UROLOGY SERVICES INQUIRY

USI Ref: Notice 9 of 2022

Date of Notice: 14th April 2022

Note: An addendum amending this statement was received by the Inquiry on 22 June 2023 and can be found at WIT-98538. Annotated by the Urology Services Inquiry.

Witness Statement of: Ms Debbie Burns

I, Debbie Burns, 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. It would greatly assist the Inquiry if you would provide this narrative in numbered paragraphs and in chronological order.**

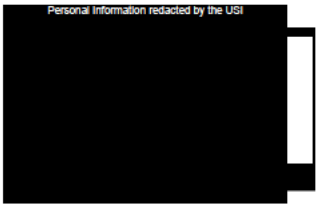
1.1 A response is provided within this statement to each individual question with regard to the nature of my knowledge of the matters which fall within the scope of the Terms of Reference of the Inquiry, including my role and responsibilities.

1.2 By way of summary of the key aspects of my role in relation to events that are of relevance to the Terms of Reference of the Inquiry I would comment as follows:

1.3 Within the Southern Trust I have held several roles which are outlined in further detail at paragraph 5.1, namely Assistant Director of Performance and Improvement (2007-2010), Project Manager, (2010-2011), Assistant Director of Clinical and Social Care Governance (2011-2013), and Director of Acute Services (2013-2015).

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

Statement of Truth

Signed: 

Dated: 9th June 2023

Urology Services Inquiry

UROLOGY SERVICES INQUIRY

USI Ref: Section 21 Notice No 9 of 2022

Date of Notice: 14 April 2022

Addendum Witness Statement of: Debbie Burns

I, Debbie Burns, will say as follows:-

1. I wish to make the following amendments to my existing response, dated 9th June 2023, to Section 21 Notice number 9 of 2022.
2. At paragraph 73.2. 10 WIT 96935 I have stated " *I do not believe on reviewing documentary email evidence this is correct. In September 2013 there are emails between myself, AD functional services Anita Carroll who escalates and me to Martina Corrigan, Eamon Mackle and Robin Brown – 4-9-2101 and 5-9-2014. Robin Brown advised he can only deal with issue with Mr O'Brien in 2 weeks as he was the Surgeon of the Week. I advise Eamon and Martina on 5-9-13 that I need this addressed as soon as possible as it is a governance issue*." This should be amended to state "I *do not believe on reviewing documentary email evidence this is correct. In September 2013 there are emails between myself, AD functional services Anita Carroll who escalates and me to Martina Corrigan, Eamon Mackle and Robin Brown – 4-9-~~2101~~ 2013 and 5-9-~~2014~~ 2013.Robin Brown advised he can only deal with issue with Mr O'Brien in 2 weeks as he was the Surgeon of the Week. I advised Eamon and Martina on 5-9-13 that I need this addressed as soon as possible as it is a governance issue*.

Statement of Truth

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

Signed: [redacted]

Date: 22.6.2023

REVIEW OF CLINICAL AND SOCIAL CARE GOVERNANCE ARRANGEMENTS

Context

The Trust has moved to implement new arrangements designed to ensure an effective assurance framework for Clinical and Social Care Governance within the Southern Trust.

Under this model, direction will be provided by the Senior Management Team working through a new post of Head of Governance. The Head of Governance will lead a "virtual" integrated Clinical & Social Care Governance (C&SCG) Team with the aim of providing assurance that Trust services are delivered to the appropriate standards in relation to quality and safety of care, and that any risks in relation to quality and safety are effectively identified and managed.

This process is designed to ensure the identification and effective control of risks within the Trust's Board Assurance Framework, assurance on the effectiveness of the Trust's C&SCG arrangements, and the provision of expert advice and support to Directorate Governance arrangements.

The Trust was not successful in making an appointment when the post was advertised internally within the Trust in January 2010 and has decided to advertise externally for the post.

Due to the urgent nature of the work to be undertaken the Chief Executive has commissioned a review of the effectiveness of current clinical and social care governance arrangements at operational level, and the information and systems available to provide assurance on the safety and quality of our care.

Review Terms of Reference

The Trust has agreed to appoint a project manager on an interim basis for three months.

Southern Health and Social Care Trust

Consultation on Proposed Structures for Clinical and Social Care Governance

Consultation Period 8th Dec to 22nd Dec 2010

"A SYSTEM OF TRUST"

achieving compliance and the resulting risks, effectively communicating these both internally and to our commissioner and DHSSPS.

Service Reviews from England and elsewhere have highlighted organisational and practice issues which have resulted in poor quality, and in some cases unsafe care. The Mid Staffordshire NHS Foundation Trust Inquiry and the resultant reports provide an important framework against which to judge our capability to provide safe, high quality care.

It is in this context that the Senior Management Team of the Trust commissioned a review of CSCG arrangements within the Trust.

Purpose and Objectives of Review

The review was commissioned by the Acting Chief Executive and SMT in March 2010 with the remit to critically appraise the Trust's current operational and assurance systems in relation to CSCG, including processes, capacity, capability and outcomes from the current system (see Appendix 2 for Terms of Reference).

Methodology

The Review, while intending to satisfy its terms of reference and benchmark the organisation against the findings of Independent Inquiries in other Trusts, for example the Mid Staffordshire Inquiry, adopted a very basic and fundamental template on which to assess the current CSCG system and make recommendations for improvement. Four basic questions were considered in the examination of the current roles, responsibilities, accountability arrangements and systems, and the resolution of these questions shaped and informed the Senior Management Team (SMT) recommendations:

1. What does the Trust mean by clinical and social care governance – what are its components?
2. Who is responsible and accountable for delivering these components?
3. How does the Trust deliver these components?

SECTION 2:

Rationale for Change

During the review, while within the Southern Trust it was evident that although there were no major operational shortcomings identified with respect to patient safety and quality of care, a number of significant system and organisational issues emerged. Through a series of workshops SMT produced recommendations and developed a pathway for change and improvement to the CSCG systems and processes within the Trust. The recommendations are summarised below:

- Effective decision making on issues of safety and quality should be taken as close to the point of service delivery as possible.
- Clarity and singularity of responsibility and accountability are required with respect to CSCG within the organisation.
- An in-depth understanding and agreement of the 'professional' Executive Director role and responsibilities, to provide the organisation with resolved professional guidance, advice and expertise in relation to standards for quality and safety of care and of the professional workforce (medical, nursing, social work and AHP). They will also independently assess and provide assurance on the levels of compliance to SMT Governance and Governance Committee, while providing a corporate alert when compliance with standards is at an unacceptable level.
- The operational management of services carries the responsibility and accountability for the safety and quality of those services and of the workforce delivering the care, supported by the Executive Directors when appropriate in relation to professional workforce matters.
- Service teams have a clear understanding of the roles and responsibilities within the organisation for clinical and social care governance. They have both confidence and ownership of their role, combined with the support mechanisms to provide the capacity for them to respond to the current and increasing CSCG agenda.

SECTION 3:

Proposed Structures

Within this section the three core components of the Trust CSCG model have been populated with the proposed structure to deliver them. How the new structure will actually work in practice is then described. It is essential that the concepts described earlier – decision making as close to the point of service delivery as possible by those who can effect change and learn from it, clarity and singularity of accountability, communication and Trust wide patient safety learning and organisational intelligence are the foundations of how the CSCG system needs to function.

We need to understand the Trust systems for CSCG:

- Who takes decisions and who is accountable for the decisions and the following action or inaction?
- How will we communicate these decisions and provide organisational intelligence to improve patient safety learning?
- How will we achieve the actions which flow from these decisions and meet the increasing CSCG agenda?

The description of Trust systems will then be followed by a brief synopsis of the processes within the CSCG model, for example complaints, incidents, etc. The description will be at a high and generic level as the core business for each Directorate varies in nature and thus so will the detail. However it is expected that the Directorate detail, if not already in place, will be worked through by the Operational Director and their teams facilitated by the Directorate Governance Coordinator when appointed.

Finally within this section a brief description of each of the new job roles within the CSCG system will be presented. Detailed job descriptions for new roles are available on request; those whose role will be essentially similar with the same banding, but whose lines of reporting will change, will be invited to participate in formulating revised job descriptions for their modified roles.

Three Core Components of CSCG - Structure

CORPORATE COORDINATION &OVERVIEW

Reporting to Chief Executive's Office:

1 wte Band 8C AD CSCG
1 wte Band 5 Governance Officer
1 wte Band 3 Governance admin Assistant
1 wte Band 7 (Temporary for 1 year) Governance Training Officer
Current central reporting team (Systems manager will report to Informatics Division)
Current Effectiveness and Evaluation team

OPERATIONAL Directors & their teams

Will be supported by a Directorate Governance team using both existing arrangements and complemented by proposed new arrangements

Existing Structure:
AMD's,
CD's,
AD's,
AD / HOS senior Directorate advisor for nursing, AHP and Social work
In reach nurse workforce, dev & training
In reach Social work governance, workforce dev & training

New Structure:
1 wte Band 8B governance coordinator reporting to Director
1 wte Band 5 governance officer (*1.6 wte in Acute services)
1 wte Band 3 governance admin assistant (*1.6 wte in Acute service)
Pro rata wte Band 7 nurse governance facilitator (previously practice support & governance lead)
1 wte AHP Directorate Lead (Operational and Governance lead)
****Acute services only**
1 wte Band 7 Patient Safety & Quality Manager (Encompass standards &Guidelines)
1 wte Band 6 Patient Safety & Quality Officer

Assurance

Support

PROFESSIONAL Executive Directors & their teams

Nursing:
2 wte Band 8C (current posts)
Education, training & Development team (current team)

AHP:
1 wte Band 8C (current post)
1 wte Band 7 workforce development and training (new post, temporary for one year in the first instance)

Social Care:
1 wte Band 8C (Current post)
Governance, workforce development and training team (current team)

Medical:
8b Medical workforce (current post)
Band 7 (Current post)
Band 6 Patient Safety Initiatives Officer (current post)
Litigation team (current posts)

- This review will complete by the end of December and its recommendations will be integrated into the implementation plan of the CSCG Review.

Process 10: Managing Poor Professional Conduct and Performance

- The processes for the above have been the subject of revision as part of the Review of Governance. The Trust processes are attached in appendix 3
- It is evident from the processes that those involved are also those who can action change and effect patient and client safety. These processes should be reported on a regular basis at Directorate level and learning issues raised through the Governance Working Body

Supporting Infrastructure - Web Based Datix

As discussed previously the above processes will be significantly enhanced and supported by the roll out across the Trust of the Web based information management system Datix. This will mean that all clinical teams will have on their desktops modules for incident management, complaints, risk management and standards and guidelines management.

Following roll out and training staff will be able to for example log incidents in real time, line managers and others can be alerted to incidents and there is a real time view of how these are being actioned and who is taking this forward. This should result in staff getting real time feedback on incidents reported and actually seeing changes to practice being made. It will also enable everyone to have access to much improved data on how safe our services are and how we are improving them.

This is an exciting new development which will give service teams the opportunity to tailor a system to meet their requirements and get real time information from it on issues of CSCG. Roll out commences in January 2011 with two pilot sites which are Delivery Suite, CAH and Bluestone Unit within Mental Health and Disability services.

review and potential revision following phased implementation of the recommendation within the governance review.

Process 1: Complaints

- Complaint received by central reporting in AD CSCG office. Logged on system. Sent electronically to Directorate Governance coordinator.
- Governance coordinator screens and prioritises for Assistant Director (AD), Associate Medical Director (AMD) and Director attention or Head of service (HOS) and service team attention. Electronically transferred to AD / AMD/ Director or HOS /team.
- Directorate governance officer monitors complaint progress and ensures timeframes adhered to as laid out in the Trust Complaints policy. Provides assistance as required to service team
- Response agreed with service team, AD, AMD and Director, as appropriate, by Directorate Governance Coordinator before being sent to complainant - eventually this process will be managed by the Directorate governance officer and rely less on input from the Governance coordinator
- It is envisaged that this system will be improved by the potential roll out of the web based datix module for complaints which will be on staff desktops. The roll out of the information management system will also significantly improve our ability to track trends of complaints and share learning at a team, division, directorate and corporate level – a role taken on by the Directorate governance coordinators and the AD CSCG. Shared learning will take place via the Governance Working Body and recommendations for change will be agreed and prioritised by SMT Governance

NB: Ombudsman issues will be dealt with in a similar format but will have input from the AD CSCG to ensure organisational learning. Chief Executive will sign off these responses.

Process 2: Incidents

This area of work will change significantly from the current process with the piloting and roll out of web based datix for incident management during the next 6- 9 months. Described below is a vision of what the process will be when the web based system is in place.

- Incident occurs within service team – reported by a member of the team via the web based system on their desktop.
- The reporting format will have been designed by the team and the incident will then be electronically alerted to the team line management
- Directorate Governance coordinator and service AD'S / AMD's /HOS will have an agreed process for service teams to action and deal with incidents in real time. An example of how this is achieved currently within one team can be found in Appendix 4. The detail of this may vary within each Division and Directorate – particularly the who and the how, however the principles of senior clinical involvement and a practical, workable mechanism to ensure learning is shared within the teams / division / directorate must be a key element of the process that is clearly visible.
- Incidents will then be reviewed on weekly real time reports by teams, Divisions, Directorates and at a corporate level, as will the recorded action and learning by the teams.
- Incidents that have not been actioned, closed and learning taken from them will be evident at team, Divisional, Directorate level and a corporate level by the AD CSCG
- Trends, learning and failure to effectively address incidents will also be identified and actioned by the Directorate Governance coordinator through the Directorate CSCG forum and the AD CSCG. These will be shared within the Governance working body and analysed as to whether escalation of learning is required to SMT Governance.

Process 3: Patient Safety & Quality (inc. Standards & Guidelines):

The Trust currently receives a significant volume of standards and guidelines and key performance indicators from various professional and patient safety bodies including NPSA, NICE, NCEPOD, RQIA, Chief Nursing Officer, the Chief Medical Officer and the Departmental Director of Safety, Quality and Standards. The following describes the process of how these publications will be dealt with.

- The office of the Chief Executive will be the central receptacle for these standards, guidelines and recommendations. Any such communication received at any other point within the Trust should be redirected to this central point.
- They will be logged on a database within the office of the AD CSCG and early distribution will take place to relevant Directors for information and consideration prior to a work plan being developed by the Governance working body.
- The AD CSCG will table the publications at the Governance working body meeting and a relevant implementation team will be identified within each Directorate including any assistance required from professional, operational and governance leads.
- A timetable and implementation plan will be agreed by this team and reports on progress and constraints and monitoring of progress will be via the Governance working body.
- Executive Directors requiring monitoring progress on any professional specific standards and guidance will also receive progress reports and updates on assurance from Directorates via their AD representatives on the Governance working body.
- The Medical Director will receive information on the specific Departmental Patient Safety Initiatives in the same way via his Band 6 representative.
- Each Directorate can then monitor the number of ongoing implementation plans and feasibility of implementing standards and

guidelines through their Directorate Governance coordinator who sits on the Governance working body

- Due to the highest percentage of standards, guidelines and recommendations requiring implementation being within the Acute Services Directorate, this service will have 1 wte Band 7 Patient Safety and Quality manager and 1 wte Band 6 Patient Safety and Quality officer
- These posts will assist with implementation of standards and guidelines within Acute services, including key performance indicators relating to specific patient safety initiatives and alerts in relation to medical devices and equipment.
- They will also maintain the ongoing programme of undertaking the ISO quality standard for equipment management in order to support the maintenance and safe use of equipment.
- The Patient Safety and Quality Manager will also chair a small sub committee of the Governance Working Body which includes estate services, representation from the older people and primary care Directorate and Acute services together with Health & Safety representation. This will ensure the ability to address any issues arising from Medical Devices on a Trust wide basis and should include the procurement of new equipment from a user and continuity perspective.

.

Process 4: Risk Management

This process will be taken forward by the Directorate Governance Coordinators and service teams. Again it is envisaged that during the phased implementation of the web based Datix management information system this process will become less labour intensive. Further work is required within this area to ensure that there is an organisational understanding of the principles behind risk management and a clear process for the management of identified risk. Risk registers should not be a long list of concerns; it is a formal record of potential / possible / probable dangers which could result in loss, harm or failure and detail how this risk

is being managed. The organisation at every level must have a mechanism for detection, prevention and contingency for risks and have a resolved position at each level in the Trust as to acceptable levels of risk which can be borne and those which cannot.

The improvement of the organisational understanding of risk management at a team, division, directorate and corporate level will be a follow up project for the AD CSCG, Directors, service teams and Directorate Governance Coordinators when the new structures are in place. Training to support effective organisational understanding and operation of risk management systems will be led by the Governance Training Officer within the central coordinating function.

Process 5: Registered & Unregistered Workforce Standards, Quality, Training & Education

- CSCG and workforce training, education and development are inextricably linked, the latter flowing from the need to ensure patient and client safety and quality care and the systems and processes of the organisational model of CSCG indicating issues of safety and quality. Therefore to ensure these links are made and that a coordinated approach is taken both across Directorates and at a corporate level and that the profile of education, training and development is raised and is targeted at supporting patient and client safety and quality care, there is a need to describe how this function will be delivered and where the lines of communication and accountability lie. This has been done in diagrammatic form earlier within the paper but will be repeated for clarity.
- The offices of the current Executive Directors will continue to be responsible for setting, advising on and monitoring standards of safety, quality, training and education of the registered workforce including Medicine, Nursing, AHP and Social work. They will also independently assess and provide assurance on the levels of compliance with these standards to SMT Governance, Governance

Committee and Trust Board, while providing a corporate alert when compliance with standards is at an unacceptable level.

- However as the Executive function is neither a line management nor an operational role, it cannot be held accountable for delivering the actions required to implement agreed workforce standards and quality and safety of care.

- This accountability, for implementing agreed workforce standards, clearly lies with the Operational Director charged with delivering this service, who must provide assurance to the Executive function that action is taking place to ensure a workforce of an acceptable standard and safe and high quality care is delivered.

- The Operational Directors will achieve this through their Directorate Governance team. The Accountability chain for implementing the required standards and for highlighting training, education and development needs flows up from Heads of Service, AHP leads and Clinical Directors to Assistant Directors and Associate Medical Directors to the Operational Director who assures the appropriate Executive Director and is accountable to the Chief Executive. This Operational team will be supported and facilitated internally by the Directorate Governance Coordinator, the Nurse Governance Facilitators, the Lead AD Nursing Advisor, the AHP lead, lead for Social Work and AMD's. They will have in reach support from the Social Work governance, workforce development and training team, Nursing and Midwifery education, training and development team, the AHP governance and workforce development and training support and the medical workforce team all of whom are within the relevant Executive Director's office.

- The vehicle for this to take place should be the Directorate, divisional and service team governance meetings, with final sign off

of any issues pertaining to workforce standards, training, education and development being achieved at the Directorate Governance meeting. This ensures that there is a coordinated approach to this issue by Directorate, due consideration given to Directorate workloads and pressures and that those who will be held accountable for implementation – the Operational Directorate - are engaged in the process. Those described above who facilitate, advise and monitor workforce issues should therefore attend the Directorate Governance meeting to provide expert advice and to seek assurances on compliance with agreed standards.

- In relation to the non registered workforce, to ensure that standards, quality and opportunities for workforce training and development are afforded to them, each staff group will have a lead Director appointed to implement this agenda.

- To ensure a corporate, value for money approach to workforce training, development and education the SMT has recommended that the Director of Human Resources chairs a Trust wide forum to enable a uniform approach to workforce development and training for both registered and unregistered staff. This forum will be fed by the collaborative working between Directorate and Executive functions described above and will have Directorate and Executive representation.

Process 6: Clinical indicators and Audit

- Executive Directors will provide expert advice and guidance on the organisational and service level quality indicators that will provide evidence of the safety and quality of care of care systems and the competence of the professional workforce within the Trust.
- The responsibility for progress and achievement of acceptable performance against these indicators rests with the Operational Directors and their teams. Again the Directorate Governance teams will support the service teams with this process.

- Directorate level audit, as agreed by SMT, will be undertaken and reviewed by service teams. The Executive Directors will also review these audits to ensure an acceptable level of compliance with quality and safety indicators and will alert the corporate organisation if performance against the indicators is unacceptable.

Process 7: Effectiveness and Evaluation

- Effectiveness and Evaluation team will in the main undertake audit of quality and safety indicators which are of a more corporate nature and provide a sound basis for a patient and client safety learning system.
- This programme of work will be decided by the SMT Governance, with advice and input from the Governance Working Body.
- Although having a corporate function and being centrally managed, the E&E team will continue to provide expert advice to Directorate teams in methodologies etc.

Process 8: Litigation

- Increased collaborative working between Operational Directors, their AMD's and AD's will be facilitated by the Medical Director and the litigation team.
- The Medical Director will bring forward a recommendation on how this will be achieved and through what forum.
- The Director of HR will act as an expert advisor on all non medical litigation, and will seek professional expert advice in relation to Social Work, AHP, and nursing when appropriate.
- The Directorate Governance coordinator will act as a conjugate within this system having a collaborative working relationship with the Litigation team.

Process 9: Morbidity and Mortality

- A review of current processes for the above has commenced with the purpose of ensuring integration and accountability structures within the wider CSCG systems in the Trust.

Appendix 3: Processes for managing poor professional performance and conduct

Step 1 Screening Process

Issue of concern i.e. conduct, health and/or clinical performance concern, raised with relevant Clinical Manager**

→ Clinical Manager/Operational Director informs:

- Chief Executive
- Medical Director
- Human Resources Department
- Practitioner

↓

Chief Executive appoints an Oversight Group – usually comprising of:

- Medical Director / Responsible Officer
- Director of Human Resources and Organisational Development

↓

Clinical Manager and HR Case Manager undertake preliminary enquires to identify the nature of the concerns and assesses the seriousness of the issue on the available information.

↓

Clinical Manager and HR Case Manager, consults with NCAS and / or Occupational Health Service for advice when appropriate.

↓

Clinical Manager and HR Case Manager notify the Oversight Group of their assessment and decision. The decision may be:

- No Action Necessary
- Informal remedial action with assistance and input from NCAS
- Formal Investigation
- Exclusion / Restriction

* If concern arises about the Clinical Manager this role is undertaken by the appropriate Associate Medical Director (AMD). If concern arises about the AMD this role is undertaken by the Medical Director

Step 2 Informal Process

A determination by the Clinical Manager and HR Case Manager is made to deal with the issues of concern through the informal process.

The Clinical Manager must give consideration to whether a local action plan to resolve the problem can be agreed with the practitioner.

If a workable remedy cannot be determined, the Clinical Manager and the operational Director in consultation with the Medical Director seeks agreement of the practitioner to refer the case to NCAS for consideration of a detailed performance assessment.

Local action plan is developed (this may not always involve NCAS)

The Clinical Manager may seek advice from NCAS and this may involve a performance assessment by NCAS if appropriate.

Referral to NCAS

Informal plan agreed and implemented with the practitioner. Clinical Manager monitors and provides regular feedback to the Oversight Group regarding

In instances where a practitioner fails to engage in the informal process, management of the concern will move to the formal process.

Directors, AMD's and supporting governance staff attended. All matters of governance were on a standing agenda which indicates that on a monthly basis we as a senior leadership group reviewed serious adverse incidents and agreed learning and recommendations, complaints management report, incident management report, regional patient safety guidance, divisional and directorate risk registers, Acute medical audit committee report, standards and guidelines and any other business in relation to clinical governance. I have no recollection of individual meetings or their content, but regular agendas and minutes are available.

33. Who oversaw the clinical governance arrangements of the unit and how was this done? As relevant to your role, how did you assure yourself that this was being done appropriately? Please explain and provide documents relating to any procedures, processes or systems in place on which you rely on in your answer.

33.1 In relation to my role as Assistant Director of Clinical and Social Care Governance, I refer to my response at paragraph 32.2. I note from the 2010 consultation document on clinical and social care governance, and outlined structures within it, the Director of Acute Services at this time, her AD, AMD and governance lead would have held responsibility for the governance of the urology service. *Please see:*

2.- 4. 20101208 Consultation of CSCG Final Version, A1-A2

33.2 I would have reported to SMT and the Trust Board on SAI's, complaints, incidents and risk across the whole organisation at a high level of Directorate accountability. Individual Directors would have then accounted for individual directorate specialities. *Please see:*

76.-79. 20120124 E with SMT Governance Papers, A1-A3

33.3 During my tenure as Director of Acute services, I refer to my role in respect of governance arrangements at paragraph 32.4.Having undertaken the role of AD CSCG previously I was assured that the systems and processes in place in respect of CSCG were appropriate and even progressive given the context of the

Heather Trouton, her medical colleagues the AMD and CD and the AD for Performance and Reform – Lesley Leeman. I refer to paragraph 29.1, which outlines that within my role as Director, I met weekly and monthly with each Assistant Director of each Division, HOS and OSL with appropriate performance colleagues and information which was reviewed. Please see:

58.-60. 20140812 Acute Patient Experience Meeting Agenda, A1-A3
61.-62. 20140818 E Acute Services HR and Finance Mtg, A1
63. 20141007 Goverance agenda
53. 20150814 Acute Clinical Governance Action notes
64.-65. 20131203 Acute Directorate Finance Meetings 2014 A1

35.5 Corporate colleagues in Performance would have also reported on the Acute Directorate to the Senior Management Team of Directors and to the Trust Board on a regular basis. I understand agendas and minutes are available. *Please see:*

58.-60. 20140812 Acute Patient Experience Meeting Agenda, A1-A3
61.-62. 20140818 E Acute Services HR and Finance Mtg, A1
63. 20141007 Goverance agenda
53. 20150814 Acute Clinical Governance Action notes
64.-65. 20131203 Acute Directorate Finance Meetings 2014 A1

35.6 I have extracted below information from the February 2015 performance report which outlines the Acute directorate position across all specialties (*please see 82. 20150326 Performance Report a and 83. 20150326 Performance Report b).* I believe this is important context for reviewing operational delivery, governance and performance:

'Acute Directorate receiving approx.

7000 new outpatient referrals per month

900 red flag referrals per month

Performing:

550 MRI scans per month

1800 CT scans per month

Regional Commissioning Targets:
62 day cancer pathway *achieving 91% patients within 62 days and no one waiting over back stop of 85 days (Target 95%) Those in excess in January 2015 1 urol internal, 1 head and neck external, 2 lung external and 5 urology external. In February 2015 all were external waits.*

31 day cancer pathway *achieving 99% against regional target of 98%*

ED 4 HOUR WAIT:

Highest in region 83% versus 95% target

Outpatient waiting target 80% no longer than 9 weeks backstop 15 weeks:

Dermatology 1688 patients over 9 weeks longest 40 weeks

Urology 1020 patients over 9 weeks longest 53 weeks

Orthogeriatrics 41 patients over 9 weeks longest 46 weeks

Orthopaedics 770 patients over 9 weeks longest 36 weeks.

Visiting ophthalmology services (BT) 2404 patients over 9 weeks longest 49 weeks

Outpatient review position – no formal commissioner target:

20,608 patients waiting over clinically indicated date

7455 = 36% in excess of 6 months

4958 = 24% 3-6 months

8195 = 40% 0-3 months

Southern Health and Social Care Trust

DIRECTORATE OF ACUTE SERVICES

Interim Director: Mrs Deborah Burns

Tel: Personal information redacted by the USI

ACUTE CLINICAL GOVERNANCE

Date: Friday, 14th August 2015 8am

1.0	**Apologies**: Mr Mackle (Mr Hall attending), Dr Hogan (Dr McCracken attending), Barry Conway (Mary Burke attending), Ronan Carroll (Fiona Reddick attending)	
2.0	**Matters Arising/Actions**	
3.0	**SAIs**: **(a)** Personal information redacted by USI Mr S O'Reilly presented the report. The issue about seniority of staff so the very sick are correctly recognised and prioritised was discussed. The staff on that night felt that the department workload was manageable yet this child waited for 6 hours. Recommendation 5 – remove 'night' as it should be at all times. Locum should stay 'locum SHO'. 'Ketones as dehydration' to be removed as this is not correct. We need to get the post mortem result as the exact cause of death is key to whether the examination of the child was correct/sufficient. 'Blood tests may have been normal' to be removed as is subjective and not logical. Personal information redacted by USI and together will try and get some more information about the post mortem findings. If it is necrotic bowel the report is fine. **(b)** Personal information redacted by – Mr S O'Reilly presented the report. The report analysis section is completely contrary and doesn't make sense and also the conclusions are flawed. Should have had a surgical opinion and admission for investigation. This needs to go back to the team and also an external opinion needs to be sought. The failure to ask for senior help is also an issue and this may be cultural. **(c)** Patient 128 – Mr Hall presented the report. Approved **(d)** Personal information redacted by USI – Mr Hall presented the report. Approved **(e)** Personal information redacted by USI – Dr McAllister presented the report. Approved **(f)** Persona – Dr McCracken presented the report. Approved. **(g)** Patient 10 - Dr Murphy presented the report. Approved	

Southern Health and Social Care Trust

Quality Care - for you, with you

Root Cause Analysis Report on the investigation of a Serious Adverse Incident

Organisation's Unique Case Identifier: [redacted]

Date of Incident/Event: 2012-2014

HSCB Unique Case Identifier:

Responsible Lead Officer: Mr Anthony Glackin

Designation: Consultant Urologist

Report Author: Review Team

Date report signed off:

Date submitted to HSCB:

Table of Contents

1.0 EXECUTIVE SUMMARY

In August 2012 aged Personal Information Patient 128 underwent right radical nephrectomy for renal cell carcinoma. Histology revealed a Fuhrman Grade III tumour. Follow-up management plan included regular CT scans and clinical reviews. Patient 128 was reviewed in February 2013. At this time a CT scan was arranged for May 2013, this was to be followed by a clinical review in June 2013.

Patient 128 did have a CT scan in May 2013 as arranged but was not reviewed in June. On 20th August 2014, concerned that Patient 128 might have recurrent disease, Patient 128's GP referred Patient 128 back to the Southern Trust Urology Service. Metastatic recurrence was identified on CT scan.

2.0 THE INVESTIGATION TEAM

Names	TITLES
Anthony Glackin	Consultant Urologist (Chair)
Simon Gibson	Assistant Director Medicine
Katherine Robinson	Booking and Contracts Centre Manager
Paula Fearon	Governance Support

3.0 INVESTIGATION TERMS OF REFERENCE

Terms of Reference for the Serious Adverse Incident Investigation are as follows:

- To carry out a review into the care provided to Patient 128, from June 2012 until September 2014 using the National Patient Safety Agency Root Cause Analysis methodology
- To use a multidisciplinary team approach to the review
- To provide an agreed chronology based on document evidence and staff accounts of events.
- To identify the key contributory factors which may have had an influence or contributed to Patient 128's treatment and care
- To ensure that recommendations are made in line with evidence based practice.
- To set out the findings, recommendations, actions and lessons learnt in an anonymous report
- To adhere to the principles of confidentiality throughout the review.
- To report the findings and recommendations of the review through the Director of Acute Services SHSCT to the staff associated with this incident
- To share the Report with Patient 128

This investigation will adhere to the principles contained within the National Patient

6.0 FINDINGS

Management 13th June 2012- 6th September 2012

The Review Team is satisfied that Patient 128's initial diagnostic investigations and subsequent surgical intervention were appropriate, timely and met Cancer Guidelines.

When it became apparent that Patient 128 required a nephrectomy Dr 1 (Consultant Surgeon) transferred Patient 128's care to Dr 2 (Consultant Urologist) who specialises in this surgery. Transfer and pre-operative support were carried out correctly. The Review Team noted surgery (29/08/12) was difficult as there was hilar lymph node disease.

Patient 128 was first discussed at a Urology Multi-disciplinary Team Meeting (MDM) after surgery (06/09/12). The Review Team is aware this is neither unusual nor unreasonable.

Patient 128's history, surgery, imaging and histology findings were discussed during MDM so that an appropriate management plan of care could be determined. It was agreed that Patient 128, who was discharged from hospital that day, should be reviewed by Dr 2 who would arrange further CT scanning in November 2012 after which Patient 128's case would again be reviewed at MDM.

Although Patient 128's discharge letter was not typed until the following April (03/04/13) a letter containing the MDM discussion (6/09/12) and management plan was sent to Patient 128's general practitioner (GP) which invited the GP to make contact if further information was required. The Review Team are satisfied that in this instance relevant information was issued to Patient 128's general practitioner through the MDM Report. The Review Team are of the opinion however that it is good practice for a discharge letter to be sent to the GP within a few weeks of patient discharge.

Post-operative Review

Dr 2 reviewed Patient 128 two weeks after surgery (15/09/12). A CT scan was requested on this date to be carried out in November 2012, prior to further discussion at MDM. The Review Team accept this was clinically appropriate.

A GP letter was not generated from this appointment. It is the opinion of the review team that the patients GP should receive a summary letter following each outpatient appointment.

Request for CT scan November 2012

Dr 2 completed an electronic CT scan referral on 15/09/12. The request specified November 2012. The scan of chest, abdomen and pelvis was not undertaken until 17th January 2013.

The Review Team ascertained that delays of up to 13 weeks were common at this time as the Radiology Department did not have the capacity to process the volume of requests received within the requested timeframes. The Review Team are of the opinion that the six week wait for this CT scan was acceptable and did not adversely impact on Patient 128's follow-up.

Review 8th February 2013

Patient 128 was reviewed by Dr 3 (Consultant Urologist) on a shared clinic code. The clinic letter to the patient's GP stated the patient was well on review. Although recurrence of renal cancer was not detected, Dr 3 advised that in view of the high risk of recurrence,

serial scans were required. Dr 3 confirmed booking a further scan for May 2013 with next review in June 2013.
The Review Team accept that the intention to scan at intervals was appropriate given Patient 128's histology findings and agree it was appropriate to book a further scan for May of that year. Dr 3 indicated Patient 128 would be reviewed in June 2013. The Review Team agreed the timing of this was acceptable as it would allow for the CT findings to be received.
The CT scan was carried out on 16th May 2013. At this time the Trust protocol was that the report which was generated on 17th May 2013 should be sent by hardcopy to Dr 3's secretary for action by Dr 3. The review team could find no record of the CT report of the 16th May 2013 being signed off or actioned in the clinical record. Dr 3, the consultant who had requested the scan, had left the Trust before the result was generated. An arrangement had not been made to forward such results to another consultant. There had been no formal transfer of cases nor was there a system in place to generate "results worklists" through which outstanding results can be readily visualised and actioned.

Review arrangements for June 2013

Patient 128 was placed on the out-patient review waiting list in use on 8th February 2013. This list did not separate oncology from non-oncology patients. Specific Uro-oncology waiting lists were introduced from mid- February 2013. The Uro-oncology lists were created to provide outpatient sessions specifically for oncology patients. It was envisioned this initiative would help to alleviate the recognised delays in Uro-oncology review waiting times, which were of concern to clinicians. Patient 128 was transferred to the appropriate Uro-oncology waiting list before the intended review date of June 2013. Unfortunately, despite the creation of the aforementioned clinics the waiting list remained long. The Review Team have established that it was likely that Patient 128 would not have been called for review until December 2014.

Discussion

There is an ongoing regional capacity deficit for Uro-oncology review. At present some consultants actively prioritise "high risk patients" that is patients who are at risk of recurrence and manually prioritise their review date from the computerised waiting list. The Review Team has considered if robust handover arrangements and results worklist as discussed above (Review 8th February 2013) may have afforded opportunities for Patient 128 to be prioritised for an earlier review. It is acknowledged that the traditional model of cancer patient review is inefficient and unsustainable (Department of Health 2011). A new model of care for cancer survivors which incorporates a "risk stratification" process to tailor follow-up to the level of care required for the individual; and which takes account of the disease process, treatments and the patients' ability to self-manage has been developed (http://www.ncsi.org.uk/what-we-are-doing/risk-stratified-pathways-of-care/risk-stratification/).
The "Recovery Package" is incorporated into the Regional Transforming Cancer Follow Up" (TCFU) initiative which is being advanced strategically by the Health and Social Care Board in partnership with Macmillan (http://be.macmillan.org.uk/be/s-689-recovery-package.aspx.). It is recognised that the roll out and sustainability of this strategy is dependent on adequate numbers of Clinical Nurse Specialist (CNS) in adult cancer being trained and in post. There is a lack of such CNSs regionally; this is hampering the implementation of TCFU in some specialities (Northern Ireland Cancer Network 2010). A recent census has revealed that with the exception of .6 whole time equivalent CNS for prostate cancer, there are no CNSs specifically for Uro-oncology

within Northern Ireland (Macmillan 2014). The Review Team is of the opinion that addressing this deficit in conjunction with implementing a risk stratified model of follow up has the potential to address the current recognised capacity issues which exist in Uro-oncology review.

Communication with Patient 128 regarding pathology and planned follow up post-surgery.

Dr 3's outpatient letter to Patient 128's GP (08/02/13) indicated assurance was given to the patient that there was no evidence of cancer recurrence on that specific date of review (08/02/13). From the medical notes it is unclear what information had been given to Patient 128 regarding diagnosis, follow-up, potential treatments and prognosis. Neither the MDM record of 06/09/12 nor the letters to Patient 128's GP from Dr 2 (dictated 03/04/13) or Dr 3 (dated 08/02/13) indicate what discussions took place with Patient 128.

Discussion

Clear communication with the patient is an integral aspect of cancer care and follow-up. In order to ensure this is effective it is important that practitioners are aware of the discussions which have already taken place with the patient so that further communication can be undertaken in a meaningful way. It is also recognised that anxiety can reduce the patient's ability to absorb information. For these reasons it is recommended that a written record of communications is documented within the patient's care record, offered to the patient and copied to the general practitioner; with a detailed treatment summary provided at the end of treatment (National Cancer Survivorship Initiative (NCIS) 2012).

Overarching Standard 21 of the Northern Ireland Cancer Services Framework (2009) states that all cancer patients within Northern Ireland should be assessed by a Clinical Nurse Specialist (CNS) at the time of diagnosis, throughout the cancer journey as necessary and at the end of every treatment stage. As indicated above there are no Uro-oncology CNSs in Northern Ireland. The review team are aware that the concept of Key Worker –that is a 'person who, with the patients' consent and agreement, takes a key role in co-ordinating the patients care and promoting continuity, ensuring the patient knows who to access for information and advice' (NICE, 2004) - is embedded in some cancer specialities within the Southern Trust and that this role is usually undertaken by the CNS. A Key Worker was not identified in Patient 128's Care Records. The Review Team cannot speculate if an identified CNS or Key Worker might have identified Patient 128 for earlier review, however concede the development of this role is central to effective and efficient follow up.

Presentation/Referral August 2014

A faxed referral from Patient 128's GP was received by the Trust on 20th August 2014 raising concerns regarding potential metastatic disease. The Review Team are of the opinion that Patient 128's management plan from this point on has been in line with Cancer Guidelines.

7.0 CONCLUSIONS

This SAI investigation was undertaken to investigate why a follow up patient review which was planned for Patient 128 at the Southern Trust Urology Service in June 2013 did not take place. The review team have concluded that the systems and processes in place for organising follow up appointments were followed. Patient 128 was placed on the correct waiting list for review; however, there was an on-going issue with capacity and demand for this service. Uro-oncology Review Clinics were established to address this in February 2013 however the wait for review remains lengthy. The Review Team have established that Patient 128 would not have been called for review from the newly created waiting list until December 2014 by which time Patient 128 had already been re-referred with symptoms of metastatic disease.

8.0 LESSONS LEARNED

There is a "capacity and demand" issue in regard to follow-up review appointments scheduled for the Uro-oncology Review Clinic Service in the Southern Trust. The numbers of patients, who require review, outnumber the number of appointment slots available to review them at the requested interval. This imbalance has resulted in patients being placed on waiting lists for review.

The Uro-oncology waiting list does not stratify the patients with regard to risk of recurrence, or identify those who need to be seen as a priority. There was no formal patient handover arrangement undertaken prior to Dr 3 leaving the Southern Health and Social care Trust. Handover presents an opportunity for the consultant who is leaving to highlight patients who require review in advance of the chronological waiting list schedule. The review team stress formal handover can enhance communication and patient safety but does not negate the need to address the root cause of waiting lists.

All radiology reports require sign off by the responsible clinician, usually a consultant. This provides an opportunity for the individual patient's management plan to be reviewed and altered or actioned if warranted. Due to the lack of formal handover arrangements for Dr 3's caseload this opportunity was lost.

There was a delay in dictating Patient 128's discharge letter post-surgery. In order to enhance seamless care it is important that all relevant information is communicated to primary care/the patient's GP as quickly as possible post patient discharge.

It was not possible to determine from the medical notes the detail of the information Patient 128 had been given regarding cancer diagnosis, follow-up and prognosis. A communication record and named Key Worker are recommended for all cancer patients within Northern Ireland. This facilitates the sign posting of patients so that they can be seen appropriately and in response to changing need as required during follow-up.

9.0 RECOMMENDATIONS AND ACTION PLANNING

Summary of Recommendations

From: Burns, Deborah
Sent: 11 March 2015 13:07
To: Fearon, Paula; Boyce, Tracey
Subject: RE: SAI Draft for consideration SAI Patient 128

Thanks. Do not raise with chair - Tracey to advise. The issue is what did the CT show not whether its included or not – if it had of been reviewed / report looked at - ???Tracey leaving with you
Issue re urology reviews – its not if its right – what are we going to do……

Debbie Burns
Acting Director of Acute Services
SHSCT
Personal Information redacted by USI
Tel: Personal Information redacted by USI

From: Fearon, Paula
Sent: 11 March 2015 13:01
To: Burns, Deborah; Boyce, Tracey
Subject: RE: SAI Draft for consideration SAI Patient 128

Dear Both

I personally don't feel there was any attempt to deflect from the Urology Service re part to play. The Chair was most receptive to get to the root cause of the problem and to try to reduce the likelihood of a similar problem happening again.

CT scan results are included in the Timeline but can also be placed in the body. Initially the entire CT Reports were include but the Chair felt that the information could be difficult for a non-medical person to understand and the conclusion should suffice, this was discussed with Dr Fawzy. If you prefer the full reports can be re-entered.

Martina Corrigan has assured that handover does now occur however this an informal agreement. From the perspective of reducing the likelihood of a similar event happening again the review team is of the opinion that a similar scenario could potentially happen in any area where a Consultant leaves. It was for that reason that it was felt this needed to be considered by all areas.

The waiting times for Urology reviews were checked and verified for this report by Katherine Robinson.

I am happy to address any areas with the Chair and Review Team.

Tracey I will await a response before raising anything with the Chair/RT.

Regards
Paula
From: Burns, Deborah
Sent: 11 March 2015 12:04
To: Boyce, Tracey; Fearon, Paula
Subject: FW: SAI Draft for consideration SAI Patient 128
Importance: High

Hi both
I am not happy with this review on a number of counts – these comments are not for sharing but tracey can you review please and see what you think and then take forward in my absence as on leave:

· This review feels like the urology team have no part to play in this at all – none bar one minor issue of the recommendations falls to them

· The CT scan results are NOT included – what did they say – they were not signed off - what did they say????
· The handover within a team of senior clinicians needs addressed but this is not a corporate issue surely – surely this is a team issue????
· The urology oncology reviews – I have not heard before now that they are well out of time – I had been told a waiting list had been separately made but the backlog is another issue – again urology have not highlighted?!?!

Tracy needs reviewed again

Thanks
D

Debbie Burns
Acting Director of Acute Services
SHSCT
Personal Information redacted by USI
Tel: Personal Information redacted by USI

From: Fearon, Paula
Sent: 09 March 2015 10:39
To: Stinson, Emma M; Burns, Deborah
Cc: Boyce, Tracey; Farrell, Roisin; Glackin, Anthony; Robinson, Katherine; Gibson, Simon
Subject: SAI Draft for consideration SAI Patient 128

Dear Both

Please see attached Draft SAI Report re Patient 128. This Draft has been agreed by the Review Team and shared with Mr O'Brien.

Regards
Paula

9.0 RECOMMENDATIONS AND ACTION PLANNING

1) The Review Team recommends a robust system for managing overdue Uro-oncology review is established.

2) A handover of patient caseload is required before a consultant leaves the trust. This arrangement must be formalised and robust.

3) All radiology reports must be actioned if required and signed off by an appropriate person.

4) A timely discharge letter should be dictated for every Urology patient.

5) The review team recommends a communication record is designed and instigated for use with Uro-oncology patients and named Key Worker

Table of analysis, recommendations and Action Planning

Summary of Analysis/Findings	Recommendation	Action Planning	Lead	Timeframe
The Urology Service has a number of Oncology patients who are not being reviewed at the required intervals	A robust system must be developed to ensure Urology Oncology patients are reviewed in a timely manner	Designated Urology Review Clinics with specific Oncology Consultant Codes Capacity-Nurse led follow-up for suitable Urology Oncology patients- advance in conjunction with NICaN Guidance	Martina Corrigan Head of Service ENT Urology and Outpatient Department	Complete In line with regional progress
The patient caseload of a Consultant leaving the Trust employ is not automatically transferred to another appropriate Consultant within the Trust	Robust handover arrangements must be put in place to ensure patients are transferred from a Consultant who is leaving to a suitable Consultant still within the Trust employ	The Southern Trust should develop a Policy for Caseload Transfer A task and finish group should be convened to advance this	Assistant Directors	3 months

Corrigan, Martina

From: Boyce, Tracey [redacted]
Sent: 12 March 2015 14:29
To: Fearon, Paula
Subject: RE: SAI Draft for consideration SAI [redacted]
Attachments: image001.jpg

Hi Paula
I had a read through the report and it is a good report – but I can see what Debbie is getting at.

As I read it different questions popped into my head – so I imagine the same would happen with the patient and/or their family

The questions I had were:
· Page 4 – Investigation method – this only lists records and procedures – did the review team speak to radiology, the consultant secretary, etc?
· Page 6 – why did it take so long for the discharge letter to be typed (this might of helped in that the GP may have noticed the follow up delay)
· Page 6 – under post-operative review – it says that an summary should be sent to GP after every OPD apt – but this isn't in the recommendations?
· Page 6 – mentions shared clinic code – small issue - but a family probably would not know what that meant?
· Page 7 – top of the page a review was planned for June 2013 – should an appointment have been made for the patient at the time?
· Page 7 - second para – did the consultant secretary actually get the CT report? What did they say?
· Page 7 - second para – there was no note in the clinical record but we get any additional info from the PACs system for example
· Page 7 – second para – what did the CT scan find – was their disease progression at that point? If yes – was it the responsibility of the secretary or someone to escalate to another consultant, knowing the patients consultant had left the organisation – or should this be a recommendation?
· Page 9 – conclusions – I don't think we can say that the systems and processes for follow-up appointments were followed? If they had been followed surely the CT would have been seen and this would not have happened?
· Page 10 – recommendations – I think 1 and 2 are fine – but in 3 and 4 we are relying on people to do the right thing which is the weakest safety net – did the team consider anything stronger in terms of making sure this didn't happen again – alerts for unread radiology reports, monitoring of discharge letter performance, etc.
· Page 11 on – recommendations – did the team run the recommendations past those named to check feasibility and timescales?

Let me know what you think and then we can talk to Debbie about how we move this forward

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
Southern HSC Trust

[redacted]

Safety Agency (NPSA) Policy documents on "*Being Open – Communicating Patient Safety Incidents with Patients and their Carers*".(Appendix 2)
http://www.npsa.nhs.uk/site/media/documents/1456_Beingopenpolicy111.pdf

4.0 INVESTIGATION METHODOLOGY

The Team applied the NPSA Root Cause Analysis methodology in order to analyse the care given to Patient 128

Review of Records

The review team analysed the following records associated with the case:

- Medical Notes
- Nursing Notes
- Radiology Reports

The Investigation of Patient Administration System

Review of Relevant Reports, Procedures, Guidelines

- Serious Adverse Incident Report

The review team also considered the following:

http://www.dhsspsni.gov.uk/serviceframeworkforcancerpreventiontreatmentandcarefulldocument.pdf

Northern Ireland Referral Guidance for Suspected Cancer – Red Flag Criteria Issue date: December 2012 Source: NICE Referral Guidelines for Suspected Cancer; 2005 http://publications.nice.org.uk/referral-guidelines-for-suspected-cancer-cg27 http://primarycare.hscni.net/

National Cancer Team (2010) Cancer peer review report-Northern Ireland Cancer Network (2010)

http://www.dhsspsni.gov.uk/transforming-your-care-review-of-hsc-ni-final-report.pdf

http://www.macmillan.org.uk/Documents/AboutUs/Research/Researchandevaluationreports/Macmillan-Census-Report-Northernireland.pdf

National Cancer Peer Review Northern Ireland Cancer Network SEPTEMBER 2010
Portland House Bressenden Place London

http://www.macmillan.org.uk/Documents/AboutUs/Research/Researchandevaluationreports/Macmillan-Census-Report-Northernireland.pdf (2014)
(2014)
http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-070115-publication-of-the.htm (FEB 2015)

http://www.ncsi.org.uk/what-we-are-doing/risk-stratified-pathways-of-care/

http://www.ncsi.org.uk/wp-content/uploads/howtoguide.pdf

http://www.macmillan.org.uk/Aboutus/Healthandsocialcareprofessionals/Macmillansprogrammesandservices/RecoveryPackage/RecoveryPackage.aspx

5.0 DESCRIPTION OF INCIDENT/CASE

On 13th June 2012 Patient 128 presented to ED with central abdominal pain and frank haematuria and was referred to the Haematuria Clinic Daisy Hill Hospital. Patient 128 was

Dr D Corrigan,

Consultant in Public Health Medicine

Public Health Agency

Tower Hill

Armagh

BT61 9DR

24 November 2011

Dear Dr Corrigan,

Thank you for your letter dated 14 November 2011 in relation to Serious Adverse Incident Personal Information redacted by the, and your constructive comments on the subsequent review report. The Trust agrees that you raise a very pertinent issue which should have been listed as a recommendation and subsequent action, namely the requirement for assurance that Consultant medical staff review all diagnostic results as they become available and do not wait until the patient is reviewed at an outpatient appointment, specifically in light of the improving but on-going backlog in outpatient review appointments.

Although this issue was not included as a recommendation or action the Trust has recognised the need for the above assurance and ~~or~~ a Trust protocol and has taken the following actions:

- The current practice of Consultant surgical staff in relation to review of diagnostic results has been scoped and this baseline of practice is being widened to all four acute divisions where appropriate.
- Initial scoping indicates that in the main Consultant surgeons are reviewing diagnostics in a timely manner, although variances in how this is being done have been highlighted.

As a result of the above findings and with the added impact of on line results being available for diagnostics, for example via PACS and order comms, it is timely that the Trust

From: Trouton, Heather

Sent: 25 July 2011 15:07

To: Reid, Trudy; Devlin, Louise; Corrigan, Martina

Cc: Mackle, Eamon; Brown, Robin; Sloan, Samantha

Subject: Results

Dear All

I know I have addressed this verbally with you a few months ago , but just to be sure can you please check with your consultants that investigations which are requested, that the results are reviewed as soon as the result is available and that one does not wait until the review appointment to look at them.

Thank you

and families to the Trust and subsequently if required, the ombudsman and the leadership teams via the Risk Register.

37.3 I refer also to my response at paragraph 32.4 in relation to the Acute Clinical Governance Forum which I chaired and was attended by AD's and AMD's which reviewed serious adverse incidents and agreed learning and recommendations, complaints, incidents, regional patient safety guidance, risk registers, medical audit committee work, standards and guidelines and any other business in relation to clinical governance.

37.4 I refer also to my response at question 55 which outlines examples of issues which could affect patient safety being raised with me and how they were escalated and managed.

37.5 Following my review of CSCG in 2010 and the implementation of the findings across the organisation of this review, the introduction of electronic incident reporting and complaints reporting I was satisfied that the Acute Directorate during 2013-2015 had a good system of CSCG. Our level of reporting, review and learning was monitored internally and by the commissioner and at no time were we escalated as an outlier in any area of governance in my recollection. I believed I had clear visibility of what was reported, where and how it was dealt with at a high level, given the size of the Directorate and its span over 3 sites. I believe one indication of this is the detection of an incident review backlog and the plan and implementation to work through this as evidenced at paragraph 40.3. I also believe that the Trust placed significant emphasis on clinical and social care governance at a time 10 years ago, when the culture was post Mid Staffordshire, and was developing and maturing. I refer to paragraph 38.3 in respect of ongoing development.

38. Did those systems or processes change over time? If so, how, by whom and why?

38.1 During my tenure 2010-2013 as Project manager and Assistant Director for CSCG – please see responses to q 5, 32 and 33. I wrote the review of CSCG referred to during this time and implemented the findings after the December 2010 consultation. *Please see:*

Governance coordinator who left her secondment to take up the AD Corporate role). It was this team that escalated the incident review backlog in October 2014, showing their effectiveness and understanding of the system.

39. How did you ensure that you were appraised of any concerns generally within the unit?

39.1 I refer to my responses to questions 32 and 33.

40. How did you ensure that governance systems, including clinical governance, within the unit were adequate? Did you have any concerns that governance issues were not being identified, addressed and escalated as necessary?

40.1 I refer to my responses at paragraph 37.5. I have no evidence to suggest issues were not identified, addressed or escalated as necessary. During my tenure as Director of Acute services I have no recollection of anything not being raised or dealt with, nor have I any evidence of same apart from the issue at paragraph 40.2 below. and the incident review backlog referred to at 40.3. However, the latter was not that incidents weren't being reported, but that the clinical teams had a delay in reviewing and learning from them due to both the new system introduction and the sheer volume of reporting and other work.

40.2 I refer to the email example referred to in response to question 55, dated 26-11-2013 in which I was not included. This email indicates that the clinical managers and Assistant Director had not involved the Medical Director in an issue relating to Mr O'Brien keeping notes at home, as I had asked, and they did not wish to do so at this time. I have no recollection of these email interactions, nor do I recollect if I was made aware that my instructions were not followed. I have no recollection of what follow up to these issues took place. No further email documentation was provided to me.

40.3 I also note from reviewing Tracey Boyce's evidence to the Inquiry, that an issue was raised in 2014 relating to a significant number of Datix being unopened. This issue was first flagged to me at the October 2014

Executive Summary

The Southern Trust was formed in 2007, and management structures have remained largely unchanged since then. With the approval of the Trust Board, the Senior Management Team met in February 2014 to consider the challenges facing the organisation, the business changes over the past seven years and the known future challenges to our core business, and to consider any key organisational changes needed to ensure the Southern Trust remained and developed as a 'fit for purpose' organisation.

Subsequent to this initial review by SMT, a number of follow up meetings were held by SMT and within individual Directorates resulting in an interim paper being circulated within Directorates at the beginning of April 2014. Feedback from these discussions indicated that the following changes were required within the Directorate structure to meet the original aims of the review.

- Creation of an Executive Director of Nursing, Allied Health Professions with an operation management role for Dementia Services

- Further re-balancing of Directorate responsibilities to achieve a more even distribution of workload and create management capacity for service areas subject to significant strategic change and development

    - Creation of a Children & Woman's Directorate for an interim period of 2 years
    - GP Out of Hours to the Directorate of Mental Health & Disability
    - Contract Monitoring to the Directorate of Finance & Procurement
    - Estate Services to the Director of Human Resources & Organisational Development

- To increase the capacity within clinical and social care governance by the appointment of a full time Assistant Director for Clinical & Social Care Governance, and to stabilise the C&SCG management arrangement in the Acute Directorate.

- Development of an Integrated Quality Framework, led by the Director of Performance and Reform, to better co-ordinate and focus the systems with the Trust to drive and achieve quality improvement

This paper outlines the rationale behind these proposals.

Acute Services Directorate – Management review Consultation

Aim

The purpose of this paper is to set out the proposals for the revised Acute Services Directorate Management Structure for the purposes of consulting internally with the Directorate managers and key stakeholders.

Proposed structure

The organisation structure chart in Appendix 1 shows how it is proposed that the work of the Acute Services Directorate will be divided between Directorate and Divisional/operational duties and how these various activities will be managed.

The Acute Senior Management Team will comprise the Director of Acute Services and 5 Divisional (operational) ADs and 3 Directorate (strategic) ADs with limited operational portfolios. The team will be supported by an aligned ADHR and an aligned Finance manager.

The 3 Directorate ADs will be as follows:-

- The **AD of Nursing and Patient Experience** will provide professional guidance, advice, expertise and assurance in relation to the Directorate's achievement against agreed standards for quality and care and the competence of the nursing workforce. The role will be separate and distinct from the 2 Trust wide professional ADs of Nursing in that the Directorate AD of Nursing and Patient Experience will be essentially strategic with regard to service developments within the Acute Services Directorate. The AD of Nursing and Patient Experience will facilitate action to devise and implement the appropriate change strategies necessary to increase quality, access, and value in a patient-centred environment. This will include the creation and adoption of innovative patient-centred care models. The role will have the operational responsibility for AHPs, Patient Flow and Patient Support services which includes Chaplains. The AD of Nursing and Patient Experience will also have overall responsibility all the aspects of change management associated with the roll out and embedding of E-Rostering across the Directorate. Ultimately it is envisaged that the role will also assume operational responsibility for Domestic and Catering services, however these will remain under the operational management of the AD with responsibility for Functional Support Services (FSS) until such time as the existing FSS management structure has been reviewed and strengthened. It has been agreed that the existing AD for Surgery and Elective Care will move into this role thereby leaving a vacant operational AD post.
  The proposed management structure to support this role is attached as Appendix 2

- The **AD of Governance** will undertake a co-ordinating and lead role in relation to supporting and providing challenge at a corporate level. It is agreed that the current Director of Pharmacy will assume this role and that this will be supported by the existing Governance team and 3 band 7 Risk Nurse/Midwife posts who will report directly to the operational ADs who will retain the operational responsibility for the delivery of the Governance agenda within their own Division. In order to reflect the

Stinson, Emma M

From:	Stinson, Emma M [redacted]
Sent:	03 October 2014 16:07
To:	Boyce, Tracey; Walker, Helen; Carroll, Anita; Carroll, Ronan; Conway, Barry; Gibson, Simon; McVey, Anne; Trouton, Heather; Burke, Mary; Carroll, Kay; Corrigan, Martina; Devlin, Louise; Donaldson, Ruth; Forde, Helen; Magee, Brian; McGeough, Mary; McGoldrick, Kathleen; McIlroy, Cathie; McLoughlin, Sandra; McStay, Patricia; Murray, Eileen; Nelson, Amie; Reddick, Fiona; Reid, Trudy; Robinson, Jeanette; Hall, Stephen; Hogan, Martina; Mackle, Eamon; McAllister, Charlie; Murphy, Philip; OReilly, Seamus
Cc:	Livingston, Laura; Marshall, Margaret; Conlon, Noeleen; Graham, Michelle; Lappin, Aideen; Murphy, Jane S; Beattie, Pauline; Lindsay, Gail; McVeigh, Elizabeth; Renney, Cathy; Slaine, Delma
Subject:	*For Information* Governance Team Realignments
Attachments:	image001.png; image002.png; image005.jpg

Dear all

From 1st October 2014 the following changes in line management arrangements within the Governance Team will be implemented:

The Acute Directorate Governance Team will be co-ordinated by Dr Tracey Boyce and Mrs Connie Connolly and Mr Paul Smith will join this team. The teams key areas of responsibility will continue to support the Directorate in the management, investigation and learning from complaints and incidents. This Team will also continue to support the Directorate with respect to directorate risk registers.

Anne Quinn and Paula Fearon will join the Patient Safety and Quality Team from the 1st October 2014. The team will provide outreach support to the Directorate in the following key areas: implementation of standards and guidelines, equipment management, level 2 and 3 SAI investigations and support required for RQIA reviews. This team will report to the Interim Assistant Director of Clinical and Social Care Governance.

In the coming weeks the teams will be engaging with Assistant Directors, AMDs and Heads of Services to seek feedback in order to ensure that their teams are effectively supporting the Directorate with regard to their areas of responsibility.

Margaret Marshall will conclude her secondment as Clinical and Social Care Governance Coordinator in the Acute Directorate from the 1st October 2014.

Please disseminate through your teams as appropriate.

Many Thanks
Emma

Emma Stinson
PA to Mrs Deborah Burns
Interim Director of Acute Services

were those concerns and with whom did you raise them and what, if anything, was done?

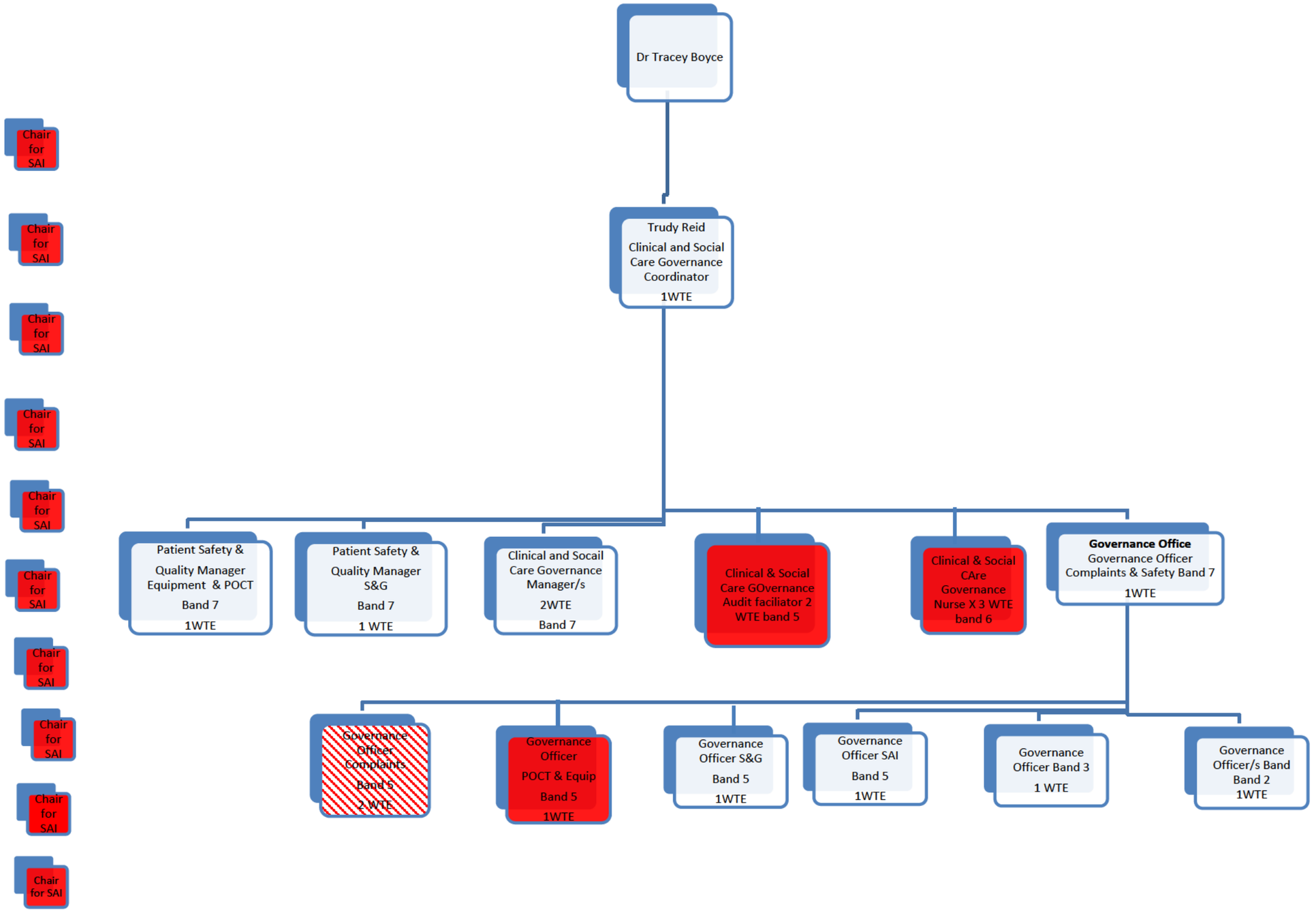
43.1 Overall, in my opinion, the governance arrangements in the Acute Directorate where not fit for purpose. This was because the Acute Governance team was chronically under resourced for the size of the tasks expected of them.

43.2 The clinical staff also did not have protected time for governance activities. When they were under severe patient flow/bed pressures, as often experienced in the Southern Trust Acute Service, the governance activity had to be put on hold.

43.4 When I was asked to look after the Acute Governance team for a period of time in October 2014 I realised that there was a back a backlog of unopened incident reports on Datix *(Attachment 32).* This backlog had not been escalated before and was unknown to the Director (Debbie Burns). These incidents, once reviewed, led to a backlog of SAI reviews.

43.5 The fact that the Governance Lead post had been given up as a saving in 2014 also demonstrated a lack of understanding of the importance of good clinical governance in my opinion. It was impossible for me to take on the full role of the governance lead on top of my substantive post as the Director of Pharmacy. As my registration as a pharmacist could have been at risk if I did not ensure the safe running of the pharmacy service, the best I could do was to offer every Tuesday morning in my diary to assist the members of the Acute Governance team as best as I could.

43.6 The two Band 7 governance officers on the team at the time were very inexperienced as they had been redeployed at short notice after the lead nurse role was stood down at that time too. I had to identify training for them to try to get them up to speed with incident investigation and report writing skills as quickly as possible.



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?

13.1 I have no recollection of involvement in the Regional review of Urology in 2010. As referred to at paragraph 9.3, I see from minutes of a meeting regarding Urology services within the Trust in December 2009 that I had attended. Unfortunately, I have no recollection of this or the work coming from this meeting.

14. As far as you are aware, were the issues raised by the *Implementation Plan* reflected in any Trust governance documents or minutes of meetings, and/or the Risk Register? Whose role was to ensure this happened? If the issues were not so reflected, can you explain why? Please provide any documents referred to in your answer.

14.1 I have no recollection of this issue being raised through governance channels in 2010. I was not holding a governance role at that time. I am not aware who was responsible for adding this issue to the Risk Register, or if it was reflected in the Risk Register. I believe as this was a service risk then the Director of Acute services at the time would have been responsible for reporting in their Directorate Risk Register. However, prior to reviewing the CSCG arrangements within the Trust during late 2010 and redefining them as AD CSCG I cannot be certain who was responsible for recording and reporting this risk.

15. To your knowledge, were the issues noted in the *Regional Review of Urology Services, Team South Implementation Plan* resolved satisfactorily or did problems persist following the setting up of the urology unit?

15.1 From reviewing email documentation from August – November 2013 and December 2014, (*please see attachments 18 - 25*), during my tenure as Director of Acute Services, it would appear problems persisted, and that the commissioner was aware of these issues including:

Southern Health and Social Care Trust

Quality care – for you, with you

REPORT SUMMARY SHEET

Meeting: **Date:**	Trust Board 26 March 2014
Title:	Monthly Performance Management Report
Lead Director:	Paula Clarke, Director of Performance and Reform
Corporate Objective:	• Provide safe high quality care • Maximise independence and choice for our patient and clients • Support people and communities to live healthy lives and to improve their health and wellbeing. • Make best use of resources.
Purpose:	For Approval

Summary of Key Issues for Trust Board

High level context:

This report reviews performance at the end of February 2014 against the Commissioning Plan standards and targets and provides an assessment of current performance.

The report highlights a number of areas of risk predominantly with respect to elective access standards.

Key issues/risks for discussion:

- **Elective Access** – The Trust continues to work to maintain and improve, where necessary, the end of September access positions (9-weeks/13-weeks with maximum backstops of 15-weeks/26-weeks). In order to achieve/sustain these access standards at the end of March 2014 the Trust requires non-recurrent funding for both in-house additionality and independent sector provision.

  Whilst HSCB have now confirmed non-recurrent allocations for Q3/4 the allocation of funding is not sufficient to meet the totality of the capacity gap. An estimated end of March position is detailed in Appendix 2 and details both the full-year performance against the funded SBA along with the estimated end of year access position.

  Whilst the non-recurrent allocation is not sufficient to meet the totality of the capacity gap the Trust will continue to work to ensure the maximum number of specialty areas are maintained within the regional backstop positions.
  Key performance risks still remain, relating to a number of common factors:

  - Recurrent investment has not yet been completed nor embedded in our systems to allow teams to routinely achieve the required level of performance. This means that teams are continuing to seek to maintain an additional level of

Southern Health and Social Care Trust

Quality Care - for you, with you

PERFORMANCE MANAGEMENT REPORT

COMMISSIONING PLAN STANDARDS/TARGETS FOR 2013/2014

INCLUDING INDICATORS OF PERFORMANCE

March 2014 Report for

February 2014 Performance

CP 4: CANCER CARE SERVICES: Lead Director – Mrs Deborah Burns, Director of Acute Services

From April 2013, ensure that 95% of patients urgently referred with a suspected cancer begin their first definitive treatment within 62-days (from date of referral). (No change envisaged in 2014/2015 CP draft targets)

Baseline: 97.73% (cumulative April 2012 – January 2013)
TDP Assessment: Likely to be achieved with some delay/partially achieved

Standard: 95%

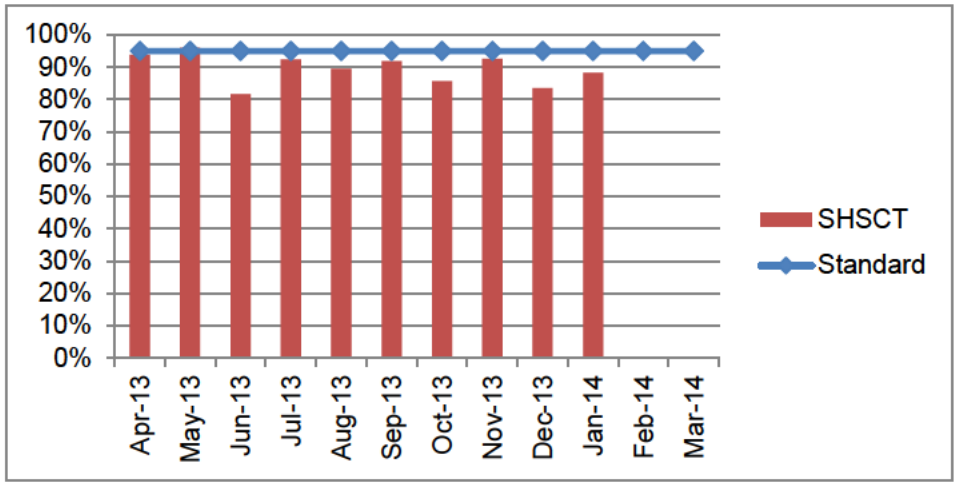
Comments: Reporting two months in arrears against the 62-day standard.

Performance against the 62-day standard is based on completed waits ie. those patients that have had their cancer confirmed and who have received their first definitive treatment. In January (88.24%) performance has improved in comparison to December (83.52%) with 7 patients in excess of the 62 day target; 3 internal patients (1 Urology; 1 Haematology; 1 Lung) and 4 external (2 Lung; 1 Head and Neck; 1 Lower GI).

Cumulative performance at the end of January demonstrates Regional position of 82% with SHSCT performance at 89%. Performance across the 5 Trusts ranges from 77% (SEHSCT) to 91% (WHSCT).

HSCB continue to focus on those patients still in the cancer pathway to ensure no actively waiting patient is waiting in excess of day 85 (D85). At the end of January 2 patients (both Urology) were in excess of 85-days with 7 in excess of 85-days at the end of February.

Urology medical manpower issues continue to impact on performance and whilst the Trust has been successful in recruiting a replacement 5th Consultant post the loss of middle grade staff and GPwSI continues to impact.



Monthly Position:												Monthly Assess	Trend
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
93.75%	95.96%	81.58%	92.39%	89.53%	91.89%	85.71%	92.63%	83.52%	88.24%			A	↑

CP 9: ELECTIVE CARE – IN-PATIENTS AND DAY CASES: Lead Director – Mrs Deborah Burns, Director of Acute Services

From April 2013, at least 70% of in-patients and day cases are treated within 13-weeks with no-one waiting longer than 30-weeks, increasing to 80% by March 2014, and no patient waits longer than 26-weeks for treatment (No change envisaged in 2014/2015 CP draft targets)

Baseline: 67.2% (<13-weeks @ 31 March 2013)
172 (>30-weeks @ 31 March 2013)

TDP Assessment: Achievable dependent upon additional funding

Target: 70% <13-weeks and 0 >30-weeks; rising to 80% <13-weeks and 0 >26-weeks

Comment/Actions:

Performance in February has remained fairly static at 70.9% in comparison to 71.4% at the end of January. The number of patients waiting in excess of the 26-week backstop has slightly increased 263 in comparison to 237 at the end of January.

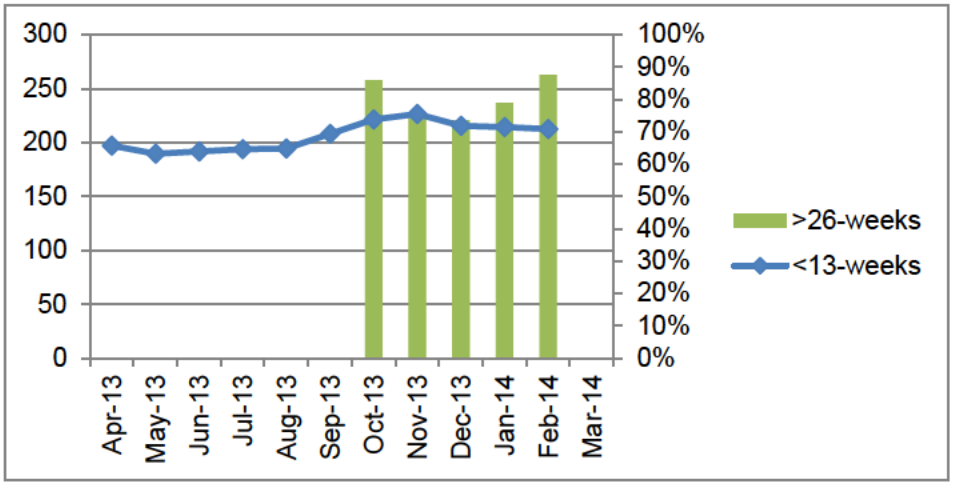
Performance at the end of January demonstrates a Regional position of 64% of patients waiting less than 13-weeks. Regionally the total number of patients waiting in excess of 13-weeks was 17,391 with the SHSCT equating to 1,765 (10%) of this. The volume of patients in excess of 13-weeks ranges across the 5 Trusts from 777 (SEHSCT) to 11,300 (BHSCT).

Regionally the total number of patients waiting in excess of 26-weeks was 5,322 with the SHSCT equating to 237 (4%) of this. The volume of patients in excess of 26-weeks ranges across the 5 Trusts from 149 (SEHSCT) to 3,905 (BHSCT).

In respect of patients waiting in excess of 13-weeks there is a total of 1770 patients. 219 of these relate to specialty areas that require to achieve 13-weeks by March 2014, whilst the remaining 1551 relate to specialty areas where the backstop target has been agreed as a maximum of 26-weeks. Specialties which did not achieve 13-weeks but achieved the 26 week backstop include: Breast Surgery; ENT; Gynaecology; Community Dentistry; Ophthalmology; Gastroenterology; Neurology.

At the end of January the following specialties were in excess of the maximum 26-week backstop:

- General Surgery – 14 patients – longest wait 33-weeks
- Urology – 220 patients – longest wait 64-weeks
- Cardiology – 2 patients – longest wait 41-weeks
- Pain Management – 8 patients – longest wait 28-weeks (under validation)
- Rheumatology – 8 patients – longest wait 30-weeks (under validation)
- Orthopaedics – 6 patients – longest wait 34-weeks (under validation)



Specialty (Required Access Standard / Backstop)	SBA Projected Performance @ March 2014	Estimated Access Time @ March 2014
Colposcopy (9-weeks)	**R (-24% = 377)** **SBA is set higher than the demand, therefore, SBA not achievable**	2 weeks and 4 weeks – only 77 patients on total waiting list (40 booked; 37 not booked)
Fertility (9-weeks)	**G (-2.4% = 3)**	9-weeks
Urodynamics (9-weeks)	**G (-1% = 4)**	9-weeks – risk into April due to staffing cover
Ophthalmology (15-weeks)	**VISITING SERVICE** **R (-16% = 595)**	**VISITING SERVICE** - 24-weeks
Paediatric Cardiology (15-weeks)	**VISITING SERVICE** **R (-32.3% = 56)**	**VISITING SERVICE** - 15-weeks if 35 patients transferred to IS under BHSCT contract accept transfer
Paediatrics (9-weeks)	**G (+5.47% = 142)**	>9-weeks <15-weeks – work on-going to secure capacity for remaining 64 unbooked patients – risk remains as outside of reasonable offer
Pain Management (9-weeks)	**G (+1% = 12)**	13-weeks (122 patients in excess of 9-weeks)
Rheumatology (15-weeks)	**G (+8% = 111)**	15-weeks
Thoracic Medicine (9-weeks)	**G (-4% = 69)**	15-weeks (128 patients in excess of 9-weeks)
T&O (13-weeks)	**G (+3% = 56)**	13-weeks
Urology (9-weeks)	**R (-15% = 1312)** **SBA underperformance on-going in 2013/2014 associated with significant loss of medical staff capacity associated with sick leave and vacancies at Middle Grade; GPwSI; and Consultant levels**	29-weeks (376 patients in excess of 15-weeks)
Haematology (9-weeks)	**G (+3% = 12)**	9-weeks

Stinson, Emma M

From: Trouton, Heather [redacted]
Sent: 21 August 2013 10:20
To: Beth Malloy [redacted]
Cc: Leeman, Lesley; Burns, Deborah; Lappin, Lynn; Corrigan, Martina
Subject: Urology plan
Attachments: Urology Review Recommendations Progress August 2013.doc

Dear Beth

Following your recent conversations with Lesley re our plan to address the deficit in our Urology SBA due to numerous medical vacancies, please see the following outline of our plan for your consideration prior to our meeting on 9th September.

Please also see attached the update on the Urology Review recommendations as requested.

Current and on- going vacancies within the service causing the deficit in SBA

Staffing Gap
1 substantive consultant
3 specialty doctors
1 GP with Specialist Interest
2 Specialist nurses

Actions already taken to address the vacancies

· We have appointed a locum urologist, however his productivity would not be as you would expect from a permanent Urologist.
· We have advertised 4 times since November for the middle grade doctors with no success. We have tried every title and have gone out to Europe and beyond.
· We have scouted for a replacement GPwSI but we are reliably advised there are no further GP's with the specialist skills in Urology out there.
· We have not appointed 2 more specialist nurses as their activity to contribute to seeing patients is curtailed by the lack of medical support. While the specialist nurse can undertake certain procedures and investigations , they need to work alongside a medic for the full diagnosis. However it will be worthwhile to increase by a further band 7 specialist nurse with the proposed model. The funding for these 2 posts has been used to fund out of hours locum cover to cover the specialty doctor gaps, supplementing the funding for the specialty doctor vacancy as locum cover comes at a premium.

Overarching plan to address deficit.

· We have now successfully recruited a substantive Urologist from England who will commence in October 2013. This will however leave the remaining gap at ICATS and middle grade level with the associate gap in core outpatient and day case activity that this service and the middle grades produce.
· To address this on an interim basis , Mr Brown our General Surgeon with an interest in Urology has agreed to move sessions from General Surgery to the urology service to undertake some outpatient and day case work displaced from the GPwSI and middle grade staff in line with his experience.

37.-38. 20150429 E with Slides for Regional Urology Mtg, A1
39.-40. 20150430 E with Slides for Regional Urology Mtg, A1
41.-44. 20150520 Papers for Urology Planning and Implementation Group, A1-A3
45.-46. 20150616 Agenda for Urology Planning and Implementation Group, A1
47. 20150622 E Concerns from AOB re Uro Planning and Implementation Group

d) I have reviewed email correspondence between myself, the urology consultant team and specifically Mr Mark Haynes which show that by 2014/2015, after the team grew to 6 consultants and changed to a team job plan, they were making progress in service reform to meet actual demand, specifically implementing new clinics and service design changes, but the backlog issues in outpatients and inpatient and day cases remained an issue of which the HSCB was aware, and which required a separate solution. *Please see:*

37.-38. *20150429 E with Slides for Regional Urology Mtg, A1*
39.-40. 20150430 E with Slides for Regional Urology Mtg, A1

15.2 I have only been able to produce the above detail in relation to urology due to email evidence made available. However, this evidence corroborates my general recollection of excessive demand and limited capacity across all Acute directorate specialties. Staffing issues at Consultant level improved mid 2014, however other vacancies at middle tier and nurse level persisted as described at 16.2.

16. Do you think the urology unit was adequately staffed and properly resourced during your tenure? If that is not your view, can you please expand noting the deficiencies as you saw them?

16.1 I refer to paragraphs 15.1-15.2, I am aware from email evidence recruitment, retention and therefore capacity and delivery remained an issue.

16.2 In January 2014 after constant advertising, we had 2 successful consultant candidates for one job – Mark Haynes and another consultant. I successfully lobbied Dean Sullivan and HSCB with the CEO to have both

Southern Health and Social Care Trust

Meeting re Urology Service

Tuesday 1 December 2009

Action Notes

Present:
Mrs Mairead McAlinden, Acting Chief Executive
Dr Patrick Loughran, Medical Director
Mr Eamon Mackle, AMD – Surgery & Elective Care
Mrs Paula Clarke, Acting Director of Performance & Reform
Mrs Deborah Burns, Assistant Director of Performance
Mrs Heather Trouton, Acting Assistant Director of Acute Services (S&E Care)
Dr Gillian Rankin, Interim Director of Acute Services

1. **Demand & Capacity**
   Service model not yet agreed, outpatients and day patients not finalised, no confidence that this will be finalised. Theatre lists not currently optimised and recent reduction in number of flexible cystoscopies per list. Recent indication that availability for lists in December 2009 will be reduced.

   Action
   - Sarah Tedford to be requested to benchmark service with UK recognised centres regarding numbers, casemix, throughput (eg cystoscopies per list). **Action – urgent within 1 week.**

   - Team/individual job plans to be drafted – Debbie Burns/Mr Mackle/Zoe Parks, for approval at meeting on 11 December 2009. To be sent to consultants and a meeting to be held within a week with consultants, Mr Mackle, Heather Trouton and Dr Rankin.

2. **<u>Quality & Safety</u>**

   <u>Key Issues</u>:-

   1. Evidence-base for current practice of IV antibiotics for up to 7 days repeated regularly requires urgent validation. Current cohort of 38 patients even though this clinical practice appeared to change after commitment given to Dr Loughran at end July 2009.

Interview with Debbie Burns
currently, Director of Care and Quality Governance, NI Hospice.

5Th June 2019 @ 08.30 in Northern Ireland Hospice, Somerton Road, Belfast.

PRESENT: Dr JR Johnston (JRJ)

Trudy Reid scheduled to be present but unavoidably unable to attend at short notice.

Debbie held post of Director of Acute Services, CAH from April 2013 – August 2015.

I indicated this interview was confined to the issue of triaging GP referrals to the Urology Service, CAH. I would not and did not wish to venture into any other issues relating to personnel in the Urology Service, CAH.

Q. *JRJ - Importance of triaging cancer referrals from GPs – especially from patient's perspective?*
A. "Vital". Patients are often anxious and depend on the system to work, dealing with diagnosis and treatment in a timely fashion.

Q. *Where does triaging rank in importance (for patients) when comparing it to other medical staff issues i.e. probity, health, performance, patient experience?*
A. "Very significant". Very high up the list in terms of importance.

Q. *What system did you inherit? Who did not triage?*
A. When Debbie was responsible for this area, Urology was ~~very much~~ an outlier~~, a "Maverick Team"~~.
Urology had poor cancer performance data. Their cancer targets were a main issue and triaging was part of this.

However, there were mitigations; they were short of staff; on call was an issue.

AO'B was the most consistent offender. He did the work in HIS own time.
MY 'covered' for him and the delays or non-performance of triaging.
EM & MY couldn't really tackle AO'B.

Q. *Why was there a problem for so long?*
A. EM & MY unable to really deal with AO'B and this problem; they did not have good working relationship.
DB then tackled issue.
DB felt AO'B was difficult to manage, with fellow clinicians finding it particularly difficult.
However, she met with AO'B – colourful language. Following discussions, DB indicated that AO'B had to stop triaging. This was at the time NICAN guidelines were issued which AO'B had done a lot of work for, chairing for Urology. Used this as a covering excuse which AO'B thanked her for – saving face.

practice and for motivation to continue to meet significant demand across all specialties with limited resources.

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 From email evidence I can see there are, as I would expect, references to informal meetings with urology staff and management. As Director for many divisions and specialties I operated an open-door policy during my tenure. As such many staff would have asked for and held informal meetings with me. I have no individual recollections of specific meetings and am relying on documentation in this regard. For example, there is an email from myself to various clinical and managerial colleagues indicating I had met Mr Aidan O'Brien with the Head of Service for Urology, Martina Corrigan on 20-02-14. I have a vague recollection of this meeting but cannot recall the details. The email states I offered Mr O'Brien additional administrative support, and that he agreed not to triage new referrals with the exception of those named to him. I would rely entirely on documentary evidence such as these emails to prompt any other recollection.

30.2 I refer also to my response to question 28 in respect of meetings held with Urology staff and management.

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 I would say yes as I have no strong recollection of medical and professional managers in Urology not working well together, nor have I seen any documentation to suggest this was the case. My overall recollection of 2013-2015 was of an entire Acute Directorate working well, in complex and difficult circumstances. I have no specific memory or recollection of any one specialty standing out as having had particular issues with working relations.

Willis, Lisa

From: Brown, Robin
Sent: 30 November 2013 14:00
To: Young, Michael; Trouton, Heather
Cc: Corrigan, Martina; Carroll, Anita
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE
Attachments: image001.png

Follow Up Flag: Follow up
Flag Status: Flagged

Heather
I wonder if could you call me on the phone to discuss this I had a lengthy one-to-one meeting with AOB in July on this subject and I talked to him again on the phone about it week before last.
I agree that we are not making a lot of headway, but at the same time I do recognise that he devotes every wakeful hour to his work – and is still way behind.
Perhaps some of us – maybe Michael Aidan and I could meet and agree a way forward.
Aidan is an excellent surgeon and I'd be more than happy to be his patient (that could be sooner than I hope!), so I would prefer the approach to be "How can we help".

Robin

From: Young, Michael
Sent: 26 November 2013 12:35
To: Trouton, Heather; Brown, Robin
Cc: Corrigan, Martina; Carroll, Anita
Subject: RE: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Understand
I will speak

From: Trouton, Heather
Sent: 26 November 2013 11:40
To: Young, Michael; Brown, Robin
Cc: Corrigan, Martina; Carroll, Anita
Subject: FW: **URGENT NEEDING A RESPONSE**** MISSING TRIAGE

Dear Both

In confidence please see below.

I personally have spoken to Mr O'Brien about this practice on various occasions and Martina has also much more often. While we very much appreciate Aidan's response, I suspect that without further intervention by his senior colleagues it will happen again.

I also spoke to him not more than 4 weeks ago both about timely triage and having charts at home and he promised me he would deal with both, however we find today that patients are still with him not triaged from August , he would have known that at the time of our conversation yet no action was taken. I am also advised today that a further IR1 form has been lodged by health records as 6 charts cannot be found.

As stated by Aidan we have been very patient and have offered any help in the past with regard to systems and processes to assist Aidan with this task but it has not been taken up and the delays continue.

Urology Cancer Analysis

Introduction

The following document describes the urology cancer performance against the required 62 day pathway for patients who are referred in as a RF by their GP or the GP referral is upgraded to RF by consultant following triage

Background

Since October 2006 the Cancer Services Team have been tracking pathway and time lines for suspect cancer referrals and newly diagnosed cancer patients in the Trust.

- By March 2009 95% of GP suspected cancer referrals to be diagnosed and commence treatment within 62 days –
- By March 2008 98% of patients diagnosed with cancer should begin treatment within 31 days of the decision to treat date.

It is accepted 62day cancer pathways are challenging as there are many steps in the pathway, each with distinct time limits.

Through the NICaN urology tumour group pathways have been agreed for prostate, renal, testicular and bladder cancers. A pathway can be split into the following sections:

1. Triage of referral – 0-2 days
2. 1st outpatient appointment – D0-D10
3. Diagnostic tests – D10- D20
4. Multi-disciplinary meeting – D20-D31
5. 1st Definitive treatment within D62

The following information describes the Urology performance against each step 1-5 (as described above). RF GP or GP referrals upgraded to RF by consultant following triage can be subdivided into two main tumour groups i.e. prostate and haematuria. For the cancer team working with the Urology HoS the challenge centres almost exclusively on haematuria RF patients.

The data and summaries presented herein do not separate out RF prostate and haematuria patients, therefore this is the entire urology RF performance. The information is extracted from Business Objects XI (BOXI) on 'closed' cases only for 62 day urology patients over Oct-Dec 2013

Budget Agreement). Whilst I have a vague recollection of this– I cannot recall the details and have no documentary evidence to confirm.

(e) How did you assure yourself that any systems and agreements that may have been put in place to address concerns were working as anticipated?

49.11 Monthly performance and clinical governance meetings were providing assurance that as each concern arose mitigations as far as possible were being put in place to address, for example, I refer to March 2015 performance reports *please see 82. 20150326 Performance Report a and 83. 20150326 Performance Report b).* As previously indicated concerns and learning through complaint investigation and SAI reviews were ongoing in the Directorate as evidenced by agendas and minutes.

49.12 In relation to the Default Process, as described above, I was not aware of and did not instruct this process to be implemented. It is my view this process would have disadvantaged patients as they did not have the benefit of a Consultant triage which may or may not have reviewed or changed their GP referral priority. I indicated both these issues to Julian Johnston in my interview in 2019. I stopped Mr O'Brien triaging in February 2014 so would not have needed this process. I was not made aware or authorise him to restart triaging nor alerted to any other issues – apart from the email from Fiona Reddick in July 2015 (referenced at paragraph 24.1 (viii) before I went on leave, which indicates he was triaging red flags and this was being tracked. I did not pick this up in July 2015.

49.13 I did not receive any evidence of issues with triage through performance reports apart from the Cancer 62 day pathway red flag triage issue which was reported by OSL Wendy Clayton in January 2014 and was further analysed by Ronan Carroll in his report of 05-03-2014. This was mitigated by stopping AOB triaging on 20-02-2014. Waiting times for routine outpatients did not flag issues with triage. The only indication of issues I can see relating to the issue was, as referred to in paragraph 55, a flag from a GP to Paula Clarke in March 2015, however Martina Corrigan then confirmed Mr O'Brien was not triaging save for

1.4 My roles and responsibilities in these roles pertaining to the Urology Service are set out in response to questions 7 and 8.

1.5 My role as Director of Acute Services has specific relevance to the Terms of Reference for the Inquiry. In this role I had overall responsibility for both the operational service delivery and the quality and governance of all Acute services and specialities including the urology service.

1.6 During my tenure as Director of Acute Services, there was a significant capacity and demand mismatch within Urology Services. I have commented on this issue in detail in response to questions 15-18 and 49. Staffing was a significant issue at all levels. In 2014 the consultant team grew to 6 consultants which somewhat addressed capacity to meet demand, however issues remained with the significant backlog of cases in outpatient review and inpatient and day cases.

1.7 Furthermore, issues were raised with me in relation to issues with delayed triage (particularly affecting red flag referrals and the 62 day cancer pathway) and patient notes being kept at home by Mr Aidan O'Brien. I refer to my responses to question 55 which details specific occasions these issues were escalated to me, and my and others response to the issues.

1.8 On 20.02.2014, I called a meeting with Mr O'Brien and Martina Corrigan, in order to address the concerns. At this meeting it was agreed Mr O'Brien would cease triaging referrals, save for referrals which specifically named him. (This was for governance reasons, as the patient may have already been known to Mr O'Brien or the GP believed him best placed to deal with the patient). It was my understanding this essentially solved the problem of delayed triage, and specifically of red flag referrals being delayed in the 62 day pathway, as Mr O'Brien was no longer undertaking this. I have referred to this meeting and its outcome in response to questions 24, 49, 52, 57 and 65.

1.9 I have referred to all concerns relating to Urology Services and how these were addressed in more detail in response to question 49.

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 24 February 2014 12:04
To: Burns, Deborah
Subject: RE: Yesterday

Hi Debbie

Had emailed Michael to ask him how we should do this operationally, and also Aidan is not back oncall until 15 March so have a bit of time to talk to the other guys etc…

Thanks

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Telephone: [redacted] (Direct Dial)
Mobile: [redacted]
Email: [redacted]

From: Burns, Deborah
Sent: 24 February 2014 10:34
To: Corrigan, Martina
Subject: FW: Yesterday

Can you discuss asap with Michael - needs in place asap

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

From: Young, Michael
Sent: 22 February 2014 13:01
To: Burns, Deborah
Subject: RE: Yesterday

Get Martina to talk to me on this –
MY

From: Burns, Deborah
Sent: 21 February 2014 19:13
To: Mackle, Eamon; Young, Michael; Corrigan, Martina
Subject: Yesterday

I had a very helpful meeting with Mr O'Brien yesterday (Martina also attended). Mr O'Brien has agreed to not triage new referrals (with exception of those named to himself). He is also to think about if any additional admin support would assist him.

Michael I know this may place an additional burden on the rest of the team but appreciate you accommodating

Following this, DB found AO'B did comply with her requests and that he became more manageable.

DB unaware that AO'B had returned to triaging before she left this post in August 2015.
However, she indicated that Cancer performance figures improved when he was not triaging.

Q. *Questioned about Informal Default Process (IDP) for dealing with non-triaging.*
A. DB not aware of IDP – even though it started during her time i.e. May '14.

Q. *DB's opinion of IDP?*
A. "Completely ridiculous" because would allow a cancer patient who should have been red flagged by their GP to go unchallenged by a Consultant triage process i.e. could have to wait for 11/12.

Q. *Discuss AO'B inability to triage. Why could/did he not do it?*
A. "Eccentric" "Disorganised"
Very good with patients when he was aware and dealing with them but left those who he wasn't aware of on the waiting list and unattended.
"He would NOT allow himself to be organised by others."

Q. *What is the evidence that problem was referred to higher authority?*
A. John Simpson MD at that time; Mairead McAlinden CEO and Roberta Brownlee Chairperson of Board.
JS not good relationship with Acute Sector Consultants.
DB cannot remember if she made JS aware of problem.
DB considered issue dealt with when AO'B taken off triaging i.e. no need to refer 'upwards'.
There were also other issues concerning AO'B which were being dealt with.

Q. *Handover of triaging issue with Ester K.*
A. DB considered issue was dealt with, so no need to handover.

Q. *Any other information*
A. In 2007, DB (while in previous post in CAH - Assistant Director of Performance and Reform) found a waiting list – 10 years long.
Worked on this with AO'B and cleaned it up; found no serious issues.

Corrigan, Martina

From: Corrigan, Martina [redacted]
Sent: 29 March 2015 14:21
To: Burns, Deborah
Cc: Trouton, Heather
Subject: RE: CB GP Forum issues

Hi Debbie

I will look into this as Aidan hasn't been triaging and I had been advised that he was up-to-date.

It may be a GP letter that he has been sent direct and I will check with his secretary tomorrow and let you know.

Martina

Martina Corrigan
Head of ENT, Urology and Outpatients
Southern Health and Social Care Trust
Craigavon Area Hospital

Telephone: [redacted]
Mobile: [redacted]
Email: [redacted]

From: Burns, Deborah
Sent: 27 March 2015 18:56
To: Corrigan, Martina
Cc: Trouton, Heather
Subject: FW: CB GP Forum issues

Can you update me if issue resolved please

Debbie Burns
Acting Director of Acute Services
SHSCT
[redacted]
Tel: [redacted]

From: Clarke, Paula
Sent: 26 March 2015 18:12
To: Burns, Deborah
Subject: CB GP Forum issues

Deb reference by GP today re referral to urology in Dec that GP chased up this week to be advised this was "still waiting for grading by Dr O'Brien". Left with secretary to come back to him but clearly this is not in line with our triage process/timelines so can you follow up please

Thanks

Paula Clarke
SHSCT Deputy Chief Executive/Director Performance & Reform