capacity of Directorate Governance Teams to maintain the accuracy of the Trust Standards and Guidelines data base to facilitate corporate reporting.
- Implementation of cross directorate guidelines

Internal/External Engagement:

- SMT
- Directorate Governance Coordinators
- Operational Teams

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NICE Clinical Guideline Update	33
Safety and Quality Learning Letter	25
PHA Correspondence	21
DoH Correspondence	20
Medical Device Alert	18
NICE Public Health Guideline	10
Patient Safety Alert	10
NICE Interventional Procedures	15
Drug Safety Update	5
Public Health Guideline	5
Antimicrobial Guidance	3
Other	2
RQIA Letter	2
Chief Pharmaceutical Officer Letter	1
CNO Letter	1
Estates and Facility Alert	1
Gain Guideline	1
Learning Matters Regional Learning Letter	1
NCEPOD Report	2
Northern Ireland NIAIC Alert	1
Total	455

4. Acute Directorate

There are **311** Standards and Guidelines recorded on the corporate database as having applicability to the Acute Directorate, of these **311** Standards and Guidelines:

- **89 (28%)** of these Standards and Guidelines are recorded as not requiring a compliance position or risk assessment completed as they are for dissemination only, or have been superseded by another Guideline.

- **79 (25%)** of these Standards and Guidelines have been indicated as being fully compliant by the Acute directorate (See table 1 below)

- **146 (47%)** of these Standards and Guidelines are recorded as either, Partially Compliant, Non-Compliant or Compliance being Reviewed (See table 1 below)

ID	Dir	Opened	Principal objectives	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)
3529	ACUTE	05/02/2014	Provide safe, high quality care	Non compliance to Standards and Guidelines issued to Southern Trust	There is often a time lag between when the external agencies require the Trust to achieve full compliance against the recommendations outlined within standards and guidelines and when this is actually achieved. Such non-compliance poses the following risks for the patient and the organisation: - Reduced ability to deliver quality patient care; Compromised patient safety and wellbeing; Poor patient outcomes - mortality/morbity, delayed discharge, increased secondary complications; Staff members are non-compliant with evidence based working practices, lack of standardised practice, vulnerable wrt registration; Organisational risk - complaints, incidents, litigation, As of April 2018 there are 1609 standards and guidelines identified on the Trust's register. 74% (1193) of these are applicable to Acute Services Directorate. Of these, 34% (405) remain at a partial or non determined level of compliance with many identifying significant external barriers impeding the Trust's ability to comply. 689 are indicated as 'Compliant ' and 99 indicated as either N/A or Superseded. It is noteworthy to state some of this data is pending QA as part of Phase 1 and 2 review work which has not been fully completed due to service capacity. Due to volume and complexity of these guidelines it is a challenge for the Trust to monitor and review the compliance status of all the standards and guidelines that have been received. There is a corporate need to invest in a more fit for purpose information system . Regionally the WHSCT is currently piloting a new system that is being developed by Microsoft - it is a modified system within Sharepoint. Funding has been allocated by BSO to take this work forward with a view of developing a regional system for use by all HSC organisations. A planned demonstration by WHSCT was planned in February 2018 but had to be	Provision of bi monthly assurance responses to the HSCB as part of the Trust's Positive Assurance response. Corporate governance have an Excel database in place for logging and monitoring S&G. Within Acute Services a directorate S&G forum has been established - inaugral meeting was held 19 January 2017. Terms of reference are in place and the forum is chaired by the Director and attended by the SMT. The forum meets twice a month to review all newly issued S&G so to ensure appointment of a clinical change lead is confirmed in a timely manner, thereby ensuring implemenation processes are put in place as early as possible. It also reviews and approves implementation plans requiring submission to the the relevant external agency. It approves any policy/procedures/guidance that has been developed as part of these implemenation plans. Standard item for discussion at the monthly Acute Clinical Governance meetings with submission of relevant reports Patients Safety & Quality Manager (Acute Services) attends all divisional governance meetings on a monthly basis and presents tailored activity reports to determine progress at an operational level Meeting schedule is in place to ensure meetings are held with the Heads of Service to review compliance against all S&G within their areas of responsibility A new Acute Services Lead Nurse, Midwifery & Radiology S&G forum - meetings held on a monthly basis Monthly summary report is issued out to Acute SMT to communicate to all staff what new regionally endorsed S&G have been issued. A copy is also shared with the M&M chairs so that they can review and share within their committee meetings	7/3/18 & 5/12/17 Information below remains current 19.7.16 - Decision needs to be made regarding the viability of re-appointing an AMD for Standards and Guidelines (Acute Services) - forms part of the current review of Acute Services structures. Administrative support for the Patient Safety & Quality Manager needs to be reviewed - there is currently no administrative support. Patient Safety & Quality Manager (Acute Services) has successfully achieved a one year NICE scholarship - project is to undertake a review of the directorate's process for implementing standards and guidelines - to be completed by 31/03/2017. Regionally the WHSCT is to undertake a pilot of Sharepoint to ascertain if this system would be fit for purpose for the development of a regional information system for the management of standards and guidelines. HSCB are involved in this process and funding to support this initiative is currently being sought. There continues to be an urgent need to put in place a more effective information system for the logging, dissemination and monitoring of standards and guidelines. Corporate governance is currently designing an inhouse system until an appropriate regional solution is agreed.	MOD
3922	ACUTE	13/11/2017	Provide safe, high quality care	Lack of funding to ensure compliance with NICE guidelines that have been regional endorsed by the DHSSPSNI.	In April 2017 a Band 5 Governance Officer commenced work within the Acute S&G team as part of a secondment from the Corporate Governance team. This secondment to the Acute S&G forum ended on 31/12/17. The purpose of this audit was to ensure that an assurance framework is in place to comply with the reporting arrangements to the relevant external agencies (such as the HSCB). The outcomes from this audit are now being operationalised and outstanding actions are presented at the Acute S&G forum and Divisional Governance meeting to ensure progression. As part of this work a significant number of NICE guidelines have been identified as having an external barrier impeding implemention. This audit identified 53 NICE guidelines where an E proforma is required. 34 E proformas have been submittted to the HSCB and a further 8 are pending submission once the baseline assessment has been completed and approved by Acute SMT. 11 E proformas are now due for review and work is progressing to undertake this process. A copy of the updated May 2018 E proforma report will provide evidence of this work. The work also provides a timely trigger for the compliance position to be reviewed in accordance with stipulated review timescales. In the past the HSCB would have reviewed 'red' status guidelines for all Trusts and for guidelines were all Trust's identified significant barriers these would have been prioritised as part of their annual work plan and there was the possibility of funding being allocated to support implementation at a local level. With effect from 01/04/2017 this is no longer the process, with all Trust' needing to manage all funding requests within existing financial resources. Given the number of competing demands this makes it very difficult to ensure that the S&G constraints are overcome and presenting a risk for the Directorate.	Provision of bi monthly assurance responses to the HSCB as part of the Trust's Positive Assurance response. The content of this report is approved by the Director of Acute Services and Director of Performance prior to submission The accountability arrangements for the management of S&G within Acute Services are well defined to ensure the risk of not complying with a guideline due to identification of an external barrier is communicated to the SMT in a timely way. There are robust processes in place to ensure timely review of E proformas to ensure any change in compliance is identified and should the compliance status be downgraded from red to green the HSCB can then be notified	June18 On-going monitoring and review within Acute S&G forum agenda Discussion with Trust SMT since this risk issue will be the same within the other operational directorates, albeit the number of guidelines are less	MOD
3940	ACUTE	26/02/2018	Provide safe, high quality care	Provision of a on-call bleeding rota	Inability to provide consultant cover every on-call night with the skills to manage patients admitted with haematemesis. Patients admitted with large haematemesis unable to be managed in a time critical manner.	Registrar manages the patient with haematemesis in the first instance. If Registrar requires support they would phone round the Gastroentrology Team if available to come in to assist.	10.4.18 Escalated to Directorate RR 26.02.18 Risk added to Divisional Register	MOD
3957	ACUTE	30/04/2018	Safe, High Quality and Effective Care	The medical team on the Daisy hill hospital site cannot provide daily senior review for all the Medical in patients	Due to medical workforce they are unable to ensure that all in patients receive a senior medical review. Delay in investigations. Delay in review of investigations. Delay in Diagnosis. Impact on the patient treatment plan. Potential to contribute to overcrowding in ED as some of in patients could be potentially discharged.	Each Ward Sister to identify at the bed meetings if patient has not had senior review. Ensure that outlyers are seen and escalate accordingly to Lead Nurse/ HOS	24.06.19 No change. Zoning introduce needs evaluated. Review workforce available.	MOD
3958	ACUTE	30/04/2018	Safe, High Quality and Effective Care	EBUS Provision lack of Funding	The risk is that patients requiring cardiac investigations are waiting in access of 13 week Pot for Harm -Delays in patients being diagnosed, commencing treatment and the appropriate way Delays may contribute to patient death.	We have Cardiac investigations teams across both acute Sites Agreed referral process to be used by CI staff at Triage Avail of funding from HSCB for additional clinics.	24.06.19 Additional EBUS session secured and we will continue to monitor. 19/11/18 Measure access times monthly and highlight to HSCB via performance team. Review of cardiac investigation demand and capacity by HSCB.	MOD
3971	ACUTE	28/08/2018	Provide safe, high quality care	Access to cath lab for NSTEMI patients	Standard 18d of Cardio vascular framework that eligible NSTEMI / ACS pts should have Cor Angio +/- PCI within 72 hrs of admission. Angiography within 72 hours improves outcomes for patients. (NICE). MINAP state: The performance of angiography and coronary intervention soon is an important facet of treatment for the majority of patients.	Monitored weekly. Access elective patients. Escalate number of patients waiting for in patient cath procedures daily to AD and Director.	24.06.19 Monitored via MINAP only 50% getting to cath lab despite modula. High volumes of inpatient activity (monitored monthly for each site) Need to secure Funding premanent for modula. Need to reduce elective to facilite inpatient. 13.08.18 Performance team to liaise with HSCB re funding	MOD

The Safe Use of Ultrasound Gel to reduce Infection Risk *3rd Line Assurance*	06/01/2022	HSC SQSD 33/21	Patient Safety Alert	n/a	14/03/2022	14/03/2022	**Yes**			Personal Information redacted by the USI	Medical	Acute, CYPS, OPPC	**Non Compliant**	**Low**	30/04/2022		
Quarterly HSC Communication - October - December 2021	04/01/2021	HE1/22/929	NICE Covid-19 Rapid Guideline	n/a	n/a	n/a	**Yes**			For dissemination			**For Dissemination**	**Not Applicable**			
Bi-Monthly HSC Communication for November & December 2021	04/01/2021	HSC (SQSD) (NICE IPG) 1/22	NICE Interventional Procedures	n/a	n/a	n/a	**Yes**			For dissemination			**For Dissemination**	**Not Applicable**			
STATUTORY AND PUBLIC HOLIDAYS HOSPITAL MEDICAL AND DENTAL STAFF	21/12/2021	TC8 1/2021	DOH Correspondence	n/a	n/a	n/a	**Yes**			For dissemination	Acute	Acute, OPPC, MHD	**For Dissemination**	**Not Applicable**			
Nivolumab with ipilimumab and chemotherapy for untreated metastatic non-small-cell lung cancer - NOT RECOMMENDED Revised HSCB Letter issued on 21/01/2022 due to error	20/12/2021	TA 724	NICE Technology Appraisal	n/a	20/01/2022	n/a	**Superceded**			Personal Information redacted by USI	Acute	Acute	N/A	**Superceded**			
Ozanimod for treating relapsing–remitting multiple sclerosis - NOT RECOMMENDED	20/12/2021	TA 706	NICE Technology Appraisal	n/a	20/01/2022	n/a	**Yes**			Personal Information redacted by USI	Acute	Acute	**Compliant**	**Low**			
Integrated Guidance Update on health clearance of healthcare workers and the management of healthcare workers living with blood born viruses	17/12/2021	HSS (MD) 83 2021	CMO Correspondence	n/a	n/a	n/a	**Yes**			For dissemination	Acute	Acute, OPPC, MHD	**For Dissemination**	**Not Applicable**			
Headaches in over 12s: diagnosis and management Update to Circular Received on 13/05/2021	17/12/2021	CG 150	NICE Clinical Guideline Update	n/a	17/03/2022		**Yes**			Personal Information redacted by the USI	Acute	Acute, OPPC	Under Review	**Under Review**			
UK Saving Lives and Improving Mother Care	17/12/2021	N/A	MBRRACE	n/a	n/a	n/a	**Yes**			Personal Information redacted by the USI	Acute	Acute	Under Review	**Under Review**		MHD emailed to Ads for info	
Managing Covid-19 Update	17/12/2021	NG 191	NICE Covid-19 Rapid Guideline Update	n/a	n/a	n/a	**Superceded**			Superseded	Acute	Acute, MHD, OPPC	Under Review	**Under Review**			
Colorectal Cancer Update to Circular Received on 24/06/2021	15/12/2021	NG 151	NICE Clinical Guideline Update	n/a	15/03/2022		**Yes**			Personal Information redacted by the USI	Acute	Acute	**Non Compliant**	**Low**			
Prostate Cancer Update to Circular Received on 04/07/2019	15/12/2021	NG 131	NICE Clinical Guideline Update	n/a	15/03/2022		**yes**			Mr Glackin, Kate O'Neill & Mr Haynes	Acute	Acute	**Non Compliant**	**Low**			
Suspected Cancer - All Documents Update to Circular Received on 08/02/2021	15/12/2021	NG 12	NICE Clinical Guideline Update	n/a	15/03/2022		**Yes**			For dissemination	Acute	Acute	**Non Compliant**	**Low**			
Managing Covid-19 Update	14/12/2021	NG 191	NICE Covid-19 Rapid Guideline Update	n/a	n/a	n/a	**Superceded**			Superseded	Acute	Acute	Superceded	**Superceded**		17.12.21 CYPS circulated to AMD, AD, CDs for information and sharing as appropriate.	
Pelvic floor dysfunction: prevention and non-surgical management *Clincial Guideline regionally endorsed by DoH on 15/02/2022*	09/12/2021	NG 210	NICE Equality Screening Questionnaire	n/a	n/a	No formal response required	**Superceded**			Personal Information redacted by the USI	Acute	Acute, OPPC	**For Dissemination**	**Not Applicable**			
Potential misuse and safe disposal of injectable medication *Recall of learning letter*	01/12/2021	LL-SAI-2021-044	Safety and Quality Learning Letter	n/a	Recalled	Recalled	**Recalled**			Personal Information redacted by the USI	Acute	Acute, CYPS, OPPC	Recalled	**Recalled**		MHD emailed to Ads 13/12/21, MHD debrief 071221	
Managing Covid-19 Update	01/12/2021	NG 191	NICE Covid-19 Rapid Guideline Update	n/a	n/a	n/a	**Superceded**			Superseded	Acute	Acute, CYPS	Superceded	**Superceded**			
Agenda for Change Pay Arrangements 2021/22 Circular	03/12/2021	HSC (AfC) (2) 2021	DOH Correspondence	n/a	n/a	n/a	**Yes**			For dissemination	For Dissemination	CYPS, OPPC	**For Dissemination**	**Not Applicable**		17.12.21 - CYPS sent to ADs for dissemination. MHD debrief 071221	
Safe management of the intoxicated, violent and aggressive patient in the Emergency Department 2nd Line Assurance	01/12/2021	SQR-SAI-2021-088	Safety and Quality Reminder of Best Practice Guidance	n/a	31/12/2021	23/12/2021	**Yes**			Personal Information redacted by the USI	Acute	Acute	Under Review	**Under Review**	30/06/2022	MHD debrief 071221	
Fever in under 5s: assessment and initial management	29/11/2021	NG 143	NICE Clinical Guideline Update	n/a	29/02/2022	n/a	**Yes**			Personal Information redacted by the USI	Acute	Acute, CYPS, OPPC	Under Review	**Under Review**		17.12.21 - CYPS requested change lead from DMD	
Type 2 Diabetes in Adults: Management *Further update to guideline issued by DoH on 15/02/2022*	24/11/2021	NG 28	NICE Clinical Guideline Update	n/a	24/02/2022		**Superceded**			Personal Information redacted by USI	Acute	Acute, OPPC					
Chronic kidney disease: assessment and management (updates and replaces CGs 157, 182 & NG8) Updates and replaces CG 157 issued on 29/07/2013	24/11/2021	NG 203	NICE Clinical Guideline	24/02/2022	24/11/2022		**Yes**			Personal Information redacted by USI	Acute	Acute	**Non Compliant**	**Low**			
Ectopic Pregnancy and Miscarriage Diagnosis and Initial Management Update	24/11/2021	NG 126	NICE Clinical Guideline Update	n/a	24/02/2022		**Yes**			Personal Information redacted by the USI	Acute	Acute	**Non Compliant**	**Low**			
Letter from Cathy Harrison, Chief Pharmaceutical Officer to stakeholders re Enteral feeds recommendations	23/11/2021	N/A	CPO Correspondence	N/A	N/A	N/A	**Yes**			For dissemination	For Dissemination	Acute, CYPS, OPPC	**For Dissemination**	**Not Applicable**		17.12.21 CYPS issued to AD and HoS for dissemination	
Managing Covid-19 Update	23/11/2021	NG 191	NICE Covid-19 Rapid Guideline Update	n/a	n/a	n/a	**Superceded**				Acute	Acute	Superceded	**Superceded**		MHD T Reid emailed to Ads 26/11/21	

Received from SHSCT on 19/05/22. Annotated by the Urology Services Inquiry.

McGoldrick, Kathleen; McGeough, Mary; Magee, Brian; McIlroy, Cathie; Nelson, Amie; Reid, Trudy; Robinson, Jeanette; Boyce, Tracey; Carroll, Anita; Carroll, Ronan; Conway, Barry; Gibson, Simon; McVey, Anne; Trouton, Heather
Subject: FW: Circular HSC (SQSD) (NICE NG12) 29/15 - Suspected cancer: recognition and referral

Dear all,

Please see attached new NICE referral Guidance for suspect cancers (NG12) which has been endorsed by the Department as applicable in Northern Ireland.

This has been discussed at Regional Network Site Specific Group meetings and comments on the implementation of the Guidance have been requested .

I would be grateful if you could circulate this Guidance through Cancer MDTs and teams so that all can view and comment back by the 30th October, 2015 so that a collective Trust response can be made.

Regards

Fiona

Fiona Reddick
Head of Cancer Services
SHSCT
Personal Information redacted by USI

I would not have been provided with any details, nor did I require any details in my role. I feel this should have happened regarding the MHPS investigation. I did not need to know all of the details; just that there was a separate investigation taking place for a particular staff member. I would then have been more informed and better able to identify any recurrent issues with a particular staff member, thereby enhancing governance.

Urology

3.8 I believe the overall responsibility for governance in Urology rested with the Assistant Director of Surgery, Associate Medical Director, and Clinical Directors who would then escalate appropriate issues to the Director of Acute Services, Medical Director, and Chief Executive. I understand there is also a governance responsibility sitting with the Chair of the MDM for Urology to ensure that recommendations made at MDM are actioned.

3.9 There appeared to me to be a “disconnect” between what was happening regarding operational decisions within Divisions and what was shared with the Acute Clinical Governance Coordinator. I was only made aware of any issues through the SAI processes or through Datix, complaints, or the Hospital at Night Report (this is a report that the Bed Manager provides every morning, detailing any incidents or issues that occurred overnight on each hospital site and which includes the number of patients waiting on beds in the Emergency Department). An example of an issue or incident could be an unexpected death on the ward or if a high-risk patient absconded. Each of these information routes might prompt me to seek further information on and / or clarification of the issue raised. Sometimes, the Assistant Director for the Division would let me know of any concerns in their Departments but generally this usually only occurred when a response was required for HSCB and my assistance was called upon. The limitation inherent in these communication channels is that you are relying on someone telling you of any issues or submitting a Datix. On reflection it was not sufficiently robust and I think there was a missed opportunity to discuss clinical concerns, perhaps as a standing agenda item, at the Acute Governance Meeting (when all the operational Assistant Directors, the Director of Acute, and the Clinical Governance Coordinator are present).

management of Standards and Guidelines (S&G) and there were two meetings a fortnight to ensure that the Acute Assistant Directors and Acute Director were aware of the Trust's responsibilities and responses required regarding S&G. I also oversaw the equipment management of medical devices within the Trust.

3.4 There was a separate team within the Trust responsible for Clinical Audit, M&M and Quality Improvement that were not under my remit.

3.5 I kept the Director of Acute appraised of any outstanding issues regarding screening, for example, when screening didn't occur and the reasons for this. This was an issue with surgical screening and the lack of attendance of the Associate Medical Director and Clinical Director as they had competing clinical priorities which made it difficult for them to attend most screening meetings. This was addressed and there was good improvement from April 2020. This may have been related to the Covid pandemic response in that all meetings became accessible remotely, which made attendance for medical managers (who were also busy clinicians) easier.

3.6 There was a separate process followed through Human Resources when issues were identified regarding a staff member's competences. As stated above at Question 1(i), the operational teams are responsible for the competency of, or professional issue with, any registrant and any issues of such a nature would be addressed through this route. Usually, the Medical Director's Office or Executive Director of Nursing would be made aware of any such issues. They would not be shared at my level in view of the confidential nature of them. Of course, the problem with that is that it prevents one from having all the information when an SAI Review is conducted. Practices have now changed somewhat so that any staff member mentioned in an SAI has to discuss this at revalidation.

3.7 As both a Lead Midwife and Risk Midwife, I was aware of midwives being referred for Supervisor of Midwives Investigations or to the NMC. These were robust investigations and could often result in sanctions. Therefore, it was not unusual for these processes to be kept confidential amongst a select number of people. However, as a Band 7 Risk Midwife I would have been made aware that a process had commenced in respect of a named individual, even though

3.10 Whilst I do not believe there was ever any intention to cover up issues, I believe that some serious issues were escalated to my senior colleagues rather than to me given the confidential nature of them. The MHPS case regarding Mr O'Brien is an example of this.

3.11 The Acute Directorate is so vast that I believe it would be impossible to have complete governance oversight of it at my level within the organisation. Whilst I could deal with issues that were made known to me, I believe those with the overall responsibility for governance in Urology (as identified above) may have had greater oversight or a greater ability to have oversight.

4. What was your understanding of the way in which governance issues might be brought to your attention? What is your view of the efficacy of those methods of identifying governance concerns?

4.1 I believe that 'governance' is an umbrella term to describe the framework by which healthcare organisations are accountable for continuously improving the quality of their service and safeguarding high quality care. This is achieved through, risk management (including complaints, clinical incidents, equipment management and Standards and Guidelines), training and education, audit, clinical effectiveness, research and development, and patient and public involvement.

4.2 Governance issues were usually highlighted from a Datix (incident report) which would be generated at an operational level. It was my responsibility to ensure all the Datix submitted were reviewed on a daily basis (working hours) and any major or catastrophic incidents were reviewed and screened weekly by the Acute Senior Management Team, which included the Associate Medical Director for the Division, Clinical Director for the Division, Assistant Director for SEC, and a governance officer in the event that I was unavailable. There are limitations with the Datix system in that, once a Datix review is completed, the Datix is closed and, unless a report is generated to look specifically at themes, then it does not remain visible to the governance team. In the circumstances, when I came into post in early 2019 I was not aware that there had previously

4.10 When I first came into post my office was on the Administration Floor in the main Craigavon Hospital building, which did help me hear if any incident had occurred because staff would drop by the office and tell me given its central and accessible location. However, my team and I were moved off the main hospital site in June 2019 as there was lack of suitable accommodation. This meant that it was more difficult to ascertain if something had happened. I had asked the Facilities Manager to scope an office back on the Administration Floor but this couldn't be facilitated.

4.11 Another drawback was that, sometimes, Surgical Screening was unable to take place due to the absence of either a Clinical Director or Associate Medical Director (or both). This was often due to competing clinical commitments. This meant that no decisions could be made regarding the screening of adverse incidents and to determine what the most appropriate method of addressing them was. Also, this impacted on the progress of existing SAIs if there were review panel members to be selected (usually the consultants were nominated by the AMD or CD). I didn't have similar concerns with screening within the other Divisions of Acute Services, so this was unique to Surgical. I raised this issue on numerous occasions with both Ronan Carroll, Assistant Director, and Mrs Melanie McClements, the Acute Director. This didn't improve until April 2020, when screening meetings began taking place over 'Zoom' and surgeons were stood down from elective work during the first Covid lockdown. Eventually, the screening day was changed to facilitate all the relevant medical personnel to attend. Screening meetings were not minuted. Rather, an outcome of screening was added to an Excel document.

4.12 Audits carried out within Acute were compliance driven ensuring a high standard of patient care. For example, the Malnutrition Universal Screening Tool (MUST) Audit, to provide assurances that patients in hospital were getting adequate nutrition, or audits on Fluid Balance Charts or Early Warning Score Charts which were directly reflective of good standards of patient care. I understand the Audit Department were not adequately resourced to assist with quality assurance audits to assess the effectiveness of our governance systems and processes. On reflection there was a missed opportunity to be

Urology Services Inquiry

k. I was responsible for facilitating and assisting with Serious Adverse Incident Reviews and Internal Reviews of patient care. When I first took up post there were 35 outstanding reviews (both SAI and Internal) awaiting either commencement or completion. There were also many more SAI added to this list following screening meetings. Please see:

1b. 20161117_Proceedure for the Reporting and Follow up of SAI version1.1. nov 2016

l. My direct involvement with SAI reviews was to facilitate the meetings, set up meetings, advise the review team of the governance processes to ensure a robust report, and record notes of meetings. I would also meet with staff members to interview them for the SAI reviews and I would record those meetings too. It would be my practice in this regard to ask the interviewee to check if I had documented the information correctly and in the proper context. It was obviously important not to misunderstand what had been said.

m. I would have had separate meetings with the Chair of the Review Panel to write up the Review and assist with the administration of it. It was my practice to advise the Chair of the Review Panel if I felt the Review was not robust enough or not sufficiently open and transparent, so that it may be addressed prior to completion of the Review. For example, in my experience some SAI Chairs would make draft recommendations based on their own opinion about 'the right thing to do' whereas, in order to ensure that the Review was robust, I would advise that the recommendation should be founded upon evidence and national guidance. I would therefore recommend that the team follow the most up to date clinical guidance to ensure that the recommendations in the report were robust.

your previous answers, please set out all details of such meeting and discussions, including dates, times, locations, those present, and details of what was discussed and any follow up actions or reviews to decisions made. Please include all relevant documentation.

6.1 As set out in my response to Question 1(i) above, I attended the Surgical Screening meeting on 31 July 2020 when two Datix were submitted by Mr Mark Haynes describing that two patients had received inappropriate care (Datix 121045 and Datix 121851). I was asked to bring them to screening by the Deputy Medical Director, Dr Damian Gormley. These were the first two patients identified for the nine SAI Reviews (and one overarching review) undertaken by Dr Dermot Hughes.

6.2 As is also discussed in my response to Question 1(i), I attended weekly Urology Oversight Meetings every Tuesday evening. The first meeting I attended was on 15 September 2020. These meetings were high level meetings involving the Medical Director, Director of Acute Services, Director of Human Resources, Associate Medical Director for Urology, Assistant Director of Surgery, Head of Services for Urology, Assistant Director of Governance, Head of Communications, and myself. The purpose of the meeting was to discuss the issues surrounding the concerns with Mr O'Brien. As discussed above, this was the first time I was made aware that an MHPS investigation had occurred previously in respect of Mr O'Brien. As also indicated above at 1(i), I attended these meetings to provide an update on the SAI Review progress. I also shared issues that the families of the SAI patients had disclosed regarding access to nursing or counselling. It was agreed at this meeting that the Trust would provide counselling services to any of the patients / family members who required it. I then shared the details back to the families. I also recommended that a family liaison person be appointed to help with keeping the families updated as I was under a lot of pressure to complete the SAI Reviews. The Urology Oversight Team agreed to appoint one of the Family Liaison Officers employed specifically for the Covid outbreak SAI to assist with the families involved in the 9 Urology SAI Reviews. Mrs Fiona Sloan was the

provide assurances that the actioned recommendations remain in place. This does happen within some areas of Acute.

7.4 I believe that the current SAI process is not an effective tool to extract early learning but, despite its limitations, it is the chosen tool regionally. Although there are recommended time frames for completion of an SAI Review, they are not realistic and don't take into account the clinical commitment required for staff who have outpatient clinics and surgeries planned. In addition, when a large team is involved in the Review, holidays have to be taken into consideration and this can affect the commencement of review team meeting and subsequent review meetings. In my opinion there needs to be a faster method of reviewing adverse incidents to extract learning and to provide assurances for patients / families that their case has been comprehensively reviewed and learning extracted and implemented promptly. I don't think we have the tool perfected yet. There is a tool called a Structured Judgement Review, in which a team of people will review the patient notes and blood results / investigations and make a judgment as to whether the care was suboptimal or not and what learning there is to be shared immediately. As it doesn't involve a lengthy report, it can often be completed within a few weeks of the incident. Whilst this review has its limitations (including that it doesn't take a Root Cause Analysis approach), there must surely be some form of composite review method (encompassing the best parts of both SAI and SJR processes) that would produce a more timely outcome. This would be different from a Case Note Review which, as I understand matters, usually involves a single clinician expert in the relevant field and is used to inform as to the need for a further, more in-depth review.

7.5 I cannot answer as to the effectiveness of the nine SAI Reviews in terms of the implementation of their recommendations as I retired from my governance role and from the Trust in June 2021, before the recommendations could be substantially implemented.

Level 3 SAI review

Introductory Meeting New Urology reviews.

Date and time: Thursday 10 September 2020 10:30 – 12:00
Venue: - Board Room Trust Headquarters CAH

Attendees:
External Chair – Dr Dermot Hughes.
Mrs Fiona Reddick – Head of Cancer Services
Ms Patricia Thompson – Clinical Nurse Specialist – urology
Mrs Patricia Kingsnorth – Acting Acute Clinical Governance Coordinator

Welcome

Patricia Kingsnorth welcomed everyone to the first meeting and introductions were made.

Dr Hughes explained the process and rationale for review to look at the service and map the pathway of the patients being presented. There would be separate reports with one overall umbrella section.

The cases 6 presented (one more to follow) will include mapping the patient's journey and compare with the existing pathway to identify deviations from the pathway.

Cases discussed.

1. Patient 1 a Personal Information redacted by USI man referred in view of increased PSA and tumour markers. Noted he had an MRI pelvis and was referred for discussion with MDT prior to biopsy. MDT recommended radiotherapy in Belfast. No done. Fiona will check out, who was present at the MDT meeting, were the appropriate people at the meeting and was the referral made to Belfast. There was some discussion about a failsafe from cancer trackers if a referral is not made how did non beam radiotherapy not happen?

2. Patient 5 - noted renal cell carcinoma. Noted the risks of surgery for this patient but patient wanted surgery. Following radiology investigation the result was not acted upon.
   There was some discussion around who follows the patient up – if surgeons then the review should be followed up in Thorndale unit, if oncology this would be done in Belfast. Patricia K will check with PACS manager if the MRI scan was viewed and by whom. Also she will check with Imran if the CT scan meets the definition of unexpected result.- index of suspicion.
   Need to map this patient's journey

3. Patient 9 patient received TURP as clinically suspicious of prostate cancer. Need to ascertain if all the tissue was there was a clinical suspicion of cancer –

A. No. The only time I was asked to find out information was in regard to where the patients - those patients in the SAI process - were on their pathway at that moment of time. That was really the only time that I was asked to go away and discover additional information. 11:35

110 Q. So, was it the understanding from the outset of your involvement that Dr. Hughes would be the only person who spoke to others; had meetings with interested parties?

A. No, I wasn't -- that wasn't made clear to me but I discovered it then subsequently in the report. I felt that I didn't have the opportunity to -- as part of that SAI Panel, I was denied that opportunity to speak to others in tandem with Dr. Hughes. 11:35

111 Q. Do you know why that was? 11:36

A. I've no idea.

112 Q. Did you ever raise it with Dr. Hughes?

A. No.

113 Q. Did you know who he was going to speak to at any given time? Did he share that information with you? 11:36

A. It wasn't very clear who the individuals were that he was. It wasn't made clear.

114 Q. You have seen the findings of the SAI, the recommendations?

A. Yes. 11:36

115 Q. Do you think that your particular role may have contributed more to the investigation if you'd have been allowed to speak to people and undertake some of the investigatory work?

Southern Health and Social Care Trust

New Urology SAI Meeting 12.10.2020 @09:30.

Attendance: Dr Dermot Hughes (Chair); Mr Hugh Gilbert Consultant Urologist; Patricia Kingsnorth ; Fiona Reddick; Patricia Thompson

Round of introductions given

PK asked was the agenda received by all. All present confirmed they had received this. Patricia Kingsnorth asked for everyone to check the notes of last meeting for accuracy. Record of what was agreed. At previous meeting they discussed 6 cases at high level and 2 cases were removed Personal Information redacted by USI following screening.

Dermot advised all cases are quite similar: 8 cases and it is important everyone has same information on each case to review.

Patricia Kingsnorth: Information can be accessed on Egress.

Patricia Kingsnorth advised there was one additional case for screening:

Dermot advised he was concerned he was asked to Chair the review in August and there are still cases added.

Patricia Kingsnorth advised will speak with directors re this.

Dermot advised everything that will be done will be scrutinised and advised it is important we take same approach to all cases. Asked to chair urology cases, quite similar, they have being independently triaged, currently 7 possibly with possibility of 8 cases. Dermot advised we can at the cases in 2 ways i.e. the processes in place and how the patients pathway progressed through.

Medical opinion: District general hospital consultant should be able to give peer opinion

Dermot explained the Urology services divided urology cancer MDTs, probably cover 400000 patients link together each week with regional MDT, there is a seamless flow of patients through the service,

Oncology services are separate; this is an outreach service that is variable throughout Trusts.

Patricia Kingsnorth advised previous introductory meeting prior to Hugh coming on board, looked at pathways briefly. The scope of the review and terms of reference, she advised we need to send draft TOR to HSCB and consider family involvement in TOR.

Patricia K read out TOR. Advised there will be separate individual reports and one overarching report with all information.

Dermot advised important we need to consider family expectation and involvement within the TOR. Normally would share TOR with family/ patient and ask them to review and contribute in some way. Usually family would have their concerns. Opportunity to express any concerns to be address in review.

Urology SAI Meeting

Meeting 02/11/2019

Dr Dermot Hughes – Retired Medical Director (Leadership Centre)
Urology Surgeon – Mr Hugh Gilbert – Retired Consultant Urologist England
Mrs Fiona Reddick – Head of Clinical Cancer Services
Mrs Patricia Thompson – Specialist Nurse Urology
Mrs Patricia Kingsnorth – Acting Acute Clinical Social Care Governance Coordinator

Patient 5 - daughter has contacted Patricia to advise Patient 5 does not want to engage in family discussion.
Patient 1 - Personal Information redacted by the USI, as dad was given 18 months sadly passed away 2 months later. WOULD LIKE TO MEET

Patient 4 s family would like to meet,
Patricia –Patricia checking notes – checking PAS – confirmed.

PK – Asked for terms of reference to be checked by everyone.
.
PK 1 Recompleted for overarching report, need to confirm all are happy with wording.
PK advised Hugh someone leaked review to local press.
Department of Health responded- SAI ongoing. PK advised at the stage Zoom to Zoom meetings with family members to happen in order to take their views on board. Hoping to meet all family's over the next 2 weeks.

Hugh – advised he has formalised each case, his version of events, case review. Hugh advised he has provided commentary and couple of questions for each case , if you need me to participate in family meeting happy to do so.

Dermot- TOR need to clear and precise. question MDT meetings were recommendations followed?

Hugh - qualitative thing questions batched together, some fundamental questions. MDT thinking when set up 2002 was intended to precisely stop this sort of behaviour, seems to significant opportunities for people to stand up and say you can't do this , this was not done. Why? Question how are results flagged up to people? Consult take on more administration role, secretaries moved shifted, difficulty keeping tabs on CT scan if infrastructure does not support it. Just do not leave them you must ensure they get to right place.

Dermot Infrastructure different across NI is different. Breast cancer better resourced; there are different levels of investment with urology cancer.

Hugh- 10 -12 years, breast cancer was draining all resources, however it was extremely well set up, rigid how they handle them

Urology there are different types of cancer , there are complexities, 5 cancers, introduction of MDT, should require a key worker for each patient. This would take

Southern Health and Social Care Trust

Acute Governance

Urology SAI review team meeting
Monday 30 November 2020 Zoom

PRESENT: **Mr Dermot Hughes (Chair)**
Mrs Patricia Kingsnorth Acute Clinical Governance Co-Ordinator
Mr Hugh Gilbert External Consultant Urologist
Mrs Patricia Thompson Clinical Nurse Specialist
Mrs Carly Connolly Clinical Governance Manager

Mr Gilbert advised he was approached by RIM to find someone to complete the same work.

Dr Hughes advised Mr Gilbert there were some developments last week, Tuesday the Health Minister announced there would be an Independent inquiry in to the consultant. Dr Hughes advised the SHSCT did not have much input into the decision it was the department of health's decision. This is on the back of 2 other ongoing enquires in Northern Ireland, one is a neurology inquiry which Dr Hughes is involved in. Dr Hughes advised it is not of the same magnitude and involves approximately 3000 patients. The question was asked where does that leave this SAI and SHSCT have been advised to continue with the SAI as it is a learning process

Dr Gilbert advised that was fine, he was in contact with Martina Corrigan to get involved to help Mr Haynes to review notes. Dr Gilbert advised he is happy to continue on with the SAI review.

Patricia Kingsnorth advised Dr Gilbert he was needed to complete the SAI review and could not afford to lose him at this stage.

Dr Hughes advised we are going through a completion process. Dr Hughes advised himself and Patricia had met with all the families and said the families were all exceptionally dignified considering the circumstances. Two families have lost their loved one and 2 are in the palliative phase of care.

Mr Gilbert said he could only imagine it being horrible having to explain to the families and relatives.

Dr Hughes advised they reassured all the families work would be complete and that the review team consisted of an external expert urologist.

Patricia Kingsnorth said it was important they keep the momentum going with the 9 cases.

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Craigavon Area Hospital
Tel: Personal Information redacted by USI
E-mail Personal Information redacted by the USI

Patricia Thompson advised Patient 5 was on the waiting list for review in December 2019 and again was not followed up , he was not a protected review.

Dr Hughes advised Patient 9 care was absolutely dreadful.

Patricia Kingsnorth thanked Patricia Thompson for input.

Dr Hughes advised when patients deteriorate they should be brought back to MDT for further discussion, it may be simple treatment. There seems to be a resistance to bring patients back. 4/9 palliative phase or died. They would have benefited from MDT input.

Patricia Thompson advised that she is only new to post and the consultant retired before she begin. Patricia advised that the general consensus was that the consultant personally did not like key worker involvement.

Dr Hughes asked if key workers were available. If they are available and kept out of the patients care is worse. It would have been wonderful for these patients to have had a key worker. If resources were there and they cannot avail of it paints a different picture. Most people do not understand what is happening , keyworker is more approachable and allows them to have a meaningful discussion. These patients were not given that opportunity.

Patricia Kingsnorth asked did most consultants use the specialist nurse/ keyworker?

Patricia Thompson advised her impression from hearing from others was that he did not like keyworker.

Dr Hughes advised specialist pay an important part in patients care and is astounded by this. Important patients get encompassing care and that SHSCT did not provide that when resources are there.

Patricia advised they will meet again next week.

Dr Hughes advised the report needs to consider the national regional standards, keyworker involved etc. Dr Hughes advised families were very dignified at meeting.

Patricia Kingsnorth agreed they were dignified, there was one family who expressed anger but advised they were scared and their dad has now had his surgery.

Dr Hughes agreed that was the best option for them as this was their concern. Dr Hughes asked Patricia Thompson that he hoped she did not find it too upsetting.

Patricia Thompson advised she found Patient 1 case quite upsetting .

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(b) More often (though not always) I was invited in at the end of the encounter to provide information, support and a contact number. This was not unique to any single Consultant.

(c) If I had a biopsy clinic, patient notes would have been set on a work counter with a request for me to meet the patient (located in the waiting area) and provide keyworker support in the form of written information, support and a contact number as soon as I was free.

(d) On occasions when I had not met the patient, I would have received phone calls over the following days from patients seeking clarification of the diagnosis/treatment plan which had been provided by the Consultant.

(e) At no time was there an expectation that I would attend any satellite sites where cancer diagnosis may also have been discussed (Banbridge Polyclinic, Armagh Community Hospital, South Tyrone Hospital or South West Acute Hospital SWAH). In recent times we have been able to provide a CNS to support the clinic at Armagh Community Hospital

(f) Nor was there an expectation that the CNS/Keyworker had the responsibility to ensure that scans were requested or onward referrals completed

50.5 Consultants managed the above challenges differently. For example, if I were not available Mr Glackin may have given out the pack with the contact number himself, Mr Haynes generally requested that the patient wait until I was available, while Mr O'Brien may only have invited me into the room if the patient required nursing intervention for example a dressing change, or for referral onto other services such as the community continence team or the palliative team. I cannot determine if Mr O'Brien gave the pack or contact number to the patient in my absence. This meant that, on occasions, I would have been involved periodically throughout the clinic and on other occasions, I would not have been involved at all. I am unable to explain the reasons as to why the Consultants adopted various approaches to this particular clinic. The time constraints of a clinic and competing challenges for the Consultant (needing to undertake another clinic or theatre session) may have contributed to these various approaches. At no stage did any of the nursing team within Thorndale Unit recognise or raise a concern that CNSs

during the SAI Review of the 9 urology patients and the Overarching Review, the Chair and I met with the Urology MDT members and some of them described noticing a considerable difference in resources in the Southern Trust in comparison with Trusts in England where there was good follow-up and where tracking was more robust, more of a priority, and had administrative support. One doctor advised us that there were weekly trackers who would liaise with consultants, enabling them to meet their cancer timelines whereas in our Trust the trackers were only funded in respect of 31-day and 62-day targets and not to act as a broader failsafe system. Please see:

107. 20210218 Notes of Meeting with MDT 18.2.2021

19.3 I think that communication or triangulation of knowledge was also poorer than it could have been. For example, I wasn't made aware in a timely manner of the MHPS process or of the recommendations that flowed from it. I was made aware verbally by Martina Corrigan, following the Dr [Personal Information redacted by USI] SAI, that there were measures in place involving administration staff monitoring the triage of letters and tracking of case notes involving Mr O'Brien. I was under the impression that this monitoring was working well. However, I was under so much pressure with the day-to-day work in governance that I didn't have time to check on it to assure myself that it was effective. I do not know if a broader information / knowledge base in this regard would have made a difference but it might have done.

19.4 The workload in Acute Services and Governance was heavy and staff were constantly trying to deal with the day to day pressures within busy hospitals. There simply wasn't enough time to do compliance audits regarding the adherence to recommendations arising out of all SAIs and complaints. This was a limitation. Audits were limited to compliance directly related to patient care, for example, audits of surgical site infections and infection rates for patients on ventilators (VAP). Whilst these are important, there also needs to be audits regarding the implementation of and adherence to recommendations and guidelines to protect patients and provide good standards of care

	Key Areas	Actions	Lead	Target Date	Update
	Key worker role	To ensure that every new urology cancer patient has a key worker identified To support full implementation of the key worker role by ensuring dedicated time for telephone and face-to-face reviews and provision of clerical support	MDT Team / Martina Corrigan	Nov 2016	Work ongoing to address
	Patient Information	To ensure that all patients receive the required information to support their journey To develop a MDT Leaflet	Urology CNS's	Oct 2016	A MDT leaflet has been developed and is now provided to all new patients
	Improve data collection to support information on clinical outcomes	Continue to collect high quality data via CaPPS	MDT Team	Ongoing	This is ongoing

1.9 As addressed in my answer to part (i) of this question, I was responsible for the governance in all aspects of Acute Services, which is a vast Directorate. It simply wasn't possible to have complete oversight of every Division and therefore I relied on the Assistant Directors of each Division and their Heads of Service to make me aware of any concerns.

1.10 As previously stated, I was aware that an SAI was being carried out by Dr Johnston into triage issues, but I wasn't fully aware of what those issues were. I had asked my line manager Dr Tracey Boyce, and Martina Corrigan, HOS for Urology, (I cannot recall the date but would guess it was in the summer of 2019) if there were any clinical issues with Mr O'Brien and was advised that the issues were purely administrative but that, once a patient was seen by Mr O'Brien, the care he provided was "gold standard". I was assured there was monitoring in place in relation to the triage of letters and storage of notes to prevent recurrence and that administrative support was in place. I was therefore reassured that there were no clinical patient safety issues and I believe that I was not informed about any other process involving Mr O'Brien (in particular, the MHPS process) during my tenure until September 2020.

1.12 As mentioned above, I believe that I wasn't aware until September 2020 (when I was asked to attend a Urology Oversight Meeting) that an MHPS process had been undertaken by the Trust in respect of Mr O'Brien during 2017 and 2018. This information was not shared with me at an earlier stage.

1.13 As also mentioned in my answer to part (i) of this question, during my involvement with the 9 SAIs and the overarching SAI review chaired by Dr Hughes, I provided weekly feedback to the Director of Acute, the Medical Director, and the Acute Senior Management Team involved in the Urology Oversight Meetings, which (I believe) duly informed a weekly / fortnightly meeting the Trust had with HSCB and DOH. The feedback I submitted related to any initial learning and themes coming out of the SAI Reviews. This was at the request of Dr Hughes, the Chair of the SAI Review. One of the issues discussed at a Review Meeting on 12 October 2020 was the inappropriate use of Bicalutamide instead of the recommended LHRH analogue. Mr Gilbert advised that this inappropriate treatment may have contributed to one patient's

Corrigan, Martina

From: Haynes, Mark [redacted]
Sent: 03 January 2020 14:47
To: Reid, Trudy; Carroll, Ronan
Cc: Connolly, Connie; Kingsnorth, Patricia; OKane, Maria; McClements, Melanie
Subject: RE: CONFIDENTIAL: SAI [redacted]
Attachments: Comments concerning the RCA Report on Review of SAI [redacted].docx; Assessment of Suspected Testicular Cancer.pptx

Within the document 'Comments concerning the RCA Report on Review of SAI [redacted].docx'nthe following statement (page 3) is included;

'…The recent waiting time for a first consultation for an urgent appointment was 85 weeks. For a routine consultation, it is over three years! Scrotal swellings considered benign by the referrer are routinely triaged by most as routine, without any imaging requested. Yet, seven of 77 such referrals (9%) have been found in a recent audit to have testicular tumours.'

I should highlight that this is not an accurate representation of the audit. The Audit was of red flag referrals for suspected testicular cancer with only 8 of 83 actually having a testicular tumour on US. This fact invalidates the point being made.

The powerpoint of the audit is attached.

Mark

From: Reid, Trudy
Sent: 18 December 2019 08:36
To: Carroll, Ronan; Haynes, Mark
Cc: Connolly, Connie; Kingsnorth, Patricia; OKane, Maria; McClements, Melanie
Subject: CONFIDENTIAL: SAI [redacted]
Importance: High

Good morning please see attached comments on SAI and supporting documentation. I will be sharing this information with the chair of the SAI as this is the consultants response to the factual accuracy checks we ask for as part of the SAI process.
There appears to be suggestions that harm has come to patients. Mark and Ronan have these concerns been escalate within SEC prior to this and if so have they been investigated? If not can you review the content of the attached documents to ascertain what detail we require to allow us review and decide the next steps, e.g. SAI screening if required?

Regards,

Trudy

Trudy Reid
Interim Assistant Director Corporate Clinical & Social Care Governance
Craigavon Area Hospital
SHSCT
Mobile [redacted]

Corrigan, Martina

From: Kingsnorth, Patricia [redacted]
Sent: 21 January 2020 10:11
To: Corrigan, Martina
Cc: Haynes, Mark; Carroll, Ronan
Subject: RE: recommendations urology SAI

Martina
Would you have a few minutes to discuss the recommendations below please?
Many thanks
Patricia

Patricia Kingsnorth
Acting Clinical Governance and Social Care Coordinator
Governance Office
Ward 2 Ramone
CAH
[redacted]

From: Haynes, Mark
Sent: 20 January 2020 14:14
To: Kingsnorth, Patricia; Robinson, Katherine; Corrigan, Martina; Carroll, Ronan
Subject: RE: recommendations urology SAI

Responses to the specific bits with my name on…

Recommendation 3
The Trust will develop written policy/guidance for clinicians and administrative staff on managing clinical correspondence, including email correspondence from other clinicians and healthcare staff. Katherine /Martina is there a policy or guidance or a process for managing clinical correspondence if not how easy is this to action?

This guidance will outline the systems and processes required to ensure that all clinical correspondence is actioned (receipt, acknowledged, reviewed and actioned) in an appropriate and timely manner. Martina is there an action plan consultants could follow?

An escalation process must be developed within this guidance. Martina Is there an escalation protocol ?

Monthly audit reports will be provided to Assistant Directors on compliance with this policy/guidance. Persistent failure to comply by clinical teams or individual Consultants should be incorporated into Annual Consultant Appraisal programmes.
Martina/ Mark If we have a process could it be formatted in a report

In the absence of written policy / guidance and escalation protocol, I cannot comment. I would imagine that if such a policy / guidance / escalation protocol existed, the SAI team would not have commented that;
'The Review Team noted that letters to Consultants are not tracked and there is no process in place to ensure they have been reviewed and actioned by Consultants.'
And that;

outcome. I shared this with the Urology Oversight Meeting the following Tuesday. Please see:

99. 20201020 Meeting

12. Did you ever feel that issues of governance and risk you raised were not dealt with properly or at all?

1. If yes, please provide all details, including the names of those to whom you spoke about the issues.

12.1 Not applicable.

2. If no, how did you assure yourself that issues raised by you were properly addressed?

12.2 As indicated at 11.3 above, I only raised one issue of governance and risk regarding Mr O'Brien: the Bicalutamide issue mentioned by Mr Gilbert in approximately October 2020. I raised it promptly through the Urology Oversight Meeting. I received assurances that the Trust was addressing this issue by taking steps to identify how many people had been prescribed the drug and by conducting a review of each relevant patient. I understand they also alerted the HSCB and DOH. The update on the progress of this issues was discussed as an agenda item in the weekly urology oversight meetings.

13. Are you aware of any issues of governance, either raised by you or others, being brought to the attention of the Board and/or any of the Board Committees?

13.1 As previously indicated in my answer to Question 1(i) above, I was aware that the Trust had escalated concerns regarding the practices of Mr O'Brien following his retirement in July 2020. I wasn't present at any Trust Board meetings or Governance Committee meetings but I was aware, through my attendance at the Urology Oversight Meetings, that the matter was being

understandably distressed. Dr Hughes and I agreed to keep the families informed of the progress of the SAI Review and to meet them midway through the Review and again at the end to share the findings with them.

ee. I was also involved in a lot of correspondence with Mr O'Brien's solicitors, who wanted copies of the notes for the 9 SAI patients, which were redacted to ensure confidentiality, along with the 9 Datix submissions, and the terms of reference for the SAI reviews including details of the Review Panel members. Dr Hughes also invited Mr O'Brien to be interviewed as part of the Review, but he declined. Dr Hughes agreed to (and did) provide a list of written questions for Mr O'Brien. No answer to the questions was provided, however, and in view of the need to avoid undue delay the report progressed without Mr O'Brien's input, with (I understood) the approval of the Trust SMT. Please see:

10.-13. 20210112 email re your client TS Live FID694915, A1-A3

14.-47. 20210306 Timeline to Tughans, 1-32

47a.-47b. 20201211email inviting AOB Pricipate SAI, A1

ff. As part of the SAI Review, Dr Hughes and I met with staff involved in the management of Urology and the Multidisciplinary Team including Mr Mark Haynes (Associate Medical Director for Surgery and Elective Care), Dr Shahid Tariq (Associate Medical Director for Clinical and Cancer Services), Dr Darren Mitchell and Professor Joe O'Sullivan (both Oncologists in Belfast), Mr David McCaul (Clinical Director for Cancer Services), Mr Anthony Glackin (Consultant Urologist), Mr Ronan Carroll (Assistant Director of SEC), Mrs Heather Trouton (Director of Nursing and AHP and former AD for SEC), and Mrs Martina Corrigan (Head of Services for Urology). We also met the Specialist Nurses as a group, to ensure that they didn't feel intimidated, and we also met the Multidisciplinary Team as a

Incidentally, he had only received some of the last documents requested as recently as 16th February?

A. DR. HUGHES: Yeah, I was not aware of that fact.

59 Q. Yes. I needn't open up the document to you, but it's recorded that he received the Datix material he had requested on 8th February and the full NICAR records on 16th February. Do you understand it took some seven weeks, I suppose, if you take the timeline from the 23rd December when he first started making requests for material, through to mid-February? 11:31 11:32

A. DR. HUGHES: I do understand. I should say the Datix reports were not part of our review. We received post triage, so we were not retrospectively reviewing how it came to be in our review process, so I am not quite sure why -- I can understand why some people would want to know that, but we certainly weren't asking questions about how a case was triaged into the process so I don't think that should have delayed the issue. 11:32

60 Q. It's recorded here:

"We are progressing well with comments in Service users A and B. Mr. Anthony is on leave next week and hopes to have comments to you on these two cases by the end of next week or the following week." 11:32

It's clear from this correspondence that Mr. O'Brien is intending to cooperate with you and is cooperating with you; is that fair?

A. DR. HUGHES: To that point, yeah.

my opinion, the Director of Acute, Mrs McClements, clearly made oversight a priority and demanded the same of me and my colleagues to ensure she was fully aware of anything going on within the Acute Directorate.

Urology Service

20.6 As stated in the first limb of this answer, the governance team was significantly under-resourced and this, I believe, was also true of the Urology Service. I believe that staff were so busy dealing with the day-to-day issues and backlogs that they accepted that their specialty was under-resourced and tried to get on with the job. This was clear to me from the meetings Dr Hughes and I had with the MDT and Specialist Nurses in the course of the 9 urology SAI Reviews. I do now believe, having been involved with those 9 SAI Reviews, that the issues with Mr O'Brien did not reflect the service provided by the other staff in the urology service. I also got the impression that some staff members in urology were afraid to challenge a senior consultant like Mr O'Brien, with so many years of experience.

108. 20210222 Notes of Meeting CNS 22.2.21

20.7 I think that the positives I take from the 9 SAI Reviews, following discussion with some of the Consultant Urologists, is that they did escalate concerns when they discovered practice issues and concerns regarding patient care. I think it is unfair to judge the Urology Service now with how it was prior to 2020 when the concerns were raised. I think that the systems and processes in place by the time of my retirement were much more rigorous than when I first took up post at the beginning of 2019, when they weren't fit for purpose.

21. What, in your opinion, could have improved the effectiveness of the governance structures and systems in place during your tenure?

21.1 More resources could have improved the efficiency and effectiveness of governance systems and structures of the Acute Directorate. Some particular reflections on this are summarised below.

Contact information urology SAI

Name	Contact Details	Date contacted	Details of conversation	GP
Patient 1 (RIP) Personal Information redacted by USI	NOK Patient 1's Daughter Personal Information redacted by the USI	Informed 26/10/2020	I spoke to Mr Patient 1 daughter and offered my sincere condolences on the death of her father. I advised that Mr Haynes had spoken to her and her father at the clinic appointment in July and advised the Trust would be reviewing your care. I advised that this review will include of a small group of people. There has been some media coverage and did not want to distress her or her mother about the review. I advised on the chair appointed and he will want to meet with all the families to participate in the review. Patient's Daughter is Personal Information redacted by USI but has zoom and will be happy to meet with the chair via zoom. I will follow up with a letter.	
Patient 9 Personal Information redacted by USI Personal Information redacted by USI	Personal Information redacted by USI NOK Personal Information redacted by USI	Informed 26/10/2020	Introductions advised Mr O'Donaghue spoke to you in the clinic on 6 July 2020 and advised we would be reviewing your care. Mr Patient 9 was not aware of this discussion taking place. I apologised as I thought he was contacted. Advised about the SAI review and that it also include a small number of people and the chair will be in contact with you by letter to invite you to participate in it. Thanked me for the call.	

22. Do you consider that, overall, mistakes were made by you or others in handling the concerns identified? If yes, please explain what could have been done differently within the existing governance arrangements during your tenure? Do you consider that those arrangements were properly utilised to maximum effect? If yes, please explain how and by whom. If not, what could have been done differently/better within the arrangements which existed during your tenure?

22.1 The SAI Reviews for the 9 urology patients and the Overarching Review identified significant failures in Trust systems and processes which to contributed to patients coming to harm whilst under the care of the Urology Service. Clearly, our systems should be designed and operated to prevent harm and keep patients safe. It is true that other MDTs worked more efficiently than the Urology one but it is also the case, I believe, that they had considerably more resources. For example, Breast MDT had the benefit of oncologists being present at the MDT.

22.2 Regarding one professional's lack of adherence to cancer pathways and recommendations from the MDT, clearly the system should have been able to pick up such non-compliance. A better system would have had a mechanism for following up the actioning of test results and referrals to other services recommended by the MDT. Lack of resources and the lack of robust processes contributed to that in my opinion.

22.3 Regardless of one person's reluctance to practice appropriately, the system should have had measures in place to prevent that happening or to stop it if it occurred.

22.4 I believe that the resources required to 'failsafe the system' could, largely or perhaps entirely, comprise Band 3 clerical staff. It doesn't require professionals to do it, just a clear process (standard operating procedure) to spell out what steps need to be taken and what actions need to occur if a missed step or breach is recognised.