Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Notice 8 of 2022

Date of Notice:

Note: An addendum amending this statement was received by the Inquiry on 1 June 2023 and can be found at WIT-96714 to WIT-96750. Annotated by the Urology Services Inquiry.

Witness Statement of: Dr Gillian Rankin

I, Gillian Rankin, will say as follows:-

General

[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 an explanation of your role, responsibilities and duties, and should provide a detailed description of any issues raised with you, meetings attended by you, and actions or decisions taken by you and others to address any concerns. You should detail all communications between you and others on matters falling within the Inquiry Terms of Reference. It would greatly assist the Inquiry if you would provide this narrative in numbered paragraphs and in chronological order.

1.1 I was appointed interim Director of Acute Services on 1 December 2009. I was appointed as Director of Acute Services on 1 March 2011 and I retired from the post on 31 March 2013. The post held responsibility for all acute services in Craigavon Area Hospital and Daisy Hill Hospital with the exception of paediatrics and neonatology services. There was also a day surgery suite in South Tyrone Hospital which was managed through the theatre service. The role covered both operational and governance responsibilities of the range of services including medical and surgical services, maternity services, diagnostic, theatre and intensive care services,

Urology Services Inquiry

[74] Given the Inquiry's Terms of Reference, is there anything else you would like to add to assist the Inquiry in ensuring it has all the information relevant to those Terms?

74.1 I have nothing further to add to the responses already set out in response to Questions 1 -73.

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

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

Signed: _____Gillian Rankin_____

Date: 14th June 2022

Urology Services Inquiry

USI Ref: Section 21 Notice Number 8 of 2022

Date of Notice: 14th April 2022

Addendum Witness Statement of: Gillian Rankin

I, Gillian Rankin, will say as follows:-

I wish to make the following amendments to my existing response, dated 14th November 2022, to Section 21 Notice number 8 of 2022.

1. I would like to amend paragraph 6.2 (WIT-15787) to add the line that appears in red and underlined text below:

> '*6.2 Director of Acute Services reported directly to the Chief Executive - Mairead McAlinden. The role held responsibility for acute services in Craigavon Area Hospital (CAH), Daisy Hill Hospital (DHH) and Day Surgical Services in South Tyrone Hospital (STH). All hospital services including support services in CAH and DHH, with the exception of paediatrics and neonatology, came under the remit of the role. The directorate had 5 Assistant Directors leading divisions all of which were responsible for the staff from all disciplines and services across both CAH and DHH and where appropriate STH. These Assistant Directors all had several Heads of Services managing smaller groups of services. The 6th Assistant Director assisted the Director in strategic issues and the Best Care Best Value Trust Programme. The Head of Pharmacy for the Trust also had a direct reporting relationship to the Director of Acute Services. The Director role was supported by the appointment of a consultant from the division as an Associate Medical Director (AMD). Each AMD was supported by one or more Clinical Directors (CD) depending on the spread of specialties in the division. These divisions were:*

Urology Services Inquiry

31/5/2013. 20130124 Learning Letter re 'Importance of taking action on x-ray reports', 20/11/2012.

While I have no data to demonstrate the performance data, the plan was to be able to identify those radiology reports which had not been read within an agreed timescale through the red flag process and subsequent software generated report. The implementation and subsequent audit of this was to report b 31/5/2013. 20130124 Learning Letter re 'Importance of taking action on x-ray reports', 20/11/2012.

Please see:

1. *20120914 Management of Results SOP*
2. *20120914 Management of Results SOP A1*
3. *20120914 Management of Results SOP A2*
4. *20110120 E with SAI and SOP*
5. *20110120 E with SAI and SOP A1*
6. *20110120 E with SAI and SOP A2*

Statement of Truth

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

Signed: Gillian Rankin

Date: 1 June 2023

(Information on the length of the period over which we met regularly was fact checked with Mr Mackle and Mrs Trouton at my request.)

29.3 These meetings were used to discuss and seek agreement on the changes necessary to address the range of issues set out by the Team South Implementation Plan. These issues are outlined in response to Question 15. These meetings were chaired by myself as Director and supported by the AMD, AD, Head of Service and an AD or other staff from the Performance and Reform Directorate. Other senior staff who attended for specific issues included the specialty urology nurses, Director of Performance and Reform, AD for HR aligned to Acute Services, Medical HR re job planning, Senior Finance office aligned to Acute Services.

29.4 Some of these weekly meetings became a review meeting with the HSCB senior staff present in order to discuss the progress made with regard to implementation of Team South.

29.5 The issues of changing the behaviour of the consultant team to meet the required new to review ratio of patients and new clinic templates in outpatient clinics, to increase the day case rate and lower the inpatient elective workload, and to meet BAUS guidelines were exceptionally difficult. Whilst agreement may appear to have been reached on one of these issues at one week's meeting, there was retrenchment from this position at the following week's meeting. It was unusual to require weekly meetings for such a long period of time to reach agreement on such issues. It was also unusual for the Director to have to formally write to each consultant setting out the requirements for change tailored to each individual's practice. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101022 Ltr to AOB Reg Uro Imp, 20101022 Ltr to MA Reg Uro Imp, 20101022 Ltr to MY Reg Uro Imp.*

29.6 It should be noted that the HSCB had previously undertaken a study of new to review ratios for all specialties in approximately 2008-2009, and indicated to Trust's the requirements by speciality as determined by the national specialty professional

HSC Southern Health and Social Care Trust

Quality Care - for you, with you

Memorandum **By E-Mail**

To: Mr Aidan O'Brien, Consultant Urologist

From: Mrs Heather Trouton, Assistant Director of Acute Services – Surgery and Elective Care

Date: 1st July 2011

Subject: **Issues and Actions from Meeting held on 9th June 2011**

Following our discussions on Thursday 9th June 2011 please see following a summary of our discussions and actions agreed.

1. Dr Rankin outlined the Trust requirement for updated Job Plans to be complete prior to end of June 2011. Dr Rankin also placed the meeting in the context of the Regional Urology Review and the necessity of demonstrating the provision of an effective, efficient and productive Urology Service if further funding was to be secured from the Regional Board. This productivity was also set in the context of the SBA Capacity Modelling exercise underway for all specialties across all Trusts.

2. **Job Planning**
   - Mr O'Brien to submit current breakdown of activities to Mr Mackle for planning into updated Job Plan as per Trust action for all Consultants Trust wide to agree an updated Job Plan by end of June 2011.
   - Update – this was submitted on Thursday 16th June 2011. Draft Job Plan to be constructed for discussion.

3. **Review Backlog**
   - Heather Trouton to meet with Mr O'Brien to discuss way forward in managing review backlog in a timely manner. Heather Trouton to set up meeting. Also to ensure that responsibility is taken to manage all outpatient appointments in such a way as to only review those who clinically require review and thereby reduce the formation of a review backlog unnecessarily.
   - A discussion was also has regarding appropriate communication with patients who have had their review appointment delayed due to the current backlog or review appointments.

Surgery and Elective Care Division, Acute Services Directorate,
Admin Floor, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
E-mail: [redacted] Personal Information redacted by USI

responses to questions below, with all the available communications of email, memos, letters and reports attached. The full details can be found mainly in response to Questions 13, 29, 50, 57 and 64.

1.10 One of the clinical issues in relation to Mr O'Brien resulted in a 'Local Review of Cystectomies' under the Maintaining High Professional Standards Process in 2010.

1.11 The other issues were managed through the rigorous application of existing systems of data reporting and developing new methods of working to mitigate the risks of the behaviour which was causing the issue.

1.12 On reflection, while there was a significant demand pressure on the urology service, there was a general resistance to change in clinical behaviour in the service. Nonetheless, when change was required in order to implement improvements for patients and to implement Team South Urology as part of the regional Review of Urology, two consultants did make these changes in their personal behaviour. However, Mr O'Brien did not always make the changes required and there were times when change was agreed and implemented for a period of time before he reverted to the previous behaviour. He therefore was unable to, or chose not to, amend his behaviour.

[2] Please also provide any and all documents within your custody or under your control relating to the terms of reference of the *Urology Services Inquiry* ("USI"), except where those documents have been previously provided to the USI by the SHSCT. Please also provide or refer to any documentation you consider relevant to any of your answers, whether in answer to Question 1 or to the questions set out below. If you are in any doubt about the documents previously provided by the SHSCT you may wish to discuss this with the Trust's legal advisors or, if you prefer, you may contact the Inquiry

2.1 I have retained no documents from the Southern HSC Trust which relate to my tenure in either of the posts of the Director of Older People and Primary Care or the Director of Acute Services. Any documents I reference or attach below are documents

c. Cancer pathways: 14 day for breast cancer, and 31 and 62 pathways for all other cancers;
d. The review backlog numbers and trends.

29.10 Actions by specialty were identified at a high level for more detailed planning after the meeting.

[30] Were there any informal meetings between you and urology staff and management? If so, were any of these informal meetings about patient care and safety and/or governance concerns? If yes, please provide full details and any minute or notes of such meetings?

30.1 Virtually all meetings with urology staff regarding patient care and safety were scheduled meetings due to the need to identify a suitable time which did not impact on the consultants' clinical schedules. These meetings were scheduled with the urgency required and all are detailed in responses to other questions. The only two informal meetings that I can recall are detailed below.

30.2 These two meetings, which were not scheduled but which were required on an urgent basis, were as follows:

a. A meeting at my request of myself as Director, Mr Mackle as AMD and Mr O'Brien, Consultant urologist. The meeting took place at the end of a working day after Mr O'Brien had completed his main theatre list. I had been notified that day that Mr O'Brien had not been triaging his red flag referrals and was travelling to the BAUS Conference in Barcelona the following day. Mr Mackle and myself impressed on Mr O'Brien the requirement and importance of triaging red flag referrals. The permission to attend the conference the following day was refused unless the red flag referrals were triaged before travelling the following day. This resulted in the red flag referrals being triaged and Mr O'Brien travelled to the conference. I have no notes of this short discussion which took place in late April 2010. The red flag referrals continued to be

triaged appropriately for a period of time. (The approximate timing of this meeting with Mr O'Brien was confirmed to me by Mr Mackle.)

b. The second meeting was at my request. I had been hearing from several people that Mr O'Brien did not appear to be himself. He was operating in theatre that day, and I left a message for him to please come and have a chat with me on his way out of the hospital after completing his theatre list. At around 6pm, Mr O'Brien joined me in my office. I said there were people concerned about him and I was therefore concerned for his welfare. I asked if there was anything which I could help him with or did he need to talk to anyone in the Trust or seek help with occupational health. He said he did not need help and was very surprised at the approach from me, but thanked me for it. I have no notes of this meeting and cannot date when it took place, except that it was likely to have been after the period of weekly /fortnightly meetings with the urologists to agree the implementation plan for Team South Urology.

30.3 The existing weekly /fortnightly meeting over approximately a 16-month period to agree the Implementation Plan for Team South was a forum in which other concerns could be raised by anyone attending the meeting.

30.4 In response to Question 31 below, I have outlined the different ways all members of staff could, and did, raise issues informally.

[31] During your tenure did medical and professional managers in urology work well together? Whether your answer is yes or no, please explain by way of examples regarding urology.

31.1 The medical and professional managers worked openly together and there was a sound and good relationship. There would have been almost daily contact between these people even if there were no meetings. The Director's office, all the Assistant Directors, and many of the Heads of Service (including urology) were based side by side in a single corridor on the first floor at the front of the hospital,

something that may be appropriate. And bearing in mind the context that the urgent case has to now ~~to~~ wait something like 84 weeks to be seen for a first consultation. And if they are suffering from, let's say something relatively simple like recurrent urinary tract infections, this person has had six in the past eight months and they haven't any ~~anti-biotic~~ antibiotic prophylaxis -- I was doing this yesterday -- you know, you contact the patient. You contact the GP. You write them to them. You get them started -- you get an ultrasound scan done, which creates more work because the result comes back to you because you requested it. And then you are talking 15 minutes.

DR JOHNSTON: This process that was put in place was in May 14 but actually the difficulty with triaging predated that --

MR O'BRIEN: It did, yes.

DR JOHNSTON: -- by, depending on what you hear, decades. It's been a chronic problem going back many, many years.

MR O'BRIEN: Decades.

DR JOHNSTON: Yes, according to many of the staff there was difficulty and not always difficulty only with yourself. It was cropping one with -- urology was particularly bad I understand and it occurred on occasions with some of the consultants, but they had particular ~~difficult~~ difficulty getting you to agree and to do this triaging of the non-red flag cases, if that's how we could describe them.

If these patients were not to be triaged by you because it was time consuming, what was going to happen to them?

MR O'BRIEN: Before the default went in --

DR JOHNSTON: That is what -- I am talking about the default in the past.

MR O'BRIEN: Prior to the default?

DR JOHNSTON: Yes, prior to that. It went on for many, many years. Gillian Rankin had various meetings with you I understand to try and get you to triage them and you --

MR O'BRIEN: I don't recall having one single meeting with Gillian Rankin about it.

DR JOHNSTON: She clearly remembers some quite difficult meetings with you.

MR O'BRIEN: She had difficult meetings with me about the number of people we -- and with my colleagues. Terrible meetings. I am not going into that detail but I don't have a memory --

DR JOHNSTON: She didn't go into any detail either, just to let you know, but she did describe them as very difficult.

MR O'BRIEN: They were difficult and contributed significantly to our third colleague leaving.

11 June 2018

FILE REFERENCE: 13

AIDAN O'BRIEN
Accompanied by MICHAEL O'BRIEN
DR J JOHNSTON

~~**(DR J JOHNSTON)**~~

Formatted: Strikethrough

Audio Transcription Prepared by:

Angela Harte
Personal Information redacted by USI

Heads of Service supported by a senior member of Performance and Reform staff with the latest data. Actions were discussed and agreed and if more detailed discussion was required then a specific meeting was set up to discuss the necessary action. These issues were also routinely discussed at the Director's 1 to 1 meetings with each AD and each AMD. The notes of both sets of meetings are no longer available.

iii. What was your role, if any, in that process?

13(iii)(a) The Director was responsible operationally for the reduction in the Review backlog. Most actions were undertaken by the surgical division. Some evidence of actions taken to address the issue by the Director were:

i. To explore the interface with primary care to seek new review pathways, where clinically safe, to review patients in primary care. This could reduce the numbers of patients being reviewed in secondary care. *Relevant document located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100727 Mtg re Uro Primary Care.* This was subsequently followed by a small workshop involving the consultants and a group of GPs to discuss 3-4 clinical pathways which had been drafted for discussion. Emails regarding this workshop are attached. Emails regarding this workshop are *located in S21 No 8 of 2022, 61. 20101130 E Urology Pathway Meeting.*

ii. The evaluation of specialties against the Review Backlog Checklist was sought by myself from each AD. The response from the AD for SEC on 3 August 2010 is attached, and it states that the discussion in the division identified ''compliant with a lot of the suggestions, or audits/work in place to provide some of the information, it did provide some new food for thought.'' *located in S21 No 8 of 2022, 62. 20100803 Review Backlog Checklist, 63. 20100803 Review Backlog Checklist A.*

iii. Seeking the involvement across divisions in the development of clinical pathways which needed to reflect the patient journey from primary care,

through the emergency department and then appropriate hospital treatment. The email from Mr Conway, AD for Medicine and Unscheduled Care ('MUSC'), sets out the key points from the AMD for Emergency Medicine regarding some draft urology clinical pathways which were in development. *Relevant document can be located at S21 No 8 of 2022, 64. 20100915 Feedback on draft Urology pathways.*

iv. A meeting chaired by myself on Outpatient Clinics and the Review Backlog Checklist with all ADs on 21 September 2010. My email regarding this and the Review Backlog Checklist are attached.

v. Formal discussion and subsequent letters to each consultant regarding the New to Review ratios for their patients. The data published in the regional Review identified that the New to Review ratios for consultants in the Southern Trust were higher than their colleagues in other Trusts. This therefore was a contributing factor to the Review Backlog and needed to be addressed. After discussion with the consultants at a Team South Project Team meeting letters were sent to each consultant. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101022 Ltr to AOB Reg Uro Imp, 20101022 Ltr to MA Reg Uro Imp, 20101022 Ltr to MY Reg Uro Imp.*

vi. A further meeting was chaired by myself on 9th June 2011, which was attended by Mr O'Brien, Mr Mackle, AMD, and Mrs Trouton, AD. The review backlog was one of the issues discussed and further action was discussed. The action notes state: ''Also to ensure that responsibility is taken to manage all outpatient appointments in such a way as to only review those who clinically require review and hereby reduce the formation of a review backlog unnecessarily.'' ''A discussion was also had regarding appropriate communication with patients who have had their review appointment delayed due to the current backlog of review appointments.'' The Issues and Actions from this meeting held on 9th June 2011, sent on 1 July 2011 to Mr O'Brien is attached. *Relevant documents located in Relevant to*

iv. Did the plan achieve its aims in your view? If so, please expand stating in what way you consider these aims were achieved. If not, why do you think that was?

13(iv)(a) From memory, my recall is that there were periodic improvements in the review backlog in urology, but it was not possible to sustain these. This was in part due to the following factors:

i. Increasing demand which was greater than the service could treat;

ii. Insufficient clinic sessions available to review all those patients in the backlog given that the 3 consultants were working full time and working additional in house sessions at weekends/evenings to treat patients needing day case or inpatient surgery;

iii. Insufficient progress was made on some of the actions required to fully address the backlog - an example of this was that both Mr Young and Mr Akhtar agreed to amend their clinic templates but Mr O'Brien refused to amend his clinic templates in October 2010. The clinic templates for all 3 consultants were amended to reflect the BAUS guidance with effect from mid November 2010. However, Mr O'Brien's clinics started to overrun by 2 hours for each clinic and this was not a sustainable position for the associated nursing and support staff needed at each clinic. The result was that the number of new patients per clinic for Mr O'Brien was then reduced by 2 new patients. This meant that Mr O'Brien saw 5 fewer new patients each week than if he had adopted the BAUS guidelines for clinic templates; and the number of reviews required would have reduced if he had agreed to move from his ratio of 1:2.04 and to adopt the BAUS guidelines of a new to review ratio 1:2;

with each consultant. *Relevant document located at Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101206 Uro Issues re Long Wait Pts*

28.3 Specific meetings not held on a regular basis included the following:

a. 1 December 2009 meetings re range of governance issues chaired by the Chief Executive, with the Medical Director, AMD, AD, Acting Director of Performance and Reform, AD of Performance, Interim Director of Acute Services. The range of issues on the agenda included:
    i Demand and capacity and the need to optimise the use of clinical sessions;
    ii Quality and safety - Medical Director to discuss with Mr Fordham seeking an urgent professional opinion on:
        A The appropriateness and safety of the current practice of IV antibiotics;
        B Triage of referrals and 1 consultant refusing to meet the current standard of triaging within 72 hours;
        C Red flag requirements and 1 consultant refusing to adopt the regional standard that all potential standards require a red flag and are tracked separately;
        D Chronological management of theatre lists for theatre with 1 consultant keeping patients' details locked in the desk.
    iii Action agreed that if there was no compliance, correspondence would be sent regarding the implications of a referral to NCAS if appropriate clinical action was not taken. *The relevant document can be located in S21 No 8 of 2022, 58. 20091201 Uro Service Mtg Notes.*

b. 7 December follow up meeting with Mr Young, Consultant Urologist after 1 December meeting. Key points of discussion are set out. *Document located in Relevant to HR, reference no 35, 20091207 Ref35 - Meeting re Urology Service*

laboratories, hospital support services such as patient and staff food, domestic and portering and decontamination services.

1.2 Issues in relation to the urology service were raised with me on my first day in post i.e., 1st December 2009. This was through a meeting chaired by the Chief Executive, which alerted me to the current and on-going issues. The regional Review of Urology had reported but was not yet signed off by the Minister. The development of the Implementation Plan for Team South Urology had commenced and I subsequently chaired a weekly /fortnightly meeting with the consultants involved to get agreement on the implementation plan and its implementation.

1.3 In early 2010, I commenced a weekly performance meeting with the full system of Assistant Directors (ADs) and Heads of Service in order to lead the weekly review of how each specialty was delivering on the various clinical elements of the Integrated Elective Access Protocol. This required 'deep dives' by services in terms of data and ensured a daily focus on delivering the activities required by the commissioner, HSCB, and agreed in the Service and Budget Agreement.

1.4 In early 2010, I also commenced two meetings on governance. These were both held monthly. One of these included the Associate Medical Directors and ADs in a review of all the data used in the governance of services. The second meeting included the ADs and used the same reports with a deeper review of the data updated to the previous month.

1.5 These processes of regular meetings reviewing reports and data on both performance and governance provided collective energy and held the system to account in a supportive system for delivery of safe and high quality care. The emphasis was on quality improvement and learning from mistakes and this was evidenced through the Trust Review of Clinical and Social Care Governance led by the Chief Executive in 2010.

1.6 With regards to urology there were several issues regarding the service and some specific issues in relation to a single consultant. The key issues for the service

with each consultant. *Relevant document located at Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101206 Uro Issues re Long Wait Pts*

28.3 Specific meetings not held on a regular basis included the following:

a. 1 December 2009 meetings re range of governance issues chaired by the Chief Executive, with the Medical Director, AMD, AD, Acting Director of Performance and Reform, AD of Performance, Interim Director of Acute Services. The range of issues on the agenda included:
    i Demand and capacity and the need to optimise the use of clinical sessions;
    ii Quality and safety - Medical Director to discuss with Mr Fordham seeking an urgent professional opinion on:
        A The appropriateness and safety of the current practice of IV antibiotics;
        B Triage of referrals and 1 consultant refusing to meet the current standard of triaging within 72 hours;
        C Red flag requirements and 1 consultant refusing to adopt the regional standard that all potential standards require a red flag and are tracked separately;
        D Chronological management of theatre lists for theatre with 1 consultant keeping patients' details locked in the desk.
    iii Action agreed that if there was no compliance, correspondence would be sent regarding the implications of a referral to NCAS if appropriate clinical action was not taken. *The relevant document can be located in S21 No 8 of 2022, 58. 20091201 Uro Service Mtg Notes.*

b. 7 December follow up meeting with Mr Young, Consultant Urologist after 1 December meeting. Key points of discussion are set out. *Document located in Relevant to HR, reference no 35, 20091207 Ref35 - Meeting re Urology Service*

consultant supported by a specific scheduler in the administrative staff. The process for scheduling Mr O'Brien's patients for surgery was changed to include the Head of Service in addition to the Operational Support Lead for Surgery and Elective Care.

c. Answered above at b.

d. The scheduling of individual patients for a specific day case list and inpatient list on a specific day had been previously undertaken by Mr O'Brien with his secretary. No one else had been involved, or perhaps been allowed to be involved, in this process. The process implemented to address the issue was that the Head of Service and the Operational Support Lead (OSL) for SEC would work with Mr O'Brien to schedule patients for each list. Mr O'Brien chose to use a different type of ranking of urgency which had 4 levels rather than was the usual practice of 3 levels. (Mrs Martina Corrigan confirmed for me at my request that this was the process put in place to manage the booking of Mr O'Brien's patients for surgery.) This on occasion, resulted in the amending of a patient's urgency ranking for surgery, resulting in minor changes in dates for a patient's surgery. These changes linked to the clinical indication for surgery necessarily are the judgement of the clinician.

e. The assurance that these systems were working as anticipated was through the OSL and Head of Service who reported to the AD, and myself. The assurances were tested by an evaluation of all those patients on the waiting list for surgery with particular reference to those waiting for surgery due to a diagnosis of cancer. In the detailed review of long waiting patients undertaken on a frequent basis the length of waits against the referral date was reviewed as a matter of routine in order to identify any patients waiting outside their order by urgency and chronology.

f. Answered at e above.

c. 7 December follow up meeting with Mr O'Brien, Consultant Urologist after 1 December meeting. Key points of discussion and the necessary actions are set out with agreed actions by Mr O'Brien to review current patients waiting to determine if urgent or routine, to put all urgent patients on to immediate lists, and other immediate actions with key staff. *Document located in Relevant to HR, reference no 35, 20091207 Ref35 - Urology Mtg*.

28.4 Other specific meetings were held with individual clinicians and these will be detailed in subsequent question responses.

28.5 Given the time commitment required to work with urology clinicians in order to work through all the issues set out in the Urology Team South Implementation Plan over an intensive period of 16 months, it is possible to say that the Director spent considerably more time with the urology clinicians than the clinicians in any other specialty in acute medicine across a range of over 16 specialties across both hospitals.

[29] Please set out the details of any weekly, monthly or daily scheduled meetings with any urology unit/services staff and how long those meetings typically lasted. Please provide any minutes of such meetings.

29.1 Specific meetings with urology staff included the following.

<u>Weekly / Fortnightly meetings on Implementation of Team South Plan</u>

29.2 With regard to the implementation of the Team South Plan this required weekly/fortnightly meetings to which the 3 consultants were invited and which were attended usually by at least 2, if not 3, consultants. The weekly/fortnightly meeting was timed in order to best suit the consultants with regard to their fixed clinical sessions of outpatient clinics and theatre lists, and lasted between 1-2 hours. These meetings took place over a period of approximately 16 months until early 2011 with occasional meetings cancelled due to leave of key people or other pressures.

Business Case for Team South Urology approved (July 2011). 3 urologists will be in post from November 2012.; Outpatient Review Backlog -the longest waits remain in urology and ophthalmology. Actions taken to address this are set out.'' *The relevant document can be located in S21 No 8 of 2022,* 57. *20121204 CRR.*

12.5 There were occasions when the service performance required a specific meeting led by the Chief Executive with the Medical Director and the Director of Acute Services. *The relevant documents can be located in S21 No 8 of 2022, 58. 20091201 Uro Service Mtg Notes and in Relevant to HR, reference no 35, 20091207 Ref35 - Meeting re Urology Service and 20091207 Ref35 - Urology Mtg.*

12.6 The Trust also analysed the demand against the capacity available in order to understand the capacity gap. This was then agreed by the Director of Performance and Reform with the HSCB. A backstop position was agreed for the Trust service to meet i.e., a new wait time in weeks which was outside of the time standards of the IEAP. It was also agreed with the HSCB how to treat the remaining patients whether by additional in-house theatre lists (Waiting List Initiative WLI) and/or referral to the Independent Sector for in year treatment. *The relevant document can be located at Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100430 E re Regional Uro Review.*

12.7 Evidence of additional meetings and actions regarding the urology service meeting the IEAP performance targets to include emails:

a. 27.7.2010 Minutes of meeting regarding the interface between urology and primary care to discuss pathways with primary care for review patients which includes actions and person responsible.
b. 5.10.2010 email of request to increase the number of cystoscopies per session and response from service that there was no obstacle to increasing the number, in order to address long waits for urology diagnostics

c. 22.9.2010 email from Aldrina Magwood, AD in Performance and Reform regarding the actions needed and support from Performance and Reform to address the urology cancer pathway delays

d. 4.1.2010 email from Head of Service to AD and Director regarding the work with Mr Young, Consultant Urologist and Service Lead on long waiting cystoscopies.

On 9th June 2011 I chaired a meeting with Mr O'Brien, Mr Mackle AMD and Mrs Trouton, AD to discuss a range of issues including performance to meet the requirements set by the HSCB for Team South Urology, review backlog, patient admission for surgery, urodynamics, pooled lists and the cancer pathway. The Issues and Actions from the meeting which were sent to Mr O'Brien on 1st July 2011 are attached. *The relevant documents can be located at Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100727 Mtg re Uro Primary Care, 20101005 E re Cystoscopies, 20100922 Uro CA Pathway, 20100909 E re Urology Cancer Pathway, 20110701 Actions from Mtg to AOB K.*

[13] The implementation plan, *Regional Review of Urology Services, Team South Implementation Plan*, published on 14 June 2010, notes that there was a substantial backlog of patients awaiting review at consultant led clinics at that stage and included the Trust's plan to deal with this backlog.

I. What is your knowledge of and what was your involvement, if any, with this plan?

II. How was it implemented, reviewed and its effectiveness assessed?

III. What was your role, if any, in that process?

IV. Did the plan achieve its aims in your view? If so, please expand stating in what way you consider these aims were achieved. If not, why do you think that was?

Southern Health and Social Care Trust

Meeting re Urology Service

Monday 7 December 2009

Action Notes

Present:
Dr Patrick Loughran, Medical Director
Mr Eamon Mackle, AMD – Surgery & Elective Care
Dr Gillian Rankin, Interim Director of Acute Services
Mr Aiden O'Brien – Consultant Urologist

Key points of discussion:

1. The Trust expects in line with the N I Integrated Elective Access Protocol, that all patients will be treated by clinical priority and chronological order. Those patients on Mr O'Brien's list as clinically urgent may not be clinically urgent. No agreed process in place with Consultants and junior staff on what is urgent or routine. If juniors designate as urgent wrongly, the patient status is not amended to routine. Agreement to review whether urgent or not by Monday 14th December. **ACTION: Mr O'Brien.**

2. Agreed to put all urgent patients on to immediate lists. **ACTION: Mr O'Brien**

3. Current problems perceived in system:

   - Patients are getting letters of offer from IS even though they have already received an in-house appointment.
   - Clinical management plans are not accurately put on PAS eg. Flex. Cystoscopy planned for annual review is booked for 3 months.
   - Suggestion of separation of dictation and onward management/booking. **ACTION: Review and process mapping of systems – Heather Trouton.**

4. Pooling of lists is acceptable if patient consents, and is aware that may be treated more quickly by another surgeon. Need to agree who has clinical responsibility post operatively (original surgeon or operating surgeon). **ACTION: Mr Mackle and Urologists.**

   The Urologists need to agree which patients/conditions can be put on a pooled list.
   ACTION: Urologists and Heather Trouton.

5. **Red Flag System**
   The N I Standard is that patients with potential cancer are tracked by the red flag system to ensure they are seen within designated timescales. This system is not used at all at present, mainly on principle because the system is blunt and does not grade the degree of clinical priority across all red flags; nor does it reconcile with non-cancer clinically urgent.

   The use of red flags is mandatory and reflects clinical evidence. (NICE and NICAN). Agreement to develop a sub-division of red flags for use in specialty. **ACTION: Mr Mackle and Urologists.**

6. Need to clarify what POA hold signifies against a patient on waiting list; and whether if a patient is not medically fit for a procedure the clock stops. **ACTION – Heather Trouton**

7. **Pre-Op Assessment**
   Needs review as patients can be called unnecessarily.

8. Confidence in Trust destroyed due to ward reconfiguration.

clinics held by Mr O'Brien. This resulted in 2 fewer new patients being seen in each clinic. This is evidenced by the template for booking outpatients used by the RBC to book each consultants' outpatient clinics.

63.6 Failure to read test results before filing of patient notes:

a. I have no evidence to identify if this issue was addressed satisfactorily by Mr O'Brien, after he was clearly informed that this was a consultant responsibility to undertake on a timely basis. If the reporting process from the radiology system as set out in response to Question 62 (vi) was implemented, this would have remedied the position and provided the opportunity for regular monitoring.

[64] Did Mr O'Brien raise any concerns regarding, for example, patient care and safety, risk, clinical governance or administrative issues or any matter which might impact on those issues? If yes, what concerns did he raise and with whom, and when and in what context did he raise them? How, if at all, were those concerns considered and what, if anything, was done about them and by whom? If nothing was done, who was the person responsible for doing something?

64.1 To my knowledge, Mr O'Brien raised a total of concerns across 3 occasions regarding patient care and safety during my tenure in post. Two of these concerns were raised by Mr O'Brien in response to requests from myself as Director of Acute Services regarding clinical behaviour. There was one concern regarding patient safety raised by the 3 consultant urologists including Mr O'Brien. This was raised in a letter on 18th January 2010. The concerns are detailed below along with the action taken in response:

a. I received a letter sent on 18 January 2010 from the 3 consultant urologists including Mr O'Brien, outlining concerns regarding the potential appointment of a locum consultant urologist in order to help address the urgent list of patients awaiting surgery. The letter also raised the issue of ''compromised inpatient care and safety as a result of the recent ward reconfiguration''. The action taken

was an immediate meeting held by the Director on the day of receipt of the letter 18 January 2010. The meeting involved all three consultant urologists, Mr Mackle AMD, myself and, from memory, Dr Loughran. Each of the issues was discussed and actions agreed as set out below:

i In relation to the appointment of a locum consultant, a range of measures to address the long waits for theatre were agreed which would ensure that no patient was waiting longer than 16 weeks at the end of March. This required the surgeons working additional hours and on the basis of this agreed position, the Trust agreed to cancel the locum appointment.

ii In relation to the compromise to inpatient care and safety as a result of the recent ward reconfiguration, the recent correspondence from Dr Loughran, Medical Director, regarding the process of clinical incident reporting was discussed and consultants advised to identify concerns over safety. Consultants were requested to immediately report any cases whereby patient safety was compromised so that urgent action could be taken. The letter of 20 January 2010 sent to the consultant urologists after the meeting also stated ‘’We would further appreciate if you could let Dr Rankin know when you have submitted the required forms so that she can ensure a speedy process.’’ *S21 No 8 of 2022, 161. 20100125 E to Dr Loughran re Consultant Urologists, 162. 20100125 E to Dr Loughran re Consultant Urologists A1*

b. Re-referral triage and amending clinic templates to reflect different new to review ratios. The letter from myself to Mr O’Brien dated 22 October 2010, indicates a previous related letter from myself and Mr Mackle to Mr O’Brien, to which Mr O’Brien had replied on 27th September 2010. While the initial concern was not raised by Mr O’Brien, the correspondence identifies the concerns which he continues to hold with regard to implementing certain aspects of the implementation of Team South Urology. These are set out below. In my letter of 22 October 2010, the following points are made:

i A commitment to triage referrals within a week and red flag referrals within a day, conditional on the cohort of consultants being sustained

ii Refusal to amend clinical practice to undertake new appointments in 20 minutes and review appointments in 10 minutes

iii Lack of undertaking to reduce new to review ratios to 1:2 as an interim step through clear discharge pathways with primary care

iv ‘‘We are writing to ask you to reconsider these issues which have been in discussion over many months. Please confirm by Thursday 28th October your agreement to amend clinic templates.’’ The letter attached sets the context of the meeting and the outcomes of the meeting held on 27th September 2010. *Relevant documents located in Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20101022 Ltr to AOB Reg Uro Imp*

c. On 25.8 2011 Mr O’Brien sent an email to the Head of Service regarding the request to read test results when they are received and before filing the patients notes. Mr O’Brien’s email set out 11 bullet points relating to concerns about the request sent through the office of the Assistant Director. Mr O’Brien’s concerns related in the main to how the process will be done, the time implications and whether there are legal implications to this proposed action. Mr O’Brien’s email was forwarded to Mr Mackle, AMD, who forwarded it on to myself on 26 August 2011 with the comment: ‘‘I think this raises a Governance issue as to what happens to the results of tests performed on Aidan’s patients. It appears that at present he does not review the results until the patient appears back on OPD.’’

i On 8 September 2011 I sent a reply to Mr Mackle, AMD, Heather Trouton, AD, and Martina Corrigan, Head of Service. As I was just about to go on summer leave for 2 weeks, I asked Heather Trouton to address with the consultants the “whole area of how results are read when they arrive rather than waiting for review apt’’. ‘‘The secretaries need to be given a

Southern Health
and Social Care Trust

Interim Director of Acute Services
Administration Floor
Craigavon Area Hospital

Mr M Young, Consultant Urologist
Mr A O'Brien, Consultant Urologist
Mr M Akhtar, Consultant Urologist

20th January 2010 **Our Ref:** GR/PL/es **Your Ref:**

Dear Mr Akhtar, Mr Young and Mr O'Brien,

Thank you for your letter of 18th January 2010 in which you outline your concerns regarding the appointment of a locum consultant urologist. These concerns were fully discussed at the meeting with yourselves on 18th January. It was agreed that each consultant with the Head of Service would determine the operating hours required to address the urgent list of patients awaiting surgery in order to ensure that no patient would be waiting longer than 16 weeks at the end of March. Additionally each surgeon would identify additional operating time through extended day, evening, Saturday or Sunday lists.

This would be achieved by Thursday lunchtime (21st January). Two surgeons agreed to patients requiring flexible cystoscopy being moved to lists operated by Mr Brown or Mr Hughes both in Daisy Hill Hospital.

It was also agreed that if further operating time was required over and above what all surgeons could commit, some sharing/pooling across surgeons would be considered. Equally an approach to Mr Kernohan was suggested to undertake additional lists in Craigavon Area Hospital.

Trust managers agreed to assure other resources required ie. POA, theatre time, beds in order to support additional patients/lists.

In light of the above and if it is clear that agreements are in place to address urgently waiting patients to 16 weeks, the Trust will cancel the locum appointment.

The last paragraph in your letter identifies compromised inpatient care and safety as a result of the recent ward reconfiguration. This is a significant statement which requires to be addressed. As you are aware Dr Loughran has recently written outlining the Trust's process of clinical incident reporting and the need to identify concerns over safety in this matter. We would entirely endorse this course of action and request you to immediately report any cases whereby patient safety was compromised so that urgent action can be taken. We would further appreciate if you could let Dr Rankin know when you have submitted the required forms so the she can ensure a speedy process.

Craigavon Area Hospital, 68 Lurgan Road, Portadown, County Armagh, BT63 5QQ Tel No 028 3861 2510
Fax No Personal Information redacted by USI Email Address Personal Information redacted by USI

Department of Urology
Craigavon Area Hospital
68 Lurgan Road
Portadown
Craigavon
BT63 5QQ

18 January 2010

Dr. Gillian Rankin
Interim Director of Acute Services
Southern Health and Social Care Trust
Craigavon Area Hospital
Craigavon
BT63 5QQ

Dear Dr. Rankin,

It was with shock and disbelief that we learned from you on Monday 11 January 2010 that the Trust had appointed a Locum Consultant Urologist, without any consultation with us and without our participation in due process of appointment. It remains for us incredible and untenable the excuse that one of us could not be contacted when the appointment was apparently made, during the third week of December 2009. In addition, we can only conclude that the failure to inform us until Monday 11 January 2010, was with intent, rather than oversight.

Previous appointments of Locum Consultant Urologists have always been conducted in consultation with, and with the active participation of, us in the due process of the construction of job descriptions, advertising, short listing and interviewing. This involvement has proven to be an indispensable component in the time – honoured method of ensuring that any appointee is qualified and adequately experienced for the post, with the ultimate objective of ensuring, so far as is possible, patient safety. In our collective experience and awareness, the manner in which the Trust has made this appointment is unprecedented.

Our concerns regarding the manner of appointment have been completed on review of the appointee's curriculum vitae. It would appear to us that the appointee did not have urological training in specialist urological departments, or in a specialist urological training programme. Since 1998, he has been employed as a Locum or Temporary Consultant General Surgeon in various locations in Ireland. Therefore, it would appear that the appointee is neither trained or qualified to be a Urologist, as a consequence of which he has not been employed as one.

As urologists, we too find ourselves unable to support the Trust's appointment, and incapable of advising the Trust on his deployment.

During the past year, and despite our expressed concerns, the Trust proceeded with its ward reconfiguration, resulting in compromised inpatient care and safety as feared, in addition to significantly diminishing the specialist status of our department. Compliance with the loss of radical pelvic surgery as proposed by the Regional Review of Adult Urological Services similarly has the potential to compromise patient care and safety, and will certainly diminish the status of our department further. The capacity to provide enhanced urological services in the future is entirely dependent upon the ability to recruit and retain specialist staff, and that is entirely dependent upon the attractiveness of the department's current status at any point in time. We would earnestly request that the management of the Trust seriously reflect upon its actions and proposals before any prospect of a future has been completely eliminated. If it is the case that only a General Surgeon can be appointed, we fear that we may have already arrived at that point,

Yours Sincerely,

Mr. Mehmood Akhtar.

Mr. Michael Young.

Mr. Aidan O'Brien.

Cc: Dr. Patrick Loughran, Medical Director, SHSCT.

also be raised with the Head of Service and possibly with the Clinical Directors. In more recent times, the Associated Medical Director would have been an early contact point as Mr Haynes, Consultant Urologist, was in this role. An example of this would have been when I recognised an issue with Personal Information redacted by USI operating capability, I mentioned this to both Mrs Corrigan as Head of Service and Mr Haynes as AMD. Initially, I had thought that Personal Information redacted by USI was just trying to get familiar with our theatre equipment but highlighted my potential concern nonetheless. This initiated a closer review of Personal Information redacted by USI practice amongst all the consultants. This process ultimately resulted in his dismissal, as detailed further below at Q57. This identified that my concerns delivered verbally were addressed. ***(Relevant document located at S21 55 of 2022, 115b. 20200309 11:19*** Personal Information redacted by USI ***n confidence).***

54. Did you feel supported in your role by your line management and hierarchy? Whether your answer is yes or no, please explain by way of examples.

54.1 During my initial ten years or so in Craigavon, it was evident that there was a struggle for the Trust to appreciate the level of need the urology department required. It was not until the External Review of the Southern Trust Urology in 2004 that this was understood. It was always an uphill and slow process. In saying this, Mr Templeton was very supportive when I had specific concerns about patients and when I hosted the BAUS national endourology meeting in the hospital in October 2003. On recognition of the issue, the ICATS service and the independent medical service of ASPEN was engaged on his instruction. The Clinical Director, Mr Stirling, and Medical Directors, Dr McCaughey, Dr Orr, and Dr Hall, were all supportive of my role as Lead Clinician and as a fellow consultant colleague. It was my opinion that the block in progress was therefore at a higher level in the management hierarchy or in the DoH.

54.2 Following the 2009 Review, I felt my role as Lead Clinician was very much supported by the immediate line management system of Heads of Service and Clinical Directors covering Urology. They have been supportive and deeply involved in all the projects our department have put forward. The immediate period following

the 2009 Review, it was my opinion that Dr Rankin, Director of Acute Services, although Chairing our steering group, was not as supportive of our department's personal thoughts on the recovery plan. This is my personal opinion as she did not fully follow my suggestions. I had thought her approach to appointing three consultants on one day unwise in 2012 and especially in the way the interview panel had been constructed. ***(Relevant document located at S21 No 55 of 2022, 25. letter to chief Executive).*** She also did not agree to the outpatient clinic template we had suggested at the time which actually did ultimately became our template (Ref: see Response in Q11). Subsequent Directors of Acute Service were supportive.

54.3 The redesign of the Stone Service has been led by the provision of an ADEPT fellow, Mr Tyson, and myself. We have been very well supported by the immediate management team of Head of Service, Mrs Corrigan, Clinical Director, Ted McNaboe, and AMD, Mr Haynes. Although a presentation to the Senior Management Team (which is an unusual opportunity as I had not done so before) appeared to be accepted with apparent positive comments, nothing came of it until the DoH (as part of the day elective care centre project) incorporated our unit in the regional ESWL service into the overall plan for day surgery for stone patients.

54.4 In conclusion, I felt well supported in my role by the immediate levels of management within the Trust in the Acute Services Division.

Concerns regarding the Urology unit

55. The Inquiry is keen to understand how, if at all, you, as Clinical Lead engaged with the following post-holders:-

(i) The Chief Executive(s);

(ii) the Medical Director(s);

(iii) the Director(s) of Acute Services;

(iv) the Assistant Director(s);

(v) the Associate Medical Director;

(vi) the Clinical Director;

66.2 With regard to support for Mr O'Brien by his clinical colleagues, the weekly rotation of triaging GP referrals for both red flag and non-urgent referrals was often undertaken by agreement by one of the other 2 consultants, who were aware of the delay in Mr O'Brien triaging referrals. This support was in place for some lengthy periods during my tenure in post. I have no knowledge of any further support for Mr O'Brien by clinical colleagues.

[67] How, if at all, were the concerns raised by Mr. O'Brien and others reflected in Trust governance documents, such as the Risk Register? Please provide any documents referred to. If the concerns raised were not reflected in governance documents and raised in meetings relevant to governance, please explain why not.

67.1 The specific concerns raised by Mr O'Brien and others were not written down in Trust Governance documents. I am unable to give an explanation for this. However it would not have been usual practice at that time to record such specific issues as raised by Mr O'Brien in Trust Board, or Directorate Risk Registers. These Risk Registers generally identified risks which existed across a range of systems in the Trust or across a full directorate. The specificity of risk would more likely be identified in divisional risk registers. This may have been the position on the journey of recording risks at that time and may have subsequently been further developed.

67.2 By way of example to my comments above the following may illustrate. The Trust Corporate Risk Registers of December 2009, June 2010, November 2011 and October 2012 all make reference to performance issues against the Priorities for Action Performance targets across a range of specialties, and the outpatient review backlog. Urology is mentioned as having the longest review backlog. The actions such as re-let contracts to the Independent Sector including urology, the approval of the urology business case in July 2011 with recruitment of 2 new urology consultants from November 2012 are documented in these Risk Registers.

67.3 The Acute Services Directorate Risk Register documents the following risks:

any major concerns regarding the overall practice. He felt that this group of patients can be very complex and difficult to manage." *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20110805 Cystectomies in the ST.*

g. The operation of cystectomy ceased to be undertaken in CAH as an elective procedure after August 2011. All patients requiring a planned cystectomy for either malignant or benign reasons were referred to Belfast. . (Prior to having full access to all the relevant documents, I clarified with Mr Mackle that the requirement to move the operation of cystectomy to the Belfast Trust included those for benign diagnoses.

i The operation of cystectomy as an emergency procedure, or as an unplanned procedure required during planned surgery, remained as a potential future occurrence but with valid reasons for the procedure

ii Such an example is patient Patient 71 who required planned surgery involving both a urologist and a gynaecologist in theatre together. The surgery took place in 2012 and, while cystectomy was not planned and was not on the theatre list as a planned procedure, it was deemed necessary when in theatre. (At my request Mrs Martina Corrigan clarified the date of patient Patient 71 surgery.)

h. Answered at g above.

50.9 Use of IV antibiotics

a.

i The concern regarding the use of IV antibiotics was raised with me by the Chief Executive at the meeting held on 1 December 2009. The use of IV fluids and IV antibiotics had become part of local urological practice for the treatment of recurrent UTIs over many years and had been identified in

therapy had been taken jointly in discussion with the Clinical Director and the consultant microbiologist. The attached email of 24 August 2010 identifies the patient cohort and the position of this cohort as at July 2010 and updated for August 2010. The list showed that both Mr Young and Mr O'Brien had continued the practice of IV therapy in both months. The numbers of patients treated with IV therapy in July was 13 (Mr O'Brien treated 9 patients and Mr Young treated 4 patients) and in August it was 3 patients (Mr O'Brien treated 2 patients and Mr Young treated 1 patient). The number of patients treated using IV therapy had reduced but was still continuing. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100824 e IV Antibiotics Fluids K.*

D In order to address this continuing practice the Director of Acute Services discussed this with the Medical Director. The timing of this coincided with the letter from Dr Corrigan of 1 September 2010 which identified an issue regarding the operation of cystectomy, in addition to concerns regarding the continuing use of IV therapy. Both issues were discussed at the meeting on 1st September between Dr Loughran, Mr Mackle, Mr Donaghy (Director of HR and Organisational Development) and myself. The letter from Dr Corrigan is attached. *Relevant to MDO, Evidence after 4 November MDO, Reference no 77, Correspondence Patrick Loughran, 20100901_Re Urology, 20100901_Re Urology_ATTACHMENT 1, 20100901_Re Urology_ATTACHMENT 2* .

E On 2 September as an outcome of the meeting held the previous day, the Medical Director wrote to the Director of Acute Services seeking assurance that the practice of treatment with intravenous therapy had stopped completely. The Director of Acute Services wrote to the 2 consultant urologists on 2 September 2010 inviting both consultants to attend a meeting with myself and Mr Mackle regarding the continuing practice with 3 patients. *Relevant to Acute,*

Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100902 Ltrs to MY and AOB

F The Director sought an updated position on 2 September 2010 on patients receiving IV therapy prior to the meeting with the consultant urologists. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100902 E IV Antibiotics Fluids K.*

G The Director had to cancel the planned meeting due to unforeseen circumstances and wrote to both consultants seeking a new date to meet in the following week*. Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100903 Ltr to AOB, 20100903 Ltr to MY*

H While I have no recovered document regarding the subsequent meeting with the consultants and Mr Mackle, I wrote to Dr Loughran on 14th September 2010 to say:' "here are the documents Mr Mackle and I used to discuss with Mr Young and Mr O'Brien separately last Thursday. You may wish to use in your response to Dr Corrigan.'' *Relevant to MDO, Evidence after 4 November MDO, Reference no 77, Correspondence Patrick Loughran, 20100914_FW Confidential --Urology letter from Dr Corrigan, 20100914_FW Confidential -- Urology letter from Dr Corrigan_ATTACHMENT 1, 20100914_FW Confidential --Urology letter from Dr Corrigan_ATTACHMENT 2 .*

I A process was implemented through the Urology Services Co-ordinator to bring to the Head of Service or AD attention if a patient had been booked to come into the ward for IV antibiotics. Attached is an email from the Urology Services Co-ordinator regarding a discussion with Mr O'Brien regarding 2 patients and an amendment to the pathway which supported oral antibiotics out of hospital. In response to this email, Heather Trouton reminded her that any

Journal of Infection (2011) xx, 1–3

ELSEVIER

BIAM British Infection Association

www.elsevierhealth.com/journals/jinf

LETTER TO THE EDITOR

Preliminary assessment of regular short-term intravenous fluids and antibiotic therapy in recurrent UTI

Dear Sir,

We read with interest on the article by Falagas et al., concerning antibiotic treatment in women with uncomplicated cystitis.[1] In this context, the management of recurrent urinary tract infection (rUTI) remains a therapeutic challenge. Within our department, we have identified a cohort of patients with rUTI, who have had multiple emergency admissions for severe rUTI episodes requiring intravenous fluid and antibiotic therapy. For years, these patients have been treated appropriately with multiple oral antibiotics treatment and prophylactic antibiotic courses by their GP, but with little success since their symptoms, in particular nausea and generally unwell being, have prevented compliance to oral antibiotic therapy and adequate oral rehydration. As a consequence, their condition deteriorates and inevitably leading to the need for emergency hospital admission.

Over their multiple emergency admissions, we have evolved our treatment strategy to electively administer a combination of short-term intravenous fluids and antibiotics therapy (IVT) regularly to this cohort. The duration of admission for treatment varied dependent on the patient's treatment response and usually ranges between 3 and 5 days. In this select cohort, their nausea symptoms have prevented adequate oral rehydration and hence about 1–2 L per day of intravenous fluid were administered during admission. The antibiotic choice used during IVT is dependent on the most recent MSSU culture sensitivity. When IVT is completed, further oral antibiotics are not given. The rationale for this strategy is to adequately treat any underlying UTI completely prior becoming symptomatically severe and therapeutically difficult to manage. This cohort of rUTI patient usually became symptomatic about 3 months after their emergency admission for severe UTI. The frequency and duration regime is not fixed, but rather flexibly adapted according to patient's symptoms. The intention is to gradually prolong the regularity of this regime, for example every 3 monthly, then 6 monthly and gradually yearly. The ultimate aim is help these rUTI patients achieve independence from IVT and yet maintain a reasonably good quality of life. We report our experience with regular short-term intravenous fluids and antibiotic therapy (IVT) as an adjunctive treatment.

A retrospective cohort analysis was done on 16 patients with rUTI on IVT, and was followed up for an average of 100 months. There were 11 female and 5 male patients with the mean age of 41.2 (SD $\pm$ 15.9) years. Five patients have ileal conduit/urostomy, 2 patients had long-term suprapubic catheter, 4 patients perform ISC, 1 patient has a Mitrofanoff formation and the remaining patient without significant comorbidity. In all patients, extensive and comprehensive investigations have been performed to exclude any urologically treatable conditions that predispose to rUTI. Comparative assessments included emergency admission, urinary culture, antibiotic usage, SF-36 and FACIT-TS quality of life questionnaires, between the period before and during IVT.

There were a total of 206 of IVT admission episodes contributing to a total of 934 days and a mean duration of hospital stay per admission of 4.7 days. The mean duration between each IVT admission was 2.9 months. The number of emergency admission (88 vs 16, $p = 0.001$, X_2) and outpatient clinic reviews (216 vs 5, $p = 0.001$, X_2) have decreased significantly. The IVT for elective admissions predominantly utilised Gentamicin, followed by Co-amoxiclav as shown in Table 1. Similarly in the emergency admissions, intravenous Gentamicin and Co-amoxiclav were the antibiotic of choice. In the outpatient or GP practice setting, the predominant oral antibiotics used were Trimethoprim followed by Ciproxin and Cefelexin. A total of 1050 MSSU culture and direct microscopic results were obtained. Majority of MSSU are obtained at GP setting as shown in Table 2. The most common cultured uropathogen was coliforms, followed by mixed growth, Enterococcus faecalis, Proteus and Pseudomonas. There was significantly more mixed growth culture results obtained during the IVT period comparatively (14.8% vs 4.2%). There was a decreased in ESBL cultures during IVT treatment. Otherwise, the IVT did not significantly change the proportion of the colonising uropathogen type cultured.

There was a complete response rate of 100% to the SF-36 QoL and FACIT-TS questionnaire. The overall negative impact of rUTI on the QoL confirmed the debilitating nature of the disease. There are statistically significant

0163-4453/$36
doi:10.1016/j.jinf.2011.08.010

Please cite this article in press as: Koo V, et al., Preliminary assessment of regular short-term intravenous fluids and antibiotic therapy in recurrent UTI, J Infect (2011), doi:10.1016/j.jinf.2011.08.010

regularity of IVT regime, but suggest that it should be adapted to patient's condition. It is hoped that this report will serve as a pilot assessment of its efficacy and proof of concept to allow for future randomised trials.

Funding

None obtained.

Competing interest statement

None declared.

Acknowledgement

The authors would like to thank Mrs Anne Quinn from the Audit Department and Mrs. Monica McCrorry from the Department of Urology in Craigavon Area Hospital, for their assistance in the facilitation of this audit project and the preparation of medical notes.

References

1. Falagas ME, Kotsantis IK, Vouloumanou EK, Rafailidis PI. Antibiotics versus placebo in the treatment of women with uncomplicated cystitis: a meta-analysis of randomized controlled trials. *J Infect* 2009;**58**:91—102.
2. Wolter JM, Cagney RA, McCormack JG. A randomized trial of home vs hospital intravenous antibiotic therapy in adults with infectious diseases. *J Infect* 2004;**48**:263—8.
3. Chapman AL, Dixon S, Andrews D, Lillie PJ, Bazaz R, Patchett JD. Clinical efficacy and cost-effectiveness of outpatient parenteral antibiotic therapy (OPAT): a UK perspective. *J Antimicrob Chemother* 2009;**64**:1316—22.

Vincent Koo*
Michael Young
Aidan O'Brien
Department of Urology, Craigavon Area Hospital, 68 Lurgan Road, Portadown BT63 5QQ, Northern Ireland, United Kingdom
E-mail address: Personal Information redacted by USI

Accepted 16 August 2011

* Corresponding author. Tel.: Personal Information redacted by USI fax: +44 Personal Information redacted by USI

Please cite this article in press as: Koo V, et al., Preliminary assessment of regular short-term intravenous fluids and antibiotic therapy in recurrent UTI, J Infect (2011), doi:10.1016/j.jinf.2011.08.010

Q An example of good practice is set out in the email of 5 July 2012 when the surgical admission of a patient for a urology procedure was detailed through a full multidisciplinary discussion prior to admission. The patient was infected with both Klebsiella and MRSA and such a detailed plan was paramount for the patient's safety and care.

b. As outlined at a above.

c. As outlined at a above.

d. As outlined at a above.

e. As outlined at a above.

f. As outlined at a above.

g. The system and agreement with the consultants put in place was largely but not completely successful. The number of patients who were subsequently treated with IV therapy were of the order of one or two per year. Mr O'Brien required repeated reminders of the process to be followed such as the meeting chaired by myself on 9th June 2011 involving Mr O'Brien. The Issues and Actions from the meeting on 9th June 2011 are set out in the Memo of 1st July from Mrs Trouton, AD to Mr O'Brien. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20110701 Actions from Mtg to AOB K.*

h. As outlined at a above.

50.10 (v) Referral of patients requiring prostatectomy or cystectomy for malignant and benign conditions to the Belfast Trust and the implementation of the regional MDM (Multidisciplinary Meeting)

Stinson, Emma M

From: Rankin, Gillian [redacted]
Sent: 07 February 2012 15:35
To: Stinson, Emma M
Subject: FW: IV Antiobiotics

From: Corrigan, Martina
Sent: Tuesday, February 07, 2012 3:34:44 PM
To: Rankin, Gillian
Subject: FW: IV Antiobiotics
Auto forwarded by a Rule

Dr Rankin,

Email from Eamon to Sam, as discussed.

Martina

Martina Corrigan
Head of ENT and Urology
Craigavon Area Hospital

Tel: [redacted] (Direct Dial)
Mobile: [redacted]
Email: [redacted]

From: Mackle, Eamon
Sent: 30 January 2012 15:08
To: Hall, Sam
Cc: O'Brien, Aidan; [redacted]; Corrigan, Martina; Rankin, Gillian
Subject: IV Antiobiotics

Dear Sam,

I have been advised that a patient [redacted] may have been admitted last week to Urology by Mr O'Brien and under his instruction was given IV Antibiotics the latter necessitating a central line to be inserted.

I have checked with Dr Rajendran and he advises me that no discussion took place prior to the administration of the antibiotics.

I would be grateful if you could formally investigate this and advise me of your findings.

Many thanks

Eamon

g. The systems put in place with the OSL and Head of Service working with Mr O'Brien were successful as they removed the sole control of the scheduling of surgery from Mr O'Brien, and ensured that the scheduling rules were applied. The performance indicators were the evaluation of the list of patients waiting and performance reports setting out the Primary Targeting List (PTL) for surgery and how long each patient had waited.

h. Answered at g above.

50.8 Surgical operation of cystectomy (excision of the bladder)

a. The concern was raised by the Commissioner on 1st September 2010 through a letter sent to Dr Loughran, Medical Director, and copied to myself and Mr Mackle, AMD. Dr Corrigan drew the Trust's attention to a slightly increased rate of cystectomy for benign pathology in Craigavon Area Hospital when compared with the rest of the NI region. The number of patients identified was of the order of 2-4 per year. The letter from Dr Corrigan to Dr Loughran is attached. *Relevant to MDO, Evidence after 4 November MDO, Reference no 77, Correspondence Patrick Loughran, 20100901_Re Urology, 20100901_Re Urology_ATTACHMENT 1, 20100901_Re Urology_ATTACHMENT 2*

b. The immediate step taken was a meeting held on 1st September between Dr Loughran, Mr Mackle, Mr Donaghy Director of HR and Organisational Development and myself. At this meeting it was agreed that a formal independent review of the appropriateness of the treatment of cystectomy was required. The action determined was to commence a 'local review' in line with the guidance provided by the document 'Maintaining High Professional Standards in the HPSS''. This process included a case note review of each patient who has undergone a cystectomy in the previous 10 years.

i Mr Young and Mr O'Brien were to be informed of the meeting, they were to be met by myself and Mr Mackle in the next few days to discuss both the review of cystectomies by an independent assessor, and the use of IV therapy. (The latter clinical issue is set out fully in point (iv)). A Memorandum sent by Dr Loughran on 2nd September 2010 to myself and copied to Mr Mackle records the discussion held on 1st September. *Relevant to MDO, Evidence after 4 November MDO, Reference no 77, Correspondence Patrick Loughran, 20100902_Memo_DrRankin_PLlw*

ii The letter of 8 September 2010 from myself to the Director of HR and OD sets the ''context for screening of a performance concern regarding the surgical procedure of cystectomy''. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100908 Ltr to KD re Cystectomies*

iii The Terms of the Local Review –the Review -Brief--into the incidence of cystectomies was set out in a document to formalise and document the review process in order to share with Mr Young and Mr O'Brien. This document is located in *Relevant to MDO, Evidence after 4 November MDO, Reference no 77, Correspondence Patrick Loughran, 20100914_FW Confidential -- Urology letter from Dr Corrigan_ATTACHMENT 1*

iv The Review Brief was shared with Dr Corrigan as requested by the Chief Executive, in the attached email. *The relevant document can be located in S21 No 8 of 2022, 151. 20100911_Urology letter from Dr Corrigan*

v Both clinicians undertaking this procedure (Mr Young and Mr O'Brien) were kept informed of the process.

vi The Trust Board were informed of this screening of a performance concern through a written confidential briefing of September 2010 which was presented to the confidential section of Trust Board by the Director of Acute Services. *The relevant document can be located in S21 No 8 of 2022, 131. 20100930 Trust Board Confidential Briefing Note*

Strictly Private and Confidential

Current Action

In line with Guidance from the National Clinical Assessment Service the Trust has commenced a process of screening where the file of each patient who has undergone cystectomy in the past 10 years will be reviewed by the Associate Medical Director for Surgery and Elective Care. The professional advice of a UK urologist with direct knowledge of this field will be sought as required.

The report of this screening review will identify if no further action is required or if a more in depth analysis is required.

Each of the two surgeons has been informed of this screening in discussion and in writing.

Regional Urology Review

One of the requirements of the implementation of the review is that all radical pelvic urological surgery is moved to the Belfast Trust. This now explicitly covers radical pelvic surgery for both malignant and benign conditions. The Trust is in discussion currently with HSCB and Belfast Trust regarding each individual case during the transition period.

Dr Gillian Rankin
Interim Director of Acute Services
September 2010

Strictly Private and Confidential

Clinical Issues in Urology Service
Briefing Note for Trust Board Confidential

Background on IV Fluids and Antibiotics

The clinical practice of managing recurrent urinary tract infections (UTIs) by intravenous (IV) fluids and antibiotics has become part of local urological practice over many years. This is not evidence based and has no acceptance in the wider community of UK urology surgeons.

When repeated to treat recurrent infections it can be difficult to get venous access, which has resulted in occasions where a central venous line has been inserted to administer fluids and antibiotics. This procedure carries risks in that the line is left inserted semi-permanently. Equally the patient no longer has any peripheral venous access.

The cohort of patients who have received this method of treatment has been reduced considerably to approximately 10 since January 2010.

Current Action

The Trust received a letter from the Commissioner seeking an assurance that this treatment had ceased and that no patient had central venous access. The Director of Acute Services and Associate Medical Director of Surgery and Elective Care have met the two surgeons individually to require the immediate case review of the cohort of patients. The review will be chaired by the Clinical Director of Surgery and Elective Care and will also involve Dr Damani, Consultant Microbiologist, to advise on optimum antimicrobial therapy. All future patients for who the surgeons seek to adopt IV therapy will also be reviewed in this manner. Both surgeons agreed to participate in this process which is now underway.

Background on Cystectomies

The Commissioner has also drawn to the Trust's attention a slightly increased rat of cystectomy for benign pathology in CAH when compared across the NI region. Cystectomy is the surgical excision of bladder. The numbers of patients identified are of the order to 2-4 per year.

Clinical Issues in Urology Service
Briefing Note for Trust Board Confidential

Review of patients on IV Fluids and Antibiotics

The clinical review and development of a management plan for patients which excludes routine IV fluids and antibiotics has been led by Ms Sloan, Clinical Director, Surgery and Elective Care. The review has been completed for 13 patients.

It has been decided by the clinical review team to undertake a review of the whole original cohort of patients and it will take several more weeks to complete this.

No patient in the cohort now has a central venous line.

Review of Cystectomies

The clinical review of the records of the small cohort of patients who have had surgical removal of the bladder is underway by Mr Mackle, AMD, Surgery and Elective Care. This will be completed in the next few weeks.

Regional Urology Review

The transfer pathway of patients with urological cancer requiring radical pelvic surgery or radiotherapy has been agreed. All patients are now being transferred to the Regional Urology Centre in the Belfast Trust.

Dr Gillian Rankin
Director of Acute Services (Interim)
November 2010

41.1 In my view, there was not a failure to engage fully with the problems within Urology Services once Trust Board were informed of the issues on 27th August 2020. From that date, Trust Board has had oversight and has been provided with regular progress reports. Board minutes attest to the scrutiny and challenge of members.

41.2 Prior to 27th August 2020, in my view there was a failure to engage fully with the problems within Urology services. From a Board perspective, Dr Rankin's briefings to Trust Board on 30th September 2010 and 25th November 2020 (ten year's earlier) advised of clinical concerns, but lacked sufficient detail.

42. **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?**

42.1 I consider that overall mistakes were made in that the information provided to Trust Board was not timely and lacked sufficient detail. In terms of what could have been done differently, the information could have been presented more regularly and in such detail to enable Board members to fulfil their role and responsibilities.

43. **Do you think, overall, the governance arrangements were and are fit for purpose? Did you have concerns specifically about the governance arrangements and did you raise those concerns with anyone? If yes, what were those concerns and with whom did you raise them and what, if anything, was done?**

43.1 I think the clinical and social care governance arrangements were not fit for purpose in that more connection was required with the corporate governance arrangements. As referenced in 41.2, the only information that was escalated and shared with Trust Board about clinical concerns in Urology was from two briefing papers Dr Rankin provided on IV fluids and Antibiotics and Cystectomies in 2010. In my view, the relevance and depth of information that was escalated and shared with Trust Board members, did not provide them with robust assurance that concerns had been addressed nor enable them to make any informed decisions. I did not have any concerns specifically and therefore, would not have raised them.

44. **If not specifically asked in this Notice, please provide any other information or views on the issues raised in this Notice. Alternatively, please take this opportunity to state anything you consider relevant to the Inquiry's Terms of Reference and which you consider may assist the Inquiry.**

44.1 I have nothing further to add.

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.

a. The regional review implementation determined in 2010 that all planned radical pelvic surgery for malignant and benign conditions would be undertaken in the Belfast Trust. This required the consultants in other Trusts to refer these patients to the Belfast Trust once it had been determined that radical pelvic surgery was required. This process of referral to another clinical unit within a speciality is usually undertaken through the regional MDM process where a patient is discussed and the collective decision recorded and implemented. The receiving consultant or clinical unit has therefore agreed the referral of the patient.

b. The members of the MDM are necessarily the consultants in the specialty, radiologists presenting the diagnostic test results, pathologists presenting on the pathology of the malignancy, the oncologists setting out the chemotherapy and radiotherapy required for the patient before or after surgery. All these specialties require to the present for an effective MDM process. The MDM process also discusses the discharge of the patient back to the original Trust for follow up care.

c. After the regional decision was taken to move all radical pelvic surgery to the Belfast Trust, there were difficulties setting up the regional MDM process through the Belfast Trust. This was due to the lack of a consultant oncologist for the urology service at that time within Belfast. The Southern Trust set up the local MDM to test systems and prepare for linkage with the Belfast Trust.

d. In May 2010, the HSCB issued the document ‘’Referral Guidelines from NICAN Regional Urology Network’’ as agreed at 8.10.2009. This document sets out clearly those conditions to be managed locally and those conditions to be referred to the Belfast Trust. The Director sent these to the AD for Surgery and Elective Care and the AD for Cancer and Clinical Services. *Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20100517 E re Referral Guidelines Uro MDTs*

e. The difficulties setting up the local MDM process and linking to the regional process are set out in a letter from Mr Akhtar, Consultant Urologist (leading on the local MDM process), to the Head of Cancer Services on 8 July 2010. The

'a. *A significant clinical incident occurred regarding the retaining of a swab after surgery on 15th July 2009, which was only identified when the patient was admitted as an emergency in July 2010. The post operative CT scan was undertaken in October 2009 as planned and identified an abnormality. Although not identified as a retained swab, one of the differential diagnoses was recurrence of the patient's cancer. A Root Cause Analysis (RCA) review of the case was required and undertaken. The final report of the RCA was taken to SMT in December 2010 ~~2011~~. The RCA identified that due to a backlog in outpatient reviews, the patient was not seen in outpatients in the 12 months after surgery, at which stage she was admitted as an emergency.*

b. *A draft of the report had been shared with the Commissioner as required and this resulted in the letter from Dr Corrigan to Mrs D Burns, AD for Clinical and Social Care Governance, on 14 November 2010 ~~2011~~. In this letter, Dr Corrigan states that ''the report records that it was the practice of the patient's consultant urologist not to review laboratory or radiology reports until patients attended for their outpatient appointment. … I believe this highlights an area where the Trust would have considered action to be appropriate. …. I am writing to ask whether this issues has been taken forward, for example by considering whether there is a need for a formal Trust policy, such as review of all test results by medical staff before filing, whether or not the patient is awaiting outpatient review".*

c. While the draft report was formally shared with Dr Corrigan, resulting in her letter of 14 November 2011, the issue of medical staff reviewing test results before filing, whether or not the patient is awaiting an outpatient appointment was understood by the Trust as a clinical risk and as learning from the RCA prior to the receipt of this letter. The Trust took the necessary action to understand the current practice of medical staff in each speciality. In the Directorate of Acute Services this was to discuss and assess the risk in each specialty through discussion with the consultants at specialty meetings.

I believe that a copy of the draft report first came to me in October 2010. This resulted in two other immediate actions within Acute Services:

i. To set out an operating process for radiology staff to implement. The 'Notification of Urgent Reports to the Referrer or Cancer Tracker' was written and implemented in early November 2010. On 20 December 2010, the Head of Radiology Services assured the Medical Director's office on request, that the Notification of Urgent Reports to the Referrer or Cancer Tracker had been implemented and 'is in operation'. 20101221 RCA Retained Swab A1 pdf, 20110120 E with SAI and SOP.pdf.

ii. The second immediate action was undertaken through the Administrative and Clerical Staff Review which was commissioned by SMT in the Trust in 2010 which provided the vehicle to set out a new standardised process for 'discharge awaiting results'. In order to undertake the Administrative and Clerical Review I set up a Project Board for Acute Services chaired by myself, with a project manager assigned from within Acute Services. Heather Trouton as AD for SEC undertook a key role. This resulted in the many variances in administrative processes across the legacy Trusts being standardised through a process mapping exercise involving clerical staff from all parts of the Acute Services Directorate. There were 5 different hospital or community clinic locations where consultants provided outpatient clinics, and as these were across 3 legacy Trusts, standardisation of processes was of key importance. One of the areas which had an initial focus was to develop the Standard Operating Procedure (SOP) for administrative and secretarial staff to manage results in the context of 'Discharge Awaiting Results'. This was signed off and first implemented in November 2010 with workshops involving all clerical and administrative staff. This SOP was reviewed in November 2011. 20120914 Management of Results SOP A1.pdf. This SOP was again reviewed and a revised version implemented in October 2012. 20121008 E from MM re DARO SOP 2012 Version. An additional action taken through the Administrative and Clerical Review was to develop a specific SOP for secretarial and typing staff regarding the Management of Results. This was implemented in October 2011. 20120914 SOP A2.pdf

Southern Health & Social Care Trust

Findings of the Root Cause Analysis – Patient 95
Incident Ref - Personal Information redacted by USI

October 2010

7 Conclusions, recommendations and Learning

The method of recording swabs which were temporarily used in the patient cavity that day in theatre is inconsistent. A standardised protocol for the counting and recording of all swabs across all theatres needs to be implemented urgently.
The responsible scrub nurse in this case is unclear because there were two scrub nurses. When the scrub nurse hands over to another scrub nurse he/she should sign off the current state of swabs in use and used.
The first post-operative scan (1st October 2009) was not reviewed at routine follow up because there was no follow up for 12 months due to the length of the urology outpatient waiting list. The urology waiting list for post-operative follow up needs to be cleared.
Several abdominal x-rays were performed on Patient 95's readmission but the swab was missed by several doctors. This is presumably because they have never seen a retained swab on a radiograph previously. This case should be presented, with the radiographs, at Surgical and Medical Morbidity and Mortality meetings to demonstrate the appearance of a retained swab.

7.1 Local Recommendations

The local recommendations are set out in table 1

7.2 Regional Recommendations

No regional recommendations are deemed necessary.

7.3 Action Planning

The action plan below sets out the proposed lead individuals and completion dates for the recommendations contained in this investigation.

Table 1 local recommendations

Recommendation	Evidence of Action	Lead Individual	Completion	Completion Date
All swab and instrument counts must be interruption free and where possible the same circulating nurse completes count –	Write SOP for all Theatre within Trust	Lead Nurse ATIC AMD's Surgery & Gynaecology	Jan 11	
Swabs that are temporarily used in a patients cavity must be recorded on the white board and struck through when removed until operation complete – the record must not be 'rubbed out'	Incorporate new SOP for all Theatres within Trust	Lead Nurse ATICs	Jan 11	
As far as is operationally possible the same nurse should remain as the scrub nurse for the entire operation.	Each month five patients charts will be reviewed to ensure all	Lead Nurse ATICs	Jan 11	

Signing off of swab status must take place by the Scrub Nurse if there is a changeover.	necessary documentation is complete			
It needs to be recognised and reaffirmed that time is required at the end of the operation to the scrub nurse to ensure that all swabs, instruments and equipment are accounted for.	This will be incorporated in WHO' Patient Safety Checklist'	Lead Nurse ATICs	Feb 11	
Where possible and practical there should be a 'surgical pause' before wound closure.	This will be incorporated in WHO' Patient Safety Checklist'	AMD's Surgery & Gynaecology	Feb 11	
Findings of the RCA will be presented at the next radiology peer review discrepancy meeting		Dr Hall	18th January	
Presentation of case with radiographs at Radiology, Surgical and Medical M&M.		AMD Radiology Dr S Hall AMD Surgery Mr E Mackle AMD Medicine Dr P Murphy	18th January	
Reduction of Urological Out-Patient follow up waiting times		Heather Trouton, AD SEC		

The AD for Surgery and Elective Care sent an email on 25 July 2011 regarding the issue to all Heads of Service for further assurance (after previous discussion) that test results were being read as soon as the results were available. The Head of Service for urology sent this email to the consultant urologists on 27 July 2011 and this resulted in an email response from Mr O'Brien on 25 August 2011. In this email Mr O'Brien raised 11 points regarding the potential impacts of reading the results of tests when they are received. This resulted in the email from Mr O'Brien being forwarded to the AMD, Mr Mackle, who raised this with myself identifying a governance issue as Mr O'Brien does not review the results until the patient appears back in outpatients.'

d. *A conversation followed with Mr O'Brien without success in terms of changing his clinical behaviour. The email sent by myself to Mr Mackle, the AD and Head of Service of 8 September outlines a high level plan as I was going on summer leave. The AD replied to state that she would look at the processes in other specialties in order to present current working processes in other areas should the need occur. Relevant to Acute, Evidence Added or Renamed 19 01 2022, Acute, Retired Staff, Dr Gillian Rankin, 20110826 E re Results and Reports of Investigations, 20110908 E re Results and Reports of Investigations, 20111209 SAI DB K, The relevant document can be located in S21 No 8 of 2022, 159. 20101221 RCA Retained Swab, 160. 20101221 RCA Retained Swab A1.*

I continued to raise the issue of not reading results when received with the AMDs. Heather Trouton as AD for SEC, at my request in my email of 8 September 2011, undertook a scoping exercise of the baseline position across all divisions in Acute Services. This scoping exercise identified that in the main results are read in a timely manner, although variances in how this is done have been highlighted. This was set out in the Trust's letter of response to the HSCB in late 2011 regarding the request for assurance on a Policy for the review of results when received. 20111205 E response to D Corrigan re. SAI,A1,A2.

The detailed results of this scoping exercise setting out the practice of each surgeon was sent by Heather Trouton to Margaret Marshall copied to myself on 30 December 2011. 20111230 E re Process Used For Dealing With Investigation Results, A1.

In September 2012, I wrote again to the Acute Services Assistant Directors, stating that despite all the efforts these procedures have not been implemented. I have no evidence on what information I had received to state this. I requested the ADs to urgently review and implement in their division, and stated that we would be 'auditing charts to see what is happening'. 20120914 (DARO); Management of results SOP.pdf

On 26 September 2012, I received assurance from Ronan Carroll, AD for Cancer Services, Anaesthetics, Theatres and Radiology, that the DARO SOP has been implemented, and staff workshops undertaken. 20120926,DARO SOP Actions Required Response from RC.pdf, 20120926,DARO SOP Actions Required Response from RC A1.pdf.

e. *Assurance that behaviour had changed was very difficult at that stage as there was no mechanism to record that any consultant had read the test results they had ordered at a point in time. A consultant could routinely order over 100 tests –both blood tests and diagnostic tests—in a week. Both the laboratory system and the WIT-15891 Page 134 regional radiology system did not report on results which had been left unread at a certain time after the report on the test was made available. The Trust undertook the implementation of the reporting process for the laboratory i.e. blood test results. In relation to the need for a report from the regional radiology system, a software upgrade was sought through the Business Services Organisation (BSO) to enable such a report to be made available. From memory the facility for a consultant to 'tick a box' when they had read a radiology result was made available in 2012. (The information in the last sentence was confirmed by Mr Mackle at my request.) A report on which results had been left unread was then feasible. However, I do not recall this being made available during my tenure*.

Standard Operating Procedure (S.O.P.)
Discharge Awaiting Results (DARO)

At the end of an outpatient clinic all attendances and disposals (AADs) must be recorded on PAS. Recording “Attendances and Disposals” is an essential part of the outpatient flow, and is required for statistical analysis of clinic outcomes and activity, and can be used for future planning of services and determining capacity & demand. Using “AAD” can also be used as a “failsafe mechanism” by secretarial staff, so as to ensure that all patients who were booked to a specific clinic have had their attendance recorded; to ensure that letters have been dictated and typed for each patient; to ensure that the correct outcome is recorded for each patient – i.e. to ensure that patients are not “lost” in the system and that patients are added to WL for procedures or added for further OP review in the future.

If a patient has attended a clinic and is awaiting results before a decision is made regarding further treatment, the following process must be followed:

Recording Clinic Disposals on PAS

1) ensure all attendances for the clinic have been recorded on PAS using function “AAD” (Attendances and Disposals) – if function “ATT” (Appointment Attendance) has been used by reception staff to record the attendances immediately after the clinic, the attendance codes will default in (i.e. ATT, DNA, CND, WLK)
2) ensure all disposals are now recorded for each patient - the disposal codes which are used within the Trust are shown below:

```
            D i s p o s a l   C o d e   M a s t e r   F i l e
    Maintenance Details                                09/11/10 09:01 CAH
+-----------------------------------+----------------------------------------+
|  Command        :LIST             |Code  Description                       |
|                                   +----------------------------------------+
|  Disposal Code  :                 |ADM   ADMIT DIRECT FROM O.P.D           |
|                                   |BKD   DATE GIVEN AT OPD TO COME IN      |
|  Description   :                  |DIS   DISCHARGE                         |
|                                   |DNA   DNA - NO FURTHER APPOINTMENT      |
|                                   |DNAR  DNA - APPOINTMENT REBOOKED        |
|                                   |REV   REVIEW APPOINTMENT                |
|                                   |RVL   REVIEW AT A LATER DATE            |
|                                   |TRT   ADDED WAIT. LIST FOR OP TREAT     |
|                                   |WL    ADDED TO WAITING LIST             |
|                                   |                                        |
|  Enter?         :                 |                                        |
|                                   +----------------------------------------+
|                                                                            |
+----------------------------------------------------------------------------+
```

3) If a patient is awaiting results prior to a decision regarding follow up treatment being made, they must be recorded as a discharge (DIS) **and not** added to the OP Waiting List for review.

4) All outcomes/disposals should be recorded on PAS for each patient. For those patients who have had a disposal code of DIS, WL, BKD, DNA or WL recorded, you will then be prompted to select each patient individually for discharge (when you enter "Yes" – when using AAD function).

```
        R e c o r d   A t t e n d a n c e   a n d   D i s p o s a l
      Outpatients                                          09/11/10 09:12 CAH
+-------------------------------------------------------------------------------+
| Clinic: CS1      Doctor:    CS1      Date: 25/10/2010  Session: 08:00-13:00  |
|                                                                               |
|Time  Status   Case Note No Name                    Attd      Disp Grade       |
|08:45 OP REG   CAH12345     BLOGGS, J               ATT      :REV :           |
|08:45 OP DSCH  CAH23456     [redacted]              :ATT     :WL  :           |
|08:45 OP DSCH  CAH10000                             :ATT     :DIS :           |
|09:00 OP DSCH  CAH45678                             :ATT     :DIS :           |
|09:00 OP REG   CAH56789                             :ATT     :REV :           |
|09:15 OP REG   CAH67890                             :ATT     :RVL :           |
|09:15 OP REG   CAH78900                             :ATT     :RVL :           |
|09:15 OP DSCH  CAH54321                             :ATT     :WL  :           |
|09:20 OP REG   CAH43210                             :ATT     :REV :           |
|09:25 OP REG   CAH10101                             :ATT     :RVL :           |
|09:25 OP REG   CAH10000                             :ATT     :REV :           |
|09:30 OP DSCH  CAHE0000                             :ATT     :WL  :           |
|                                                                               |
|                                                                               |
+-------------------------------------------------------------------------------+
```

Personal information redacted by USI

For those patients who require test results before a decision is made regarding follow-up treatment:

Record using function "AAD" on PAS –

- Record "Discharge On" (discharge date) as the date of the clinic.
- Record Disposal "Reason Code" as ***DARO (Discharge Awaiting Results - Outpatients)***
- Record an appropriate comment in the "Reason Text" field – for example:

    - Await MRI results
    - Await CT scan/x-rays/barium enema/ultrasound etc.
    - Await injection
    - Await blood results
    - Await urodynamics
    - Await histology results
    - Await physiotherapy treatment
    - Await Anaesthetic Assessment

Please Note – a patient must not be added to the OP Waiting List if they are awaiting results and no decision has been made regarding their review date.

Management & Monitoring

A list of all patients who have been discharged using the reason code DARO can be produced by the OSL's/ Service Administrators and used as a failsafe mechanism for checking that all results are returned and that all charts taken are returned.

91. As detailed in Questions 16-18 above, Consultant numbers varied until 2014 and this had an effect on the percentage of emergency work for each individual surgeon to the detriment of their elective work.

[21] Did your role change in terms of governance during your tenure? If so, how?

92. In 2012 (I am unsure of the exact date) I was informed that that the Chair of the Trust (Mrs Roberta Brownlee) reported to Senior Management that Aidan O'Brien had made a complaint to her that I had been bullying and harassing him. I was called into an office on the Administration floor of the hospital to inform me of the accusation. I was advised that I needed to be very careful where he was concerned from then on. I recall being absolutely gutted by the accusation and I left and went down the corridor to Martina Corrigan's office. Martina immediately asked me what was wrong, and I told her of what I had just been informed. In approximately 2020, I truthfully had difficulty recalling who informed me. Martina Corrigan said I told her at the time that it was Helen Walker, AD for H.R. I now have a memory of same but can't be 100 percent sure that it is correct. I recall having a conversation with Dr Rankin who advised that, for my sake, I should step back from overseeing Urology and I was advised that Robin Brown should assume direct responsibility. I was also advised to avoid any further meetings with Aidan O'Brien unless I was accompanied by the Head of Service or the Assistant Director. As a result, I instructed Robin Brown to act on all Governance issues regarding Urology and in particular any issue concerning Aidan O'Brien. At my next meeting with John Simpson, I advised him of the issue and the change in governance structure in Urology. There was no formal investigation of the complaint, and I have checked with Zoe Parks (Head of Medical HR) and she says that there is no record on my file of the accusation.

[69] Having had the opportunity to reflect, do you have an explanation as to what went wrong within urology services and why?

69.1 On reflection, and setting out the range and number of issues in urology services, I believe that the following is clear:

a. The service was under considerable pressure due to increasing referrals; and was insufficiently resourced to meet the catchment population needs. The long term absence of the ICATS urology doctor (contracted for 7 sessions per week), contributed to the consultant pressures as they had to see all referrals in outpatients.

b. There was also additional pressure due to the consultant clinical behaviour of Mr O'Brien which meant that smaller numbers of patients were seen in each outpatient clinic and more patients were reviewed than consultant peers would review. There was also little appetite in the service to agree protocols with primary care to review certain cohorts of patients.

c. There was poor professional practice which had been longstanding. It proved to be difficult to get agreement with Mr O'Brien to change this behaviour. When change in his behaviour was agreed, the specific behaviour was not always sustained and he would revert to previous poor practice. An example of this was when Mr O'Brien agreed to triage referrals within the required time standards; it became apparent subsequently that this change in behaviour was not sustained and required regular checking.

[70] What do you consider the learning to have been from a governance perspective regarding the issues of concern within urology services and the unit, and regarding the concerns involving Mr. O'Brien in particular?

70.1 There are several points of learning from a governance perspective which are set out below:

a. When a service is under pressure with insufficient resources to meet the population need for a prolonged period, it might be reasonably assumed that the risk level within the service may increase.

b. A service under pressure to meet population need may have little appetite or space for the development of implementation plans and then implementing this change. However, it could reasonably be assumed that most services and the senior staff in those services would welcome the opportunity for growth of the service and improvements in services for patients.

c. Systems to collect data, to provide the full functionality required to identify staff behaviour, and provide the required reports to monitor this behaviour are not always available at the point in time when needed (reference the regional radiology system).

d. Governance systems which require action on behalf of all staff, e.g., being open about concerns or completion of clinical incident data on the Datix system, take time for staff to be trained, time for the processes to become embedded, and time for staff confidence to use them to build. This process is a journey of improvement for a large organisation rather than an overnight change.

e. It is difficult to monitor all consultant behaviour. If there is evidence of agreed changes in behaviour not being sustained then additional action should be considered, particularly where this involves what might be regarded as required clinical consultant behaviour especially when this is outside the accepted 'normal' behaviour of peers.

[71] Do you think there was a failure to engage fully with the problems within urology services? If so, please identify who you consider may have failed to engage, what they failed to do, and what they may have done differently. If your answer is no, please explain in your view how the problems which arose were properly addressed and by whom.

71.1 I believe that there was a failure to engage fully in the following ways:

71.2 There was resistance to change in clinical behaviour. Resistance to change was the general sense in the urology service. However, when change was required in order to implement improvements for patients, two consultants did make these changes in their personal behaviour. Examples of changed behaviour are changing clinic templates and the new to review ratios to reflect BAUS guidance; setting up the local MDM (Multidisciplinary meeting) in preparation for the regional MDM; agreeing new patient pathways such as 1-stop clinics. These 2 consultants also undertook additional work, such as triaging on behalf of Mr O'Brien when he failed to cooperate in undertaking this process in the required time standards. Mr O'Brien tested the new clinic templates and his clinics regularly overran by 2 hours. He therefore was unable to, or chose not to, amend his behaviour in outpatient clinics.

71.3 It is difficult to state what could have been done differently within the Trust, and without reference to outside professional bodies, to change the behaviour of a single consultant who was resistant to change and refused to acknowledge that there was a requirement to work within a clinical system where the DoH, the Commissioner (HSCB), and the Trust had set out the parameters. Examples of such requirements are the time standards set out in the DoH IEAP, the HSCB requirements to use BAUS guidance for outpatient clinic templates and numbers of review appointments, and the challenge made to the referral of the initial cohort of patients to Belfast for radical pelvic surgery. However, perhaps earlier action may have been appropriate in seeking an external assessment of competence to practice.

71.4 In terms of other issues in the service, there was full support to obtain agreement and funding for both in-house additional theatre lists (where the consultants